Scott&White HEALTH PLAN
part of Baylor Scott & White Health

SMALL EMPLOYER EVIDENCE OF COVERAGE with POINT OF SERVICE BENEFITS

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

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

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

Corporate Office
1206 West Campus Dr.
Temple, Texas 76502
(254) 298-3000
(800) 321-7947

CERTIFICATE OF COVERAGE

In consideration of the completed and accepted Enrollment Application and timely payment of the Required Payments, Scott and White Health Plan agrees to provide or arrange to provide the benefits specified in this Agreement, in accordance with and subject to the terms stated herein and all applicable local, state and federal laws. This Agreement, application, forms and any attachments to them form the entire contract.

In consideration of the Health Plan's Agreement to provide those Health Care Services specified in this Agreement and subject to the terms stated herein, You and the Contract Holder promise to pay all Required Payments when due, abide by all of the terms of this Agreement and comply with all applicable local, state and federal laws.

Important Notices:

1. The initial rates agreed upon by Group and Scott and White Health Plan are effective during the initial year from and after the effective date of this Agreement. Thereafter, Health Plan reserves the right to change rates upon 60 days notice prior to renewal.

2. The coverage provided under this Agreement is health maintenance organization (HMO) coverage with Point of Service (POS) benefits for Out-of-Network services. As an HMO, the Health Plan contracts with only certain providers; therefore, with certain exceptions as explained herein, You and Your Covered Dependents are required to use those providers in order to receive the coverage described at the HMO benefit level. Those providers shall determine the methods used and the form of Treatment to be provided. The Health Plan does not intend that all alternative forms and methods of Treatment will be eligible for coverage. If You or Your Covered Dependents elect to receive Treatment from a non-Health Plan provider, , You may be required to pay the POS benefit level for the Covered Services provided by that non-Participating provider.

3. Scott and White Health Plan is a named fiduciary to review claims under this Agreement. Group delegates to Health Plan the discretion to determine whether You and Your Covered Dependents are entitled to the benefits of this Agreement. In making these determinations, Health Plan has the authority to review claims in accord with the procedures contained herein and to construe this Agreement to determine if You and Your Covered Dependents are entitled to its benefits. If Group is subject to the Employee Retirement Income Security Act, a federal law, this Agreement may be governed by the provisions of that law.

In witness whereof Scott and White Health Plan has caused this Health Care Agreement to be executed as of the Effective Date.

_____

Jeffery C. Ingrum
President and Chief Executive Officer
Scott and White Health Plan
1206 West Campus Dr.
Temple, Texas 76502

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Scott and White Health Plan's toll-free telephone numbers for information or to make a complaint at:

1-800-321-7947

You may also write to Scott and White Health Plan at:

1206 West Campus Dr.
Temple, TX 76502

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

1-800-252-3439

You may write the Texas Department of Insurance

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007
Web: www.tdi.texas.gov
E-Mail: Consumer Protection @tdi.texas.gov

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

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

AVISO IMPORTANTE

Para obtener información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de Scott and White Health Plan's para obtener información o para presentar una queja al:

1-800-321-7947

Usted tambien puede escribir Scott and White Health Plan

1206 West Campus Dr.
Temple, TX 76502

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

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007
Sitio web: www.tdi.texas.gov
E-Mail: Consumer Protection@tdi.texas.gov

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

ADJUNTE ESTE AVISO A SU POLIZA: Este aviso es solo para propósito información y no se convierte en parte o condición del documento adjunto.

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HEALTH CARE EVIDENCE OF COVERAGE

1. DEFINITIONS

The following terms shall have the meaning stated. The various attachments to this Evidence of Coverage may contain additional definitions which pertain to the Health Care Services set forth in this Agreement. Capitalized words are defined terms throughout this Agreement.

1.1 **"Acquired Brain Injury"** means a neurological insult to the brain, which is not hereditary, congenital, or degenerative, in which 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.

1.2 "**Adverse Determination**" means a determination by Health Plan that the Health Care Services furnished or proposed to be furnished to a member are not medically necessary as defined in this Evidence of Coverage or are experimental or investigational.

1.3 "**Age of Ineligibility**" means the age at which dependents are no longer eligible for coverage, subject to the definition of Eligible Dependent. Unless amended by Your Group, Age of Ineligibility will be 26.

1.4 "**Agreement**" means this Scott and White Health Plan evidence of coverage and all attachments and riders herein.

1.5 **"Amino Acid-Based Elemental Formulas"** means complete nutrition formulas designed for individuals who have an immune response to allergens found in whole foods or formulas composed of whole proteins, fats and/or carbohydrates. Amino Acid-Based Elemental Formulas are made from individual (single) nonallergenic amino acids (proteins) broken down to their "elemental level" so that they can be easily absorbed and digested.

1.6 "**Appeal**" is an oral or written request for Health Plan to reverse a previous decision.

1.7 "**Applied Behavior Analysis**" means the design, implementation, and evaluation of systematic environmental changes to produce socially significant change in human behavior through skill acquisition and the reduction of problematic behavior. Applied behavior analysis includes direct observation and measurement of behavior and the identification of functional relations between behavior and the environment. Contextual factors, establishing operations, antecedent stimuli, positive reinforcers, and other consequences are used to produce the desired behavior change.

1.8 **"Autism Spectrum Disorder"** means a neurobiological disorder that includes autism, Asperger's syndrome, or Pervasive Developmental Disorder—Not Otherwise Specified.

1.9 "**Calendar Year**" means the twelve month period from January 1 through December 31.

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

1.11 "**Chemical Dependency Treatment Center**" means a facility which is a Participating Provider and, which provides a program for the Treatment of chemical dependency pursuant to a written Treatment plan approved and monitored by a Participating Physician and which facility is also:

- affiliated with a hospital under a contractual agreement with an established system for patient referral; or
- accredited as a chemical dependency treatment center by the Joint Commission on Accreditation of Health Care Organizations; or
- licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or
- licensed, certified, or approved as a chemical dependency treatment program or center by any other

agency of the State of Texas having legal authority to so license, certify, or approve.

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

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

1.14 "**Coinsurance**" means the percentage, if any, shown in the Point of Service Schedule of Benefits, of the Allowed Amount of Health Care Services for which the You are responsible.

1.15 "**Community Reintegration Services**" means services that facilitate the continuum of care as an affected Member transitions into the community.

1.16 "**Complainant**" means a member, or a physician, provider, or other person designated to act on behalf of a member, who files a complaint.

1.17 "**Complaint**" is any oral or written expression of dissatisfaction with any aspect of Health Plan's operation, including but not limited to dissatisfaction with 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 way a service is provided; or disenrollment decisions expressed by a Complainant. The term does not include a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information. The term does not include dissatisfaction or disagreement with an adverse determination.

1.18 "**Contract Date**" means the date on which coverage for Your Employer's Health Benefit Plan commences.

1.19 "**Contract Holder**" means the person or entity with whom the Health Plan has entered into an agreement to provide health care services. Under this evidence of coverage, the Group is the Contract Holder.

1.20 "**Contract Year**" means that period of time which begins at 12:00 midnight on the Contract Date and ends at 12:00 midnight one year later.

1.21 "**Controlled Substance**" means a toxic inhalant or a substance designated as a controlled substance in the Texas Controlled Substances Act (Chapter 481 of Texas Health and Safety Code).

1.22 "**Copayment**" means the dollar amount or the percentage of the cost of Health Care Services, if any, shown in the Schedule of Benefits payable by the Member to a Participating Hospital, Participating Physician, or Participating Provider, when Health Care Services are obtained from that Participating Hospital, Participating Physician, or Participating Provider.

1.23 "**Covered Dependent**" means a member of Your family who meets the eligibility provisions of this Agreement, whom you have listed on the Enrollment Application, and for whom the Required Payments have been made.

1.24 "**Creditable Coverage**" means any group health coverage or individual health coverage, including services from insurance or a health maintenance organization, that qualifies under regulations implementing the Federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), provided such coverage ended within the sixty-three (63) day period directly preceding the applicant's request to enroll in this Plan.

1.25 "**Custodial Care**" means care designed principally to assist an individual in engaging in the activities of daily living, or services which constitute personal care, such as help in walking and getting in and out of bed;

assistance in bathing, dressing, feeding and using the toilet; preparation of special diets; and supervision of medication, which can usually be self-administered and which does not entail or require the continuing attention of trained medical or other paramedical personnel. Custodial Care is normally, but not necessarily, provided in a nursing home, convalescent home, or rest home or similar institution.

1.26 **"Deductible"** means the dollar amount, if any, shown in the Schedule of Benefits payable by the Member for Health Care Services before benefits under this Agreement will be payable.

1.27 **"Diabetic Equipment"** means blood glucose monitors, including those designed to be used by blind individuals, insulin pumps and associated attachments, insulin infusion devices, and podiatric appliances for the prevention of diabetic complications.

1.28 **"Diabetic Self-Management Training"** means any of the following training or instruction provided by a Participating Physician or Participating Provider following initial diagnosis of diabetes: instruction in the care and management of the condition, nutritional counseling, counseling in the proper use of diabetic equipment and supplies, subsequent training or instruction necessitated by a significant change in the Member's symptoms or condition which impacts the self-management regime, and appropriate periodic or continuing education as warranted by the development of new techniques and treatments for diabetes.

1.29 **"Diabetic Supplies"** means test strips for blood glucose monitors, visual reading and urine test strips, lancets and lancet devices, insulin and insulin analogs, injection aids, syringes for administering insulin, oral agents available with or without a prescription for controlling blood sugar levels, and glucagon emergency kits.

1.30 **"Durable Medical Equipment"** or **"DME"** means equipment that:

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

All requirements of this definition must be met before an item can be considered to be Durable Medical Equipment.

1.31 "**Effective Date**" means the date the coverage for You or Your Covered Dependent actually begins. It may be different from the Eligibility Date or the Contract Date.

1.32 "**Eligible Dependent**" means a member of Your family who falls within one of the following categories:

1. Your legal spouse
2. Your Son or Daughter who is:
    a. Under the Age of Ineligibility; or
    b. if the Age of Ineligibility or older
        i. incapable of self-sustaining employment by reason of physical disability or mental incapacity; and
        ii. chiefly dependent upon You for support and maintenance.
3. Your grandson or granddaughter who is:
    a. A dependent of the Insured for federal tax purposes at the time of application of coverage for the grandchild is made;
    b. Unmarried; and
    c. Under the Age of Ineligibility; or
        i. if the Age of Ineligibility or older
            1. incapable of self-sustaining employment by reason of physical disability or mental incapacity; and
            2. chiefly depend upon You for support and maintenance; and

4. Any child for whom You are obligated to provide health coverage by a Qualified Medical Support Order pursuant to the terms of that order.

1.33 "**Eligible Employee**" means an employee who works on a full-time basis and consistently works at least thirty (30) hours a week. This term may also include a sole proprietor, a partner, or an independent contractor so specified as an employee under the Group's Health Plan. The term does not include:

1. an employee who works on a part-time, temporary, seasonal or substitute basis; or
2. an employee who is covered under:
   - another health benefit plan;
   - a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established according to Employee Retirement Income Security Act of 1974 (29 U. S. C. Section 1001 et seq.);
   - Medicaid; even if the employee elects not to be covered;
   - another federal program such as CHAMPUS or Medicare, even if the employee elects not to be covered; or
   - a benefit plan established in another country, even if the employee elects not to be covered.

1.34 "**Eligibility Date**" means the date the Member satisfies the definition of either Eligible Employee or Dependent and is in a class eligible for coverage under the Health Plan.

1.35 "**Emergency Care**" shall mean Health Care Services provided in a hospital emergency facility, freestanding emergency medical care facility, or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

1. placing his or her health in serious jeopardy;
2. serious impairment to bodily functions;
3. serious dysfunction of any bodily organ or part
4. serious disfigurement;
5. in the case of a pregnant woman, serious jeopardy to the health of the fetus; or
6. in the case of a woman having contractions, there is inadequate time to effect a safe transfer to another hospital before delivery, or if transfer may pose a threat to the health or safety of the woman or the unborn child.

1.36 "**Employer**" means Group.

1.37 "**Enrollment Application**" means any document(s) which must be completed by or on behalf of a person in applying for coverage.

1.38 "**Experimental**" **or** "**Investigational**" means a health care treatment, service, or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service or device but yet not broadly accepted as the prevailing standard of care.

1.39 "**Group**" means Your Employer which is the party contracting with Health Plan to purchase coverage for its employees who become Subscribers on an aggregate basis. Your Employer must pay the applicable Premium Contribution for the plan selected for each Eligible Employee who elects to be covered. No less than the applicable Participating Percentage of the Eligible Employees must be covered. Your Employer must be located within the Service Area. A Group must maintain a Minimum Group Size of at least two Eligible Employees.

1.40 "**Health Benefit Plan**" means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services.

1.41 "**Health Care Services**" means those Medically Necessary services which are included in the Description of Benefits and any amendments or riders thereto, and which are performed, prescribed or authorized by a Physician, Provider or Hospital.

1.42 "**Health Plan**" means Scott and White Health Plan.

1.43 "**Health Professionals**" means those health care professionals, licensed in the State of Texas (or, in the case of Health Care Services rendered on referral, licensed in the State in which that care is provided) who are associated with, or engaged by, directly or indirectly, Health Plan to provide Health Care Services in the Service Area. "Health Professionals" includes a Doctor of Dentistry, a Doctor of Podiatry, a Doctor of Optometry, a Doctor of Chiropractic, a Doctor in Psychology, Acupuncturists, a Licensed Audiologist, a Licensed Speech-Language Pathologist, a Licensed Hearing Aid Fitter and Dispenser, a Licensed Dietitian, a Licensed Master Social Worker-Advanced Clinical Practitioner, a Licensed Professional Counselor or a Licensed Marriage and Family Therapist, and other practitioners of the healing arts as specified in the Texas Insurance Code.

1.44 **"Home Infusion Therapy"** means drug infusion services provided when You or Your Covered Dependent is medically homebound, or when Your home is determined by the Medical Director to be the most appropriate setting for the drug infusion.

1.45 "**Independent Review Organization**" means an organization selected as provided under Texas Insurance Code Chapter 4202.

1.46 "**Individual Treatment Plan**" means a Treatment plan prepared or approved by the Member's Participating Physician with specific attainable goals and objectives appropriate to both the Members and the Treatment modality of the program.

1.47 "**Late Enrollee**" means an employee or Dependent, eligible for enrollment in Health Plan, who requests enrollment in Health Plan after the expiration of the initial enrollment period established under the terms of the first Health Benefit Plan for which that employee or Dependent is eligible through the Employer or after the expiration of an Open Enrollment Period.

1.48 "**Life-Threatening Disease or Condition**" means a disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

1.49 "**Medical Director**" means any Physician designated by the Health Plan who shall have such responsibilities for assuring the continuity, availability and accessibility of Health Care Services as shall be assigned. These responsibilities include, but are not limited to, monitoring the programs of quality assurance, utilization review and peer review; determining Medical Necessity; and determining whether or not a Treatment is Experimental or Investigational.

1.50 "**Medically Necessary**" means those Health Care Services which, in the opinion of Member's Participating Physician or Participating Provider, whose opinions are subject to the review, approval or disapproval, and actions of the Medical Director or the Quality Assurance Committee in their appointed duties, are:

1) essential to preserve the health of Member; and
2) consistent with the symptoms or diagnosis and Treatment of the Member's condition, disease, ailment or injury; and
3) appropriate with regard to standards of good medical practice within the surrounding community; and
4) not solely for the convenience of the Member, Member's Physician, Hospital, or other health care provider; and
5) the most appropriate supply or level of service which can be safely provided to the Member.

1.51 "**Medicare**" means Title XVIII of the Social Security Act, and amendments thereto.

1.52 "**Member**" means You or Your Covered Dependent.

1.53 "**Minimum Group Size**" means the minimum number of Eligible Employees required to be employed by the employer in order to avoid termination of this Agreement. The Minimum Group Size is two Eligible Employees.

1.54 **"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 a Member, a Member's family, or others.

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

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

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

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

1.59 **"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.

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

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

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

1.63 "**Open Enrollment Period**" means the period each calendar year, at the time mutually designated by Health Plan and Group of not less than thirty-one (31) consecutive days which any eligible person who meets the eligibility provisions of this Agreement, including a Late Enrollee, on behalf of himself or his Eligible Dependents, may elect to become enrolled under this Agreement. A completed Enrollment Application form must be received by Health Plan within the open Enrollment Period and all other requirements of this Agreement must be met.

1.64 **"Orthotic Device"** means 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.

1.65 "**Out-of-Pocket Expenses**" means the portion of Covered Services for which a Member is required to pay at the time services and treatments are received. Out-of-Pocket Expenses apply to Covered Services only. Medical services and treatments, which are not covered by this Plan or are not Medically Necessary, are not included in determining Out-of-Pocket Expenses.

1.66 "**Out-of-Pocket Maximum**" means the total dollar amount of Out-of-Pocket Expenses which a Member will be required to pay for Covered Services during a Calendar Year. Out-of-Pocket Maximum is determined for

Covered Services and not for any medical services or treatments which are not Medically Necessary or not covered. The HMO Out-of-Pocket maximum and POS Out-of-Pocket maximum are separate amounts.

1.67 "**Out-of-Pocket Maximum, Family**" means the total amount of Out-of-Pocket Expenses which one family will be required to pay in any one Calendar Year.

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

1.69 "**Participating Hospital**" means an institution licensed by the State of Texas as a hospital which has contracted or arranged with Health Plan to provide Health Care Services to Members and which is listed by Health Plan as a Participating Provider.

1.70 "**Participating Physician**" means anyone licensed to practice medicine in the State of Texas and who has executed a contract with Health Plan to provide Health Care Services.

1.71 "**Participating Provider**" means any person or entity that has contracted, directly or indirectly, with Health Plan to provide Health Care Services to Members. Participating Providers includes but is not limited to: Participating Hospitals, Participating Physicians, Health Professionals, Urgent Care Facilities, and Contracted Pharmacies, within the service area.

1.72 "**Participation Percentage**" means the minimum percentage of total Eligible Employees of Your Employer who must participate in the Health Plan.

1.73 "**Permanent Legal Residence**" means the address at which a Member intends to reside during the Calendar Year. For a student enrolled in an education, trade, or technical school, the Permanent Legal Residence is presumed to be that of the parent with whom the Dependent resided prior to attending school.

1.74 "**POS**" means Point of Service

1.75 "**POS Benefits**" means Health Care Services provided by non-Participating Providers, unless such Health Care Services would otherwise be covered under the HMO Documents.

1.76 **"POS Deductible"** means the dollar amount, if any, shown in the Point of Service Schedule of Benefits payable by You or Your Covered Dependent for Health Care Services before benefits under the POS Rider will be payable.

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

1.78 "**Post-Acute Care Treatment Services**" means services provided after acute care confinement and/or treatment that are based on an assessment of the Member'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 mechanisms.

1.79 "**Postdelivery Care**" means postpartum health care services provided in accordance with accepted maternal and neonatal assessments including, but not limited to, parent education, assistance and training in breast-feeding and bottle-feeding, and the performance of any necessary and appropriate clinical tests.

1.80 "**Premium**" means those periodic amounts required to be paid to Health Plan for or on behalf of a

Subscriber and Dependents, if any, as a condition of coverage under this Agreement.

1.81 "**Premium Contribution**" means the minimum percentage of premium which Your Employer must pay for Your coverage.

1.82 "**Preventive Care Services**" means the following, as further defined and interpreted by appropriate statutory, regulatory, and agency guidance:

1) Evidence-based items or services with an "A" or "B" rating from the U.S. Preventive Services Task Force (USPSTF);
2) Immunizations for routine use in children, adolescents and adults with a recommendation in effect from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
3) Evidence-informed preventive care and screenings for infants, children and adolescents provided in guidelines supported by the Health Resources and Services Administration (HRSA); and
4) Evidence-informed preventive care and screening for women provided in guidelines supported by HRSA and not otherwise addressed by the USPSTF.

1.83 "**Primary Care Physician**" means a Participating Physician specializing in family medicine, community internal medicine, general medicine, geriatrics or pediatrics selected by You or Your Covered Dependent.

1.84 **"Prosthetic Device"** means an artificial device designed to replace, wholly or partly, an internal body organ or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ, or to replace an arm or leg. Prosthetic Devices designed to replace an arm, including the hand, or a leg, including the foot, are described as Limb Prosthetic Devices.

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

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

1.87 "**Qualified Medical Support Order**" means an order issued by a Texas Court or enforceable by a Texas Court which sets forth the responsibility for providing health care coverage for Eligible Dependents.

1.88 "**Quality Assurance Committee**" means a committee or committees used by the Health Plan to establish programs to monitor the appropriateness and effectiveness of the Health Care Services provided for or arranged by the Health Plan, record the outcome of Treatment, and provide a means for peer review.

1.89 **"Remediation"** means the process(es) of restoring or improving a specific function.

1.90 "**Required Payments**" means any payment or payments required of the Group, an applicant for coverage hereunder, or a Member in order to obtain or maintain coverage under this health care Agreement, including application fees, Copayments, subrogation, Premiums, late fees and any other amounts specifically identified as Required Payments under the terms of this Agreement.

1.91 "**Research Institution**" means the institution or other person or entity conducting a phase I, phase II, phase III or phase IV clinical trial

1.92 **"Routine Patient Care Costs"** means the costs of any medically necessary health care service for which benefits are provided under a health benefit plan, without regard to whether You or Your Covered Dependent is participating in a clinical trial. Routine patient care costs do not include:

1) the cost of an investigational new drug or device that is not approved for any indication by the United

States Food and Drug Administration, including a drug or device that is the subject of the clinical trial;
2) the cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in a clinical trial;
3) the cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
4) a cost associated with managing a clinical trial; or
5) the cost of a health care service that is specifically excluded from coverage under this Agreement.

1.93 "**Schedule of Benefits**" means the attachment to this Agreement which describes, among other things, the Copayments, Coinsurance, and other information applicable to Your Health Plan and Health Care Services set forth in the Description of Benefits attachment to this agreement and any amendments or riders thereto.

1.94 "**Service Area**" is that geographic area more fully described in the Scott and White Health Plan Service Areas and Provider Locations attachment to this Agreement, in which Health Plan may offer this Agreement.

1.95 "**Short-term Therapy**" is that therapeutic service, or those therapeutic services, which when applied to a covered injury or illness under this agreement, meet or exceed Treatment goals in accordance with the Individual Treatment Plan.

1.96 "**Son or Daughter**" means
1) a child born to You or Your Legal Spouse; or
2) a child who is Your legally adopted child with legal adoption evidenced by a decree of adoption, who is the object of a lawsuit for adoption and You are a party to such lawsuit; or who has been placed with You for adoption.

1.97 "**Specialty Pharmacy Drug**" means any prescription drug regardless of dosage form, identified as a Specialty Pharmacy Drug on the drug formulary, or a drug which requires at least one of the following in order to provide optimal patient outcomes:
- specialized procurement handling; distribution, or is administered in a specialized fashion;
- complex benefit review to determine coverage;
- complex medical management requiring close monitoring by a physician or clinically trained individual;
- FDA mandated or evidence-based medical-guideline determined comprehensive patient and/or physician education; or
- has any dosage form with a total cost greater than $1,000 per retails maximum day's supply.

1.98 "**Subscriber**" means the Eligible Employee or other person whose employment or other status, except family dependency, is the basis for eligibility under the terms, conditions, and limitations of this Agreement and for or on behalf of whom the Premiums are paid by the Group.

1.99 "**Toxic Inhalant**" means a volatile chemical under the Texas Controlled Substance Act (Chapter 481 of the Texas Health and Safety Code).

1.100 "**Treatment**" **or** "**Treatments**" means services, supplies, drugs, equipment, protocols, procedures, therapies, surgeries and similar terms used to describe ways to treat a health problem or condition.

1.101 "**Urgent Care Facility**" means any licensed Facility that provides physician services for the immediate treatment only of an injury or disease, and which has contracted with the Health Plan to provide Members such services.

1.102 "**Urgent Care**" means services provided for the immediate treatment of a medical condition that requires prompt medical attention but where a brief time lapse before receiving services will not endanger life or

permanent health. Urgent conditions include, but are not limited to, minor sprains, fractures, pain, heat exhaustion, and breathing difficulties other than those of sudden onset and persistent severity. An individual patient's urgent condition may be determined emergent upon evaluation by a Participating Provider.

1.103 **"Usual and Customary"** means the amount based on a percentage of available rates published by Centers for Medicare and Medicaid Services (CMS) or a benchmark developed by CMS for the same or similar services within a geographic area or that have been negotiated with one or more Participating Providers in a geographic area for same or similar services.

1.104 "**Waiting Period**" means the period of time specified by Group, but not longer than 90 days, that must pass before a person becomes eligible for coverage under this Agreement.

1.105 "**You**" means the Subscriber.

1.106 "**Your**" means relating or pertaining to the Subscriber

2. ELIGIBILITY PROVISIONS

2.1 CLASSES OF INDIVIDUALS ELIGIBLE FOR COVERAGE

2.1.1 Eligible Employees

Except for continuation coverage, to be eligible for coverage You must be an Eligible Employee of the Contract Holder.

2.1.2 Eligible Dependents

Except for continuation coverage, to be eligible for coverage as a dependent, a person must apply for coverage and be an Eligible Dependent as defined in the Definitions section of this Agreement.

2.2 GENERAL ELIGIBILITY PROVISIONS

2.2.1 Requirements for Eligibility

To be eligible for coverage under this Agreement, You must:

A. work, live or reside in the Service Area, and

B. Eligible Dependents may reside anywhere in the United States. If a Covered Dependent being covered under a Qualified Medical Support Order resides outside of the Service Area, Health Plan shall not enforce any otherwise applicable provisions which deny, limit, or reduce medical benefits because the child resides outside the Services Area, including, but not limited to, any provision which restricts benefits to Emergency Care only while outside the Service Area. However, Health Plan may utilize an alternative delivery system to provide coverage or provide alternate coverage. If the coverage is not identical to coverage under this Agreement, it shall be at least actuarially equivalent to the coverage Health Plan provides to other Dependent children under this Agreement. Eligible Dependents, not subject to a Qualified Medical Support Order, may be limited to HMO Network restrictions.

2.2.2 Dependent coverage requirement of Subscriber Enrollment

Except for continuation coverage, in order for a dependent to be eligible and remain eligible for coverage hereunder as a dependent, the Subscriber upon whose enrollment the dependent's eligibility is based must enroll and remain enrolled in the Health Plan.

2.3 ENROLLMENT AND EFFECTIVE DATES OF COVERAGE

The Effective Date is the date the coverage for a Member actually begins. It may be different from the Eligibility Date. The following paragraphs describe the operation of the Effective Date and Eligibility Date.

2.3.1 Timely Applications

To enroll in the Health Plan, You and Your Eligible Dependents must make appropriate and timely application, which includes:

1) a completed Enrollment Application which must be received by Health Plan during the enrollment period, and
2) payment of the Premium when due.

IF YOU FAIL TO PAY A REQUIRED PAYMENT WHEN DUE, YOU MAY BE DISENROLLED FROM THE HEALTH PLAN, IN ACCORDANCE WITH THE PROCEDURES SET FORTH IN THIS AGREEMENT.

IF A GROUP FAILS TO PAY A REQUIRED PAYMENT WHEN DUE, THE GROUP (AND ITS ENROLLEES) MAY BE DISENROLLED FROM THE HEALTH PLAN, IN ACCORDANCE WITH THE PROCEDURES SET FORTH IN THIS AGREEMENT.

2.3.2 Coverage Upon Initial Eligibility

If You apply for coverage for Yourself or for Yourself and Your Eligible Dependents, the Effective Date is determined as follows:

1) If You are eligible on the Contract Date and the application is received by the Health Plan prior to or within 31 days following such date, the Effective Date for You and Your Eligible Dependents for whom an application was submitted is the Contract Date;
2) If You and Your Eligible Dependents enrolled during an Open Enrollment Period, the Effective Date is the date mutually agreed to by Group and Health Plan. If there is no such date, the Effective Date is the first day of the calendar month following the end of the Open Enrollment Period.
3) If an Eligible Employee is subject to a Waiting Period, and if application is received within 31 days following the end of the Waiting Period, the Effective Date is the first day of the month following the date the Waiting Period ended.
4) If You become eligible after the Contract Date and if Your application is received by Health Plan within the first 31 days following Your Eligibility Date, Your Effective Date is the first day of the month following the date You satisfy the requirements of this Agreement, unless another date is specified in this Agreement.

2.3.3 Effective Dates – Late Enrollee

If Your application is not received within 31 days from the Eligibility Date, You will be considered a Late Enrollee. If an application for Your Dependent is not received within the time period specified in the appropriate Dependent Special Enrollment Period provision in Section 2.3.6 of this Agreement, Your Dependent will be considered a Late Enrollee. As a Late Enrollee, You or Your Dependent are ineligible for coverage until the next Open Enrollment Period.

2.3.4 Avoidance of Late Enrollee Designation by Loss of Other Health Insurance Coverage

You will not be considered a Late Enrollee, and You will be eligible to apply for coverage under the Health Plan for Yourself and Your Eligible Dependents, if each of the following conditions are met:

1. You are covered under a Health Benefit Plan, self-funded health benefit plan or had other health insurance coverage at the time this coverage was previously offered; and
2. You declined coverage under the Health Plan in writing, on the basis of coverage under another health benefit plan or self-funded health benefit plan;
3. You provide written proof that Your prior health benefit plan or self-funded plan:
    a. Continuation coverage has been exhausted; or
    b. Was terminated as a result of legal separation, divorce, death, termination of employment or a reduction in the number of hours of employment, or employer contributions toward such coverage were terminated; or
    c. Was ended as a result of termination of the other plan's coverage; and
4. You request to enroll no later than 31 days after the date coverage ends under the prior Health Benefit Plan or self-funded health benefit plan. Your Effective Date will be the first day of the month following receipt of the application by the Health Plan.

If all conditions described above are not met, You will be considered a Late Enrollee.

2.3.5 Dependent Special Enrollment Period

2.3.5.1 Newborn Children

Coverage of Your newborn child will be automatic for the first 31 days following the birth of Your child. Required Premium will be calculated from the date of birth of your newborn. For coverage to continue beyond this time, You must notify Your employer within 60 days of birth, complete proper application to add the newborn child and pay any required Premium within that 60-day period or a period consistent with the next billing cycle. With such notice, the Effective Date for Your newborn Child will be the date of birth. If You notify the Health Plan after that 60-day period, Your newborn child will be considered a Late Enrollee.

2.3.5.2 Adopted Children, Children Involved in a Suit for Adoption, and Children Placed for Adoption

Coverage of Your adopted child will be automatic for the first 31 days following the date of adoption, the date You become a party to a lawsuit for adoption or the date the child was placed with You for adoption. For coverage to continue beyond this time, You must notify Your Employer within 60 days of the date the adoption became final, the date You became a party to the lawsuit for adoption, or the date the child was placed with You for adoption, and pay any required Premium within that 60-day period or a period consistent with the next billing cycle. The Effective Date is the date of adoption, the date You became a party to the lawsuit for adoption, or the date the Child was placed with You for adoption. If You notify the Health Plan after that 60-day period, Your adopted child will be considered a Late Enrollee.

2.3.5.3 Court Ordered Dependent Children

If a court has ordered You to provide coverage for a child, written application and the required Premium must be received within 31 days after Your Group receives notice of the court order. The Effective Date will be the day application for coverage is received by the employer or Health Plan and the required premium is received. If You notify the Health Plan after the 31-day period, the Dependent Child will be considered a Late Enrollee.

2.3.5.4 Court Ordered Coverage for a Spouse

If a court has ordered You to provide coverage for a spouse, written enrollment and the required premium must be received within 31 days after issuance of the court order. The Effective Date will be the first day of the month following the date the application for coverage and the required premium is received. If application is not made within the initial 31 days, Your spouse will be considered a Late Enrollee.

2.3.5.5 Loss of Child's Coverage under a Governmental Program

If Your Dependent Child loses coverage under Title XIX of the Social Security Act (Medicaid) or under Chapter 62 of the Texas Health and Safety Code (CHIP), written enrollment and the required premium must be received within 31 days after the date on which coverage was lost. If application is not made within the initial 31 days, the Dependent Child will be considered a Late Enrollee.

2.3.6 Other Dependents

2.3.6.1 Written application must be received within 31 days of the date that a spouse or child first qualifies as an Eligible Dependent. The Effective Date will be the first day of the month following the date the application for coverage is received, so long as the required premium is paid within the 31-day period. If application is not made within the initial 31 days, then Your Dependent will be considered a Late Enrollee.

2.3.6.2 If You ask that Your Dependent be covered after having canceled his or her coverage while Your Dependent was still entitled to coverage, Your Dependent's coverage will become effective in accordance with the provisions for Late Enrollees.

2.3.6.3 In no event will Your Dependent's Effective Date be prior to Your Effective Date.

2.3.7 Employee Special Enrollment Period

2.3.7.1 If You acquire a Dependent through birth, adoption, or through suit or placement for adoption, and You previously declined coverage for reasons other than loss of other coverage, as described above, You may apply for coverage for Yourself, Your spouse, and the newborn child, adopted child, or child involved in a suit or placed for adoption. If the written application is received within 31 days of the birth, adoption, or date on which the suit for adoption was filed or the child was placed with You for adoption, the Effective Date for the child, You and/or Your spouse will be the date of the birth, adoption, placement for adoption or date suit for adoption is sought.

2.3.7.2 If you marry and You previously declined coverage for reasons other than loss of coverage as described above, You may apply for coverage for Yourself and Your spouse. If the written application is received within 31

days of the marriage, the Effective Date for You and Your spouse will be the first day of the month following receipt of the application by the Health Plan.

2.3.7.3 No eligible person who properly enrolls during a period of enrollment shall be refused enrollment because of health status related factors. An eligible person who fails to enroll when first eligible during a period of enrollment is a Late Enrollee.

2.4 ADDITIONAL REQUIREMENTS

2.4.1 The composition of Group and the requirements determining eligibility for membership in Group's health benefit plan as defined in the Group's application and which exists at the Contract Date are material to the execution of this Agreement by Health Plan. During the term of this Agreement, no change in Group's eligibility, contribution, or participation requirements shall be permitted to affect eligibility or enrollment under this Agreement unless such change is agreed to in writing by Health Plan.

2.4.2 It is Your responsibility to inform:

1) Your Group immediately of all changes that affect Your eligibility and that of Your Covered Dependents, including, but not limited to:
   - marriage of a Dependent grandchild, and
   - death;
2) the Health Plan immediately of all changes that affect administration of Your, and Your Covered Dependents, Health Plan benefits, including, but not limited to:
   - address changes.

2.4.3 The Group must inform Health Plan in writing of all enrollments, terminations, or changes as they occur on forms required by Health Plan and provide information necessary to allow Health Plan to comply with its legal obligation with regard to issuing certificates of Creditable Coverage.

2.4.4 No person is eligible to enroll or remain enrolled for coverage under this Agreement in the absence of a valid written contract between Group and Health Plan arranging for coverage under this Agreement.

2.4.5 No person may receive coverage under this Health Plan as both a Subscriber and a Dependent, or as a Subscriber more than once during any enrollment period.

3. PROVIDERS OTHER THAN HEALTH PLAN PROVIDERS

3.1 HEALTH PLAN NOT LIABLE FOR EXPENSES OF PROVIDERS OTHER THAN HEALTH PLAN PROVIDERS

Health Plan will not be liable for services until the Member, in advance, authorizes Health Plan to assume full responsibility for arranging Member's care utilizing Participating Physicians and Participating Providers. Services are not covered under this Agreement until such date that the Health Plan assumes full responsibility for the Member's care except as follows:

- for Emergency Care or services for a Covered Dependent child who lives outside of the Service Area;
- for a Member who is confined in a hospital, which is not a Participating Hospital or under the care of a physician or provider who is not a Participating Provider on the date coverage under this Agreement would otherwise become effective.

Health Plan shall not be required to cover, provide or pay costs of, or otherwise be liable for, services rendered to the extent that such services were rendered prior to the Effective Date of coverage, or if such services would not have been covered under this Agreement.

3.2 CONTRACT STATUS OF PROVIDERS

You should be aware of the contract status of the providers from whom you receive treatment, especially participating hospitals, as some facility-based physicians or other health care practitioners such as neo-natologists, anesthesiologists, pathologists, and radiologists may not be included in Health Plan's network and may balance bill for amounts above the Usual and Customary paid by Health Plan. In order to determine the contract status of providers you may consult the provider manual on the Health Plan website at www.swhp.org, or contact a Health Plan Customer Service Representative at 800-321-7947.

4. TERMINATION OF COVERAGE

4.1 TERMINATION OF COVERAGE FOR MEMBERS

Coverage under this Agreement shall terminate for You and/or Your Covered Dependents as follows:

1. except for continuation privileges, on the date on which You and/or Your Covered Dependents cease to be eligible for coverage in accordance with this Agreement; or
2. thirty-one (31) days after written notice from Health Plan that You have failed to pay any Required Payment when due; or
3. 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, thirty (30) days after written notice from Health Plan; or
4. the date Group coverage terminates.

4.2 TERMINATION OR NON-RENEWAL OF COVERAGE FOR GROUP

This Agreement shall continue in effect for one (1) year from the Effective Date. After that, this Agreement may be renewed annually. This Agreement may be terminated or non-renewed for one or more of the following reasons:

1. Group fails to pay a Required Payment as required by this Agreement;
2. Fraud or intentional misrepresentation of a material fact by Group;
3. Group fails to comply with the terms and conditions of this Agreement;
4. Group fails to meet Minimum Group Size for at least six (6) consecutive months;
5. No Eligible Employees of the Group work, live or reside in the Service Area;
6. Health Plan elects to cease providing coverage to all small employers or large employers in its Service Area;
7. Health Plan elects to discontinue a particular type of coverage; or
8. Group elects to terminate this agreement.

4.3 NOTICE OF TERMINATION OR NON-RENEWAL OF GROUP

If termination or non-renewal is due to reason (1) or (3) above, Health Plan shall give Group thirty (30) days advance written notice, except, if termination is due to Group's failure to meet the required Participation Percentage, termination shall be upon the first renewal date which occurs after Group has failed to maintain the required Participation Percentage for at least six (6) consecutive months. If termination is due to reason (2) above, Health Plan shall give Group at least fifteen (15) days advance written notice. If termination is due to reason (5) above, Health Plan shall give Group at least sixty (60) days advance notice. If termination is due to reason (4) above, termination shall be upon the first day of the next month following the end of the 6 consecutive month period during which the Group failed to maintain the Minimum Group Size. If termination is due to reason (6), Health Plan shall give all affected Groups at least 180 days advance written notice. If termination is due to reason (7), Health Plan shall give Group at least ninety (90) days advance written notice and offer Group the option to purchase other coverage. If termination is due to reason (8), Group shall give Health Plan at least sixty (60) days advance written notice; however, if termination is due to a material change by Health Plan to any provisions required to be disclosed to Group or Members pursuant to State law or regulation which adversely affects benefits or services provided, Group shall give Health Plan at least thirty (30) days advance written notice.

4.4 LIABILITY

Upon termination of coverage as described above, Health Plan shall have no further liability or responsibility under this Agreement except as may be required under the continuation privileges.

5. CONTINUATION OF COVERAGE OPTION

5.1 LOSS OF ELIGIBILITY

Members who lose eligibility under this Agreement may be eligible to continue coverage under this Agreement according to state or federal law. If elected by Group, continuation administrative services will be provided by Health Plan or its designee at no additional expense to Group. Contact the Group for more information if eligibility for membership ends due to the occurrence of one of the following qualifying events:

1. the death of the covered Subscriber;
2. the termination (other than for gross misconduct) or reduction of hours of the Subscriber's employment;
3. the divorce or legal separation of the Subscriber from the Subscriber's spouse;
4. the Subscriber (excluding Dependents who may continue coverage under this Agreement) becomes entitled to benefits under Medicare;
5. a Dependent child ceases to be a Dependent child under the generally applicable requirements of the Group;
6. the Contract Holder commences Chapter 11 bankruptcy proceedings; or
   Group coverage ends for any other reason except involuntary termination for cause and the Member has been covered continuously under the group coverage (including any replacement group coverage) for at least three consecutive months immediately prior to termination.

5.2 COBRA CONTINUATION OF COVERAGE

The Group will provide written notice to each Member enrolled through the Group of the continuation coverage available to Members under the Consolidated Omnibus Budget Reconciliation Act (COBRA). If any Member is granted the right to continue coverage beyond the date when Member's coverage would otherwise terminate, this Health Plan will be deemed to allow continuation of coverage to the extent necessary to comply with COBRA requirements. Member should contact the employer or Group Contract Holder for verification of eligibility and to obtain procedures for obtaining benefits.

5.3 ADDITIONAL CONTINUATION PROVISIONS

Upon completion of any continuation of coverage as provided under COBRA, any Member whose coverage under this Agreement has been terminated for any reason except involuntary termination for cause, and who has been continuously covered under this Agreement or any similar group contract providing similar services and benefits which it replaces for at least three (3) consecutive months immediately prior to termination shall be eligible to continue coverage as follows:

1. Continuation of group coverage must be requested not later than the 60th day following the latter of:
   a. the date the group coverage will terminate; or
   b. the date the Member is given notice of the right of continuation by either the employer or the Contract Holder.
2. A Member electing continuation coverage must pay to the employer or Contract Holder on a monthly basis, in advance, the Premiums, plus 2% of the total health premium when due. The continuation premium must be made not later than the 45th day of the initial election for continuation coverage and on the due date of each payment thereafter. Following the first payment made after the initial election, premium payment is considered timely if made on or before the 30th day after the date on which the premium is due.
3. Continuation coverage will continue until the earliest of:
   a. if Member is not eligible for continuation coverage under COBRA 9 months after the date the election for continuation is made;

b. if Member is eligible for continuation coverage under COBRA, 6 additional months following any period of continuation under COBRA;
c. the date on which failure to make payments would terminate coverage;
d. the date on which the Member is covered for similar services and benefits by another health plan; or
e. the date on which this Agreement terminates as to all Members.

4. If the Subscriber dies, retires or the Subscriber's family relationship with Covered Dependents is otherwise terminated due to "divorce," which term shall include annulment and legal separation for purposes of this Section, and a Covered Dependent loses coverage, the Subscriber's Covered Dependent may continue group coverage pursuant to this Agreement. Continuation coverage will not be conditioned in any way on the Covered Dependent's health status or condition. However, this continuation coverage does not include Covered Dependents who have been covered pursuant to this Agreement for less than one year, except for covered dependent children less than one year of age. The premiums charged for this continuation coverage shall be no more than the premiums charged for all other individuals covered by this Agreement. To elect this continuation coverage, the subscriber, his or her personal representative or the Covered Dependent must notify Group within fifteen (15) days of the Subscriber's death, retirement or divorce. Upon receipt of such notice, the Group will immediately give written notice to each affected Covered Dependent. The Covered Dependent must give written notice to the Group of its desire to continue coverage under this Agreement within sixty (60) days of the Subscriber's death, retirement or divorce. Coverage under this Agreement will remain in effect during the sixty (60) day period, provided that written notice is given, and the required premium paid, within the sixty (60) day period. This continuation coverage shall be concurrent with any other continuation coverage provided for under this Agreement. This continuation coverage will terminate upon the earlier of the following:
   a. the day a premium is due and unpaid; or
   b. the day the Covered Dependent becomes eligible for similar coverage; or
   c. three (3) years from the date of the Subscriber's death, retirement or divorce.

6. REQUIRED PAYMENTS

6.1 PREMIUMS

6.1.1 Payment of Premiums

Premiums are due in the office of the Health Plan, 1206 West Campus Dr., Temple, Texas 76502 on or before the date indicated in the monthly billing statement issued to Group by Health Plan. The Contract Holder is responsible for informing Health Plan of any events which render an individual enrollee ineligible for coverage under this Agreement. Generally the Contact Holder is liable for premiums for a covered individual from the time that individual is no longer eligible for coverage until the end of the month in which the Contract Holder notifies Health Plan of that covered individual's ineligibility for coverage. However, if a covered member loses eligibility for coverage during the last seven (7) calendar days of any Month, and Health Plan receives notice from the Contract Holder of that covered individual's ineligibility for coverage during the first three business days of the immediately succeeding month, the Contract Holder is not liable for that individual's premium for that succeeding month.

Notice of an individual's loss of eligibility of coverage may be provided prior to the end of a month by United States Mail, postage prepaid or by other means. Mailed notice shall be deemed to have been received by Health Plan as of the date of delivery to the post office. Notice given during the first three business days of a succeeding month must be by a method that provides immediate notification, including hand delivered, internet portal, e-mail or facsimile.

For example, if a covered member loses eligibility by ceasing employment with the Contract Holder on June 2, and the Contract Holder doesn't inform Health Plan of this loss of eligibility until July 2, the employee, as well as that employee's covered dependents, would be entitled to coverage until through July 31, and the Contract Holder would be liable for those individual's premiums. If, however, the same employer lost eligibility on June 25, and the Health Plan received notice from the contract holder of that individual's ineligibility for coverage during the first three business days of July, the Contract Holder is not liable for that individual's premium for the month of July. It is the Contract Holder's responsibility to collect any premium contribution due from its covered employees. Premiums are Required Payments.

6.1.2 Premium Changes

Pursuant to Texas Law, Health Plan may change premium rates at any time upon 60 days prior written notice. Not less than sixty (60) days prior to expiration of the Contract Year, the Contract Holder shall be advised of the premium rates applicable for the upcoming year.

6.1.3 Contribution Requirements

A Group must contribute for any Subscriber who enrolls in Health Plan at least the same dollar amount as it contributes for any Subscriber who enrolls in other health coverage provided by the Group. A Group which pays a proportion of an employee's premium based on some percentage or other formula must contribute for a Subscriber who enrolls in Health Plan the same proportion of the Subscriber's total health premium as it contributes for any Subscriber who enrolls in other health coverage provided by the Group.

6.2 COPAYMENTS

You are responsible for paying any applicable Copayment for Health Care Services. Copayments are due at the time the service is rendered. Copayments are Required Payments from You.

6.3 SUBROGATION AND COORDINATION OF BENEFITS PAYMENTS

If You, Your Covered Dependents, or anyone on behalf of You or Your Covered Dependents receives benefits or monies subject to the coordination of benefits or subrogation provisions of this Agreement, You or Your Covered Dependent must submit to Health Plan within 31 days of receipt of such benefits or monies, the amount to which Health Plan is entitled. In the event You, Your Covered Dependents, or anyone on behalf of You or Your Covered Dependents should recover amounts due under the subrogation or coordination of benefits provisions, any amount due is considered to be a Required Payment from You or your covered Dependent.

6.4 LATE PAYMENT FEE

A late payment fee may be assessed on any Premium not received by Health Plan at its offices when due. Such late payment fee will be calculated by Health Plan at the rate of 10% per annum. In no event will any such charge for late payments exceed the maximum rate allowed by law. Any late payment fee is considered to be a Required Payment from the Group.

6.5 GRACE PERIOD AND CANCELLATION OF COVERAGE

If any Premium is not received by the Health Plan within thirty (30) days of the due date, Health Plan may terminate coverage under this Agreement after the 30th day. During the 30-day grace period, coverage shall remain in force. However, if payment is not received, Health Plan shall have no obligation to pay for any services provided to You or Your Covered Dependents during the 30-day grace period or thereafter, and You shall be liable to the Provider for the cost of those services.

7. HEALTH CARE SERVICES

7.1 PHYSICIAN SELECTION

7.1.1 How to Select An In-Network Physician

For the best medical care and continuity of care, Health Plan encourages You and Your Covered Dependents to establish long term patient-physician relationships. You may select a Participating Physician from among the Providers listed in our Provider Directory published and distributed by Health Plan, and made available on the Health Plan website at www.swhp.org. The Provider Directory is updated on a regular basis.

7.2 HEALTH CARE SERVICES OUTSIDE OF THE SERVICE AREA

Other than for Emergency Care, out-of-area referrals approved under the terms of this Agreement or covered medical services for Your covered Dependent child under a Qualified Medical Support Order, if You or Your Covered Dependent are outside of the Service Area, You or Your Dependent must return to the Service Area and Participating Providers to receive Health Care Services at the HMO benefit level as provided under this Agreement.

7.3 LIMITATIONS AND EXCLUSIONS

The Health Care Services and other benefits to be provided under this Agreement are limited by or excluded from coverage as stated in the Description of Benefits.

7.4 HEALTH CARE SERVICES THAT ARE NOT MEDICALLY NECESSARY

In the event that the Medical Director determines that a Health Care Service proposed or provided, to You or Your Covered Dependent is not medically necessary, You, or a person acting on Your behalf and the Physician or Provider requesting or providing such Health Care Service shall be notified of this determination, and an Adverse Determination will be issued.

An Adverse Determination will include the reason for the Adverse Determination, the clinical basis for the Adverse Determination, a description of the criteria used in making the Adverse Determination, and a description of the complaint and appeals process. You and the Physician or Provider requesting the Health Care Service will be notified as follows:

- Within one hour for post-stabilization care subsequent to emergency treatment;
- Within 24 hours when care is requested while You or Your Dependent is Hospitalized; or
- Within three calendar days in other circumstances.

The initial notice of Adverse Determination may be by telephone or electronic transmission to Your Provider, and will be followed by written notice to You and Your Provider within two calendar days.

7.5 NATURE OF COVERAGE PROVIDED AND HEALTH PLAN'S RIGHT TO CONTRACT

7.5.1 Health Care Services and Your Beliefs

You understand that the HMO benefits under this Agreement are health maintenance organization benefits and not indemnity insurance benefits and that Health Plan arranges for the provision of HMO benefit level Health Care Services through contractual arrangements with certain providers. Health Plan reserves the right to contract with such providers of Health Care Services as it shall determine can reasonably provide them. Health Plan's Participating Providers shall determine the manner of provision of those Health Care Services and such services are subject to their discretion. Not every form of Treatment may be provided, and even though certain of Your personal beliefs or preferences may be in conflict with the care as offered by Participating Providers, You shall not be entitled to any specific class of licensed provider, school of approach to such services or otherwise be able to

determine the providers who will care for You or Your Covered Dependents other than as provided in this Agreement. This provision does not restrict Your right to consent or agree to any procedure or Treatment. However, this provision defines the coverage provided under this Agreement. Your decision to follow medical advice or to seek any particular Treatment is solely yours and you agree to bear all legal and ethical consequences of the decision without regard to the coverages provided hereunder.

7.5.2 Provision of Health Services

Except as specified in the Description of Benefits, if Participating Providers fail to, or become unable to, render the Health Care Services which they have agreed to provide, Health Plan agrees to coordinate through its Medical Director the provision of HMO benefit level Health Care Services to Members.

7.6 REFUSAL TO ACCEPT TREATMENT

Should You or Your Covered Dependent refuse to cooperate with or accept the recommendations of Participating Providers with regard to health care for Your or Your Covered Dependent, Participating Providers may regard such refusal as a failure of the patient relationship and as obstructing the delivery of proper medical care. In such cases, Participating Providers shall make reasonable efforts to accommodate You or Your Covered Dependent. However, if the Participating Provider determines that no alternative acceptable to the Participating Provider exists, You shall be so advised. If You or Your Covered Dependent continues to refuse to follow the recommendations, then neither Health Plan or its Participating Providers shall have any further responsibility under this Agreement to provide care at the HMO benefit level for the condition under Treatment.

7.7 COORDINATION OF HEALTH CARE SERVICES

7.7.1 Designation of Physician

At the time of enrollment under this Agreement, You or Your Covered Dependents may designate a Primary Care Physician. Should You or Your Covered Dependent decline to designate a Primary Care Physician, Health Plan will not assign one.

7.7.2 Selection of Physician

Primary Care Physicians may be selected from the list of Physicians published by the Health Plan. The ability to select a particular Participating Physician as a Primary Care Physician is subject to that physician's availability. A current, updated list of Participating Providers may be found on Health Plan's website, www.swhp.org.

7.7.3 Changing Your Physician

You or Your Covered Dependents may change Your Physician anytime.

7.8 CONTINUITY OF TREATMENT

7.8.1 Notice of Termination of Treating Physician or Provider

Each contract between the Health Plan and a physician or provider provides that no less than thirty (30) days advance notice be given to You and Your Covered Dependents under Treatment by a physician or provider of the physician's or provider's impending termination from the Health Plan.

7.8.2 Continued Treatment by Terminated Physician or Provider

Except for medical incompetence or unprofessional behavior, the termination does not release the Health Plan from reimbursing the Participating Provider for providing Treatment to You or Your Covered Dependent in certain special circumstances. Special circumstance means a condition which Your physician or provider, or Your Covered Dependent's physician or provider reasonably believes could cause harm to You or Your Covered Dependent if the physician or provider discontinues Treatment of the Member, and include a disability, acute condition, life-threatening illness, or being past the twenty-fourth week of pregnancy. However, the Participating Provider must first identify the special circumstance and submit a request to Health Plan's Medical Director that You or Your Dependent be permitted to continue Treatment under the Participating Provider's care. The Participating Provider

must agree not to seek payment from You or Your Covered Dependent of any amounts for which You would not be responsible if the Health Professional or Participating Physician were still under contract with the Health Plan. If the request is granted, the Health Plan's obligation to pay for the services of the Participating Provider shall not exceed 90 days from the date of termination or nine (9) months in the case of a terminal illness with which You or an Covered Dependent was diagnosed at the time of the termination and shall not exceed the contract rate. If You or a Covered Dependent is past the twenty-fourth (24^{th}) week of pregnancy at the time of termination, Health Plan's obligation to reimburse a terminated Participating Provider for services extends through delivery of the child, immediate postpartum care and the follow-up checkup within the first six weeks of delivery.

7.9 HEALTH CARE SERVICES NOT AVAILABLE FROM CONTRACTING PROVIDERS

To the extent the Health Plan would have covered such services at the HMO benefit level under the terms of this Agreement, Medically Necessary Health Care Services which are prescribed by a Participating Physician but which are not available from a Participating Provider shall be authorized as described under the heading, Out-of-Network Referrals, in the Description of Benefits to this Agreement, within a time appropriate to the circumstances relating to the delivery of services and the condition of the patient, but in no event to exceed five (5) business days after receipt of reasonably requested documentation, to be received from a physician or provider who does not contract with the Health Plan upon the request of the Participating Physician and the approval by the Medical Director. If approved, Health Plan shall fully reimburse the non-contracting physician or provider according to the terms of the Health Care Agreement at the usual and customary or agreed upon rate, except for Copayments, and charges for non-covered services. Prior to issuing a denial, the Medical Director must provide for a review by a specialist of the same or similar specialty as the type of physician or provider to whom a referral is requested.

7.10 HOW TO ACCESS YOUR TWO LEVELS OF BENEFITS

7.10.1 HMO (In-Network) Benefits

The key to this HMO with Point of Service Plan is understanding the difference between HMO (In-Network) and POS (Out-of-Network) benefits. HMO benefits provide You with more coverage for less money. You receive HMO benefits whenever You see a Participating Provider for Your medical care.

7.10.2 POS (Out-of-Network) Benefits

When You seek care from a non-Participating Provider, Your POS Out-of-Pocket cost-sharing ("Coinsurance", "Deductible") will be higher. In addition to having Out-of-Pocket cost-sharing when seeing non-Participating Providers, you will incur any difference between the Provider's billed charges and the Allowed Amount paid by Health Plan for POS (Out-of-Network) services. Please refer to Your Schedule of Benefits.

For example, assume You plan to receive hospital services from a non-Participating Provider, By consulting Your Schedule of Benefits you determine that Out-of-Network hospitalization is subject to a $5,000 deductible and a 50% coinsurance. Additionally, assume that the Allowed Amount for the service you are seeking is $20,000, but the non-Participating Hospital bills $35,000 for this service. Your out of pocket amount would be as follows:

Deductible: $5,000

Coinsurance: $7,500 (50% of the difference of the 20,000 allowed amount minus 5,000 deductible)

Billed Charges Remainder $15,000 (difference between $35,000 billed charges and $20,000 allowed amount)

Total out-of-pocket cost: $27,500

8. CLAIM PROCEDURE

8.1 NECESSITY OF FILING CLAIMS

You will not ordinarily need to pay any person or facility for Health Care Services provided under this Agreement. However, if you receive Health Care Services from facilities which do not routinely contract with Health Plan, for example in the case of an emergency, you may be asked to pay that person or facility directly. You are entitled to reimbursement for such payments to the extent those Health Care Services are covered under this Agreement provided (1) You submit written proof of and claim for payment to Health Plan at its office, (2) the written proof and claim for payment are acceptable to Health Plan, (3) Health Plan receives the written proof and claim for payment within 60 days of the date the Health Care Services were received by You and Your Covered Dependent, and (4) You have complied with the terms of this Agreement.

8.2 EFFECT OF FAILURE TO FILE CLAIM WITHIN 60 DAYS

Failure to submit written proof of and claim for payment within the 60 day period shall not invalidate or reduce Your entitlement to reimbursement provided it was not reasonably possible for You to submit such proof and claim within the time allowed and written proof of and claim for payment were filed as soon as reasonably possible. Written proof and claim for payment submission should consist of itemized receipts containing: name and address where services were received, date service was provided, amount paid for service, and diagnosis for visit. Claims for reimbursement should be sent to Scott & White Health Plan, Attn: Claims Dept., 1206 West Campus Drive, Temple, TX 76502. In no event will Health Plan have any obligation under this paragraph if such proof of and claim for payment is not received by Health Plan within one (1) year of the date the services were provided to You or Your Covered Dependent.

8.3 ACKNOWLEDGEMENT OF CLAIM

Not later than the fifteenth (15^{th}) day after receipt of Your claim, the Health Plan will acknowledge in writing receipt of the claim; begin any investigation of the claim; and request from You any necessary information, statements or forms. Additional requests for information may be made during the course of the investigation.

8.4 ACCEPTANCE OR REJECTION OF CLAIM

Not later than the fifteenth (15^{th}) business day after receipt of all requested items and information, Health Plan will notify You in writing of the acceptance or rejection of the claim and the reason if rejected; or notify You that additional time is needed to process the claim and state the reason Health Plan needs additional time. If additional time is needed to make a decision, Health Plan shall accept or reject the claim no later than the forty-fifth (45^{th}) day after you have been notified of the need for additional time.

8.5 PAYMENT OF CLAIMS

Claims will be paid no later than the fifth (5th) business day after notification of acceptance.

8.6 PAYMENT TO PHYSICIAN OR PROVIDER

Payment by Health Plan to the person or facility providing the services to You or Your Eligible Dependent shall discharge Health Plan's obligations under this Section.

8.7 LIMITATIONS ON ACTIONS

No action at law or in equity shall be brought to recover payment of a claim under this Agreement prior to the expiration of sixty (60) days from the date written proof of and claim for payment, as described above, was received by Health Plan. In no event shall such action be brought after three (3) years from such date.

9. EFFECT OF MEDICARE, SUBROGATION AND COORDINATION OF BENEFITS

9.1 EFFECT OF MEDICARE

Regardless of any other provisions of this Agreement to the contrary, on and after the first day You or Covered Dependent become entitled to coverage under Medicare and Medicare would be the primary payor of benefits, You or Your Covered Dependent shall not be eligible for, nor entitled to receive, any further benefits under this Agreement unless:

1) You and Your Covered Dependent shall qualify for, and remain continuously qualified for, coverage under both Part A and Part B of Medicare; and
2) You shall pay the required premiums for Medicare coverage; and
3) You shall cooperate fully in the coordination of Your health care benefits, including coverage under Parts A and B of Medicare, in accordance with the other terms of this Agreement, and perform such acts as shall be necessary and desirable to facilitate the maximum reimbursement by Medicare to Health Plan, and Participating Providers for the services provided.

9.2 SUBROGATION/LIEN/ASSIGNMENT/REIMBURSEMENT

If the Plan pays or provides medical benefits for an illness or injury that was caused by an act or omission of any person or entity, the Plan will be **subrogated** to all rights of recovery of a plan participant, to the extent of such benefits provided or the reasonable value of services or benefits provided by the Plan. The Plan, once it has provided any benefits, is granted a **lien** on the proceeds of any payment, settlement, judgment, or other remuneration received by the plan participant from any sources, as allowed by law, including but not limited to:

- a third party or any insurance company on behalf of a third party, including but not limited to premises, automobile, homeowners, professional, DRAM shop, or any other applicable liability or excess insurance policy whether premium funded or self insured;
- underinsured/uninsured automobile insurance coverage;
- no fault insurance coverage, such as personal injury or medical payments protection;
- any award, settlement or benefit paid under any worker's compensation law, claim or award;
- any indemnity agreement or contract;
- any other payment designated, delineated, earmarked or intended to be paid to a plan participant as compensation, restitution, remuneration for injuries sustained or illness suffered as a result of the negligence or liability, including contractual, of any individual or entity;
- any source that reimburses, arranges, or pays for the cost of care.

9.2.1 ASSIGNMENT

Upon being provided any benefits from the Plan, a plan participant is considered to have **assigned** his or her rights of recovery from any source including those listed herein to the Plan to the extent of the reasonable value of services as determined by the Plan or benefits provided by the Plan

No plan participant may assign, waive, compromise or settle any rights or causes of action that he/she or any dependent may have against any person or entity who causes an injury or illness, or those listed herein, without the express prior written consent of the Plan and/or the Plan administrator.

9.2.2 REIMBURSEMENT

If a plan participant does not reimburse the Plan from any settlement, judgment, insurance proceeds or other source of payment, including those identified herein, the Plan is entitled to reduce current or future benefits payable to or on behalf of a plan participant until the Plan has been fully reimbursed.

9.2.3 PLAN'S ACTIONS

The Plan in furtherance of the rights obtained herein may take any action it deems necessary to protect its interest, which will include, but not be limited to:

- place a lien against a responsible party or insurance company and/or anyone listed herein;
- bring an action on its own behalf, or on the plan participant's behalf, against the responsible party or his insurance company and/or anyone listed herein;
- cease paying the plan participant's benefits until the plan participant provides the Plan Sponsor with the documents necessary for the Plan to exercise its rights and privileges; and
- the Plan may take any further action it deems necessary to protect its interest.

9.2.4 OBLIGATIONS OF THE PLAN PARTICIPANT TO THE PLAN

- If a plan participant receives services or benefits under the Plan, the plan participant must immediately notify the Plan Sponsor of the name of any individual or entity against whom the plan participant might have a claim as a result of illness or injury (including any insurance company that provides coverage for any party to the claim) regardless of whether or not the plan participant intends to make a claim. For example, if a plan participant is injured in an automobile accident and the person who hit the plan participant was at fault, the person who hit the plan participant is a person whose act or omission has caused the plan participant's illness or injury.

- A plan participant must also notify any third-party and any other individual or entity acting on behalf of the third-party and the plan participant's own insurance carriers of the Plan's rights of subrogation, lien, reimbursement and assignment.

- A plan participant must cooperate with the Plan to provide information about the plan participant's illness or injury including, but not limited to providing information about all anticipated future treatment related to the subject injury or illness.

- The plan participant authorizes the Plan and The Bratton Firm, to pursue, sue, compromise and/or settle any claims described herein, including but not limited to, subrogation, lien, assignment and reimbursement claims in the name of the plan participant and/or Plan. The plan participant agrees to fully cooperate with the Plan in the prosecution of such a claim. The plan participant agrees and fully authorizes the Plan and the Bratton Firm to obtain and share medical information on the plan participant necessary to investigate, pursue, sue, compromise and/or settle the above-described claims. The Plan and The Bratton Firm specifically are granted by the plan participant the authorization to share this information with those individuals or entities responsible for reimbursing the Plan through claims of subrogation, lien, assignment or reimbursement in an effort to recoup those funds owed to the Plan. This authorization includes, but is not be limited to, granting to the Plan and The Bratton Firm the right to discuss the plan participant's medical care and treatment and the cost of same with third and first-party insurance carriers involved in the claim. Should a written medical authorization be required for the Plan to investigate, pursue, sue, compromise, prosecute and/or settle the above-described claims, the plan participant agrees to sign such medical authorization or any other necessary documents needed to protect the Plan's interests.

- Additionally, should litigation ensue, the plan participant agrees to and is obligated to cooperate with the Plan and/or any and all representatives of the Plan, including subrogation counsel, in completing discovery, obtaining depositions and/or attending and/or cooperating in trial in furtherance of the Plan's subrogation, lien, assignment or reimbursement rights.

- The plan participant agrees to obtain consent of the Plan before settling any claim or suit or releasing any party from liability for the payment of medical expenses resulting from an injury or illness. The plan participant also agrees to refrain from taking any action to prejudice the Plan's recovery rights.

- Furthermore, it is prohibited for plan participant to settle a claim against a third party for non-medical elements of damages, by eliminating damages relating to medical expenses incurred. It is prohibited for a plan participant to waive a claim for medical expenses incurred by plan participants who are minors.

- To the extent that a plan participant makes a claim individually or by or through an attorney for an injury or illness for which services or benefits were provided by the Plan, the plan participant agrees to keep the plan updated with the investigation and prosecution of said claim, including, but not limited to providing all correspondence transmitted by and between any potential defendant or source of payment; all demands for payment or settlement; all offers of compromise; accident/incident reports or investigation by any source; name, address, and telephone number of any insurance adjuster involved in investigating the claim; and copies of all documents exchanged in litigation should a suit be filed.

- Nothing in these provisions requires the Plan to pursue the plan participant's claim against any party for damages or claims or causes of action that the plan participant might have against such party as a result of injury or illness.

- The Plan may designate a person, agency or organization to act for it in matters related to the Plan's rights described herein, and the plan participant agrees to cooperate with such designated person, agency, or organization the same as if dealing with the Plan itself.

9.2.5 WRONGFUL DEATH/SURVIVORSHIP CLAIMS

In the event that the plan participant dies as a result of his/her injuries and a wrongful death or survivorship claim is asserted the plan participant's obligations become the obligations of the plan participant's wrongful death beneficiaries, heirs and/or estate.

9.2.6 DEATH OF PLAN PARTICIPANT

Should a plan participant die, all obligations set forth herein shall become the obligations of his/her heirs, survivors and/or estate.

9.2.7 CONTROL OF SETTLEMENT PROCEEDS

A plan participant may not use an annuity or any form of trust to hold/own settlement proceeds in an effort to bypass obligations set forth herein. A plan participant agrees that they have actual control over the settlement proceeds from the underlying tort or first party claim from which they are to reimburse the plan whether or not they are the individual or entity to which the settlement proceeds are paid.

9.2.8 PAYMENT

The plan participant agrees to include the Plan's name as a co-payee on any and all settlement drafts or payments from any source.

The fact that the Plan does not assert or invoke its rights until a time after a plan participant, acting without prior written approval of the authorized Plan representative, has made any settlement or other disposition of, or has received any proceeds as full or partial satisfaction of, plan participant's loss recovery rights, shall not relieve the plan participant of his/her obligation to reimburse the Plan in the full amount of the Plan's rights.

9.2.9 SEVERABILITY

In the event that any section of these provisions is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of the Plan. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the plan.

9.2.10 INCURRED BENEFITS

The Plan reserves the right to reverse any decision associated with the reduction or waiver of charges related to services or benefits provided if and when the Plan discovers that the plan participant has been involved in an injury or accident and may be compensated by one of the sources set forth herein. Should this occur, the plan participant is deemed to have incurred the full billed charges or the full cost of the benefits or services rendered.

9.2.11 NON-EXCLUSIVE RIGHTS

The rights expressed in this document in favor of the Plan are cumulative and do not exclude any other rights or remedies available at law or in equity to the Plan or anyone in privity with the Plan.

The provisions herein bind the plan participant, as well as the plan participant's spouse, dependents, or any members of the plan participant's family, who receives services or benefits from the Plan individually or through the plan participant.

9.3 COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one plan. Plan is defined below.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accord with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans equal 100 percent of the total allowable expense.

Definitions

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

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

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

Each contract for coverage under (a)(1) or (a)(2) is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

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

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

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

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

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

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

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

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

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

(d) "Allowed amount" is the amount of a billed charge that a carrier determines to be covered for services provided by a nonpreferred 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 insured is responsible.

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

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

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

(a) The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.

(b) Except as provided in (c), a plan that does not contain a COB provision that is consistent with this policy is always primary unless the provisions of both plans state that the complying plan is primary.

(c) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage must be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

(d) A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

(e) If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan must pay or provide benefits as if it were the primary plan when a covered person uses a noncontracted health care provider or physician, except for emergency services or authorized referrals that are paid or provided by the primary plan.

(f) When multiple contracts providing coordinated coverage are treated as a single plan under this subchapter, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan must be responsible for the plan's compliance with this subchapter.

(g) If a person is covered by more than one secondary plan, the order of benefit determination rules of this subchapter decide the order in which secondary plans' benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan that, under the rules of this contract, 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, policyholder, 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, policyholder, 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:

(I) the plan covering the custodial parent;

(II) the plan covering the spouse of the custodial parent;

(III) the plan covering the noncustodial parent; then

(IV) 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, policyholder, 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

(a) 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.

(b) 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 nonpanel 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. Organization responsible for COB administration 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 Organization responsible for COB administration any facts it needs to apply those rules and determine benefits.

9.4 FACILITY OF PAYMENT

A payment made under another plan may include an amount that should have been paid under this plan. If it does, Organization responsible for COB administration 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. Organization responsible for COB administration 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.

9.5 RIGHT OF RECOVERY

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

10. RECORDS

10.1 RECORDS MAINTAINED BY HEALTH PLAN

Health Plan is entitled to maintain records on You or Your Covered Dependents necessary to administer this Agreement. The Contract Holder or You or Your Covered Dependents shall provide the information required by the Health Plan within a reasonable period of time. The records of the Contract Holder or You or Your Covered Dependents which have a bearing on this Agreement shall be made available to Health Plan for inspection at any reasonable time.

10.2 NECESSITY OF REQUESTED INFORMATION

To the extent it is dependent upon the information for an appropriate determination, Health Plan shall not be required to discharge an obligation under this Agreement until requested information has been received by Health Plan in acceptable form. Incorrect information furnished to Health Plan may be corrected without Health Plan invoking any remedies available to it under this Agreement or at law provided Health Plan shall not have relied upon such information to its detriment.

10.2.1 Authorization for Health Care Information from Physicians and Providers

Health Plan is entitled to receive from any physician or provider of health care to You or Your Covered Dependents information reasonably necessary in connection with the administration of this Agreement but subject to all applicable confidentiality requirements. By acceptance of Health Care Services under this Agreement, You or Your Covered Dependents authorize every physician or provider rendering health care hereunder to disclose, as permitted by law upon request, all facts pertaining to You or Your Covered Dependent's care, Treatment and physical condition to Health Plan or to any other physician or provider who is a Participating Provider or Referral Physician rendering services to You or Your Covered Dependents, and to render reports pertaining to the same to, and permit copying of such records and reports by, Health Plan or other such physicians and providers.

10.3 NOTIFICATION OF CHANGES IN STATUS

You shall notify Health Plan immediately in writing of any fact which may affect eligibility or benefits under this Agreement, including but not limited to:

- any change in the eligibility status of You or Your Covered Dependents;
- eligibility for Medicare;
- coverage under another plan which may be subject to coordination of benefits; and
- eligibility for recovery from a third party of benefits which may be subject to subrogation.

11. COMPLAINT AND APPEAL PROCEDURE

11.1 PURPOSE

11.1.1 Health Plan recognizes that a member, physician, provider, or other person designated to act on behalf of a member may encounter an event in which performance under this Agreement does not meet expectations. It is important that such an event be brought to the attention of the Health Plan. The Health Plan is dedicated to addressing problems quickly, managing the delivery of Health Care Services effectively, and preventing future complaints or appeals. Health Plan will not retaliate against You because You, Your Provider or a person action on Your behalf files a complaint or appeals a decision made by Health Plan.

11.1.2 The Medical Director has overall responsibility for the coordination of the complaint and appeal procedure. For assistance with this procedure, individuals should contact the Health Plan office.

11.2 COMPLAINTS

11.2.1 Health Plan will send an acknowledgment letter of the receipt of oral or written Complaints from Complainants no later than five (5) business days after the date of the receipt of the Complaint. The acknowledgment letter will include a description of Health Plan's Complaint procedures and time frames. If the Complaint is received orally, Health Plan will also enclose a one-page Complaint form, which must be returned for prompt resolution of the Complaint.

11.2.2 Health Plan will acknowledge, investigate, and resolve all Complaints within thirty (30) calendar days after the date of receipt of the written Complaint or one-page complaint form from the Complainant. However, investigation and resolution of Complaints concerning emergencies or denials of continued stays for hospitalization shall be concluded in accordance with the immediacy of the case and will not exceed one (1) business day from receipt of the Complaint.

11.2.3 Health Plan will investigate the Complaint and issue a response letter to the Complainant within thirty (30) days from receipt of the Complaint explaining the specific medical and/or contractual reasons for the resolution and the specialization of any physician or other provider consulted. The response letter will contain a full description of the process for appeal, including the time frames for the appeals process and the time frames for the final decision on the appeal.

11.3 APPEALS OF COMPLAINT

11.3.1 If the Complainant is not satisfied with Health Plan's resolution of the Complaint, the Complainant will be given the opportunity to appear in person before an appeal panel at the site of which enrollee normally receives health care services or at another site agreed to by the Complainant, or address a written Appeal to an appeal panel.

11.3.2 Health Plan will send an acknowledgment letter of the receipt of oral or written appeal from Complainants no later than five (5) business days after the date of the receipt of the Appeal. The acknowledgment letter will include a description of Health Plan's Appeal procedures and time frames. If the Appeal is received orally, Health Plan will also enclose a one-page Appeal form, which must be returned for prompt resolution of the Appeal.

11.3.3 Health Plan will appoint members to the complaint appeal panel, which shall advise the Health Plan on the resolution of the Complaint. The complaint appeal panel shall be composed of one Health Plan staff member, one Participating Provider, and one member. No member of the complaint appeal panel may have been previously involved in the disputed decision. The Participating Providers must have experience in the same or

similar specialty that typically treats the medical condition, performs the procedure or provides the treatment in the area of care that is in dispute and must be independent of any physician or provider who made any prior determination. If specialty care is in dispute, the Participating Provider serving on the appeal panel must be a specialist in the field of care to which the appeal relates. The members may not be an employee of Health Plan.

11.3.4 No later than five (5) business days before the scheduled meeting of the panel, unless the Complainant agrees otherwise, the Health Plan will provide to the Complainant or the Complainant's designated representative:

1. any documentation to be presented to the panel by Health Plan staff;
2. the specialization of any physicians or providers consulted during the investigation; and
3. the name and affiliation of each Health Plan representative on the panel.

11.3.5 The Complainant, or designated representative if the enrollee is a minor or disabled, is entitled to:

1. appear before the complaint appeal panel in person or by other appropriate means;
2. present alternative expert testimony; and
3. request the presence of and question any person responsible for making the prior determination that resulted in the Appeal.

11.3.6 Notice of the final decision of Health Plan on the Appeal will include a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision. The notice will also include the toll-free telephone number and the address of the Texas Department of Insurance.

11.3.7 Health Plan will complete the Appeals Process no later than the thirty (30) calendar days after the date of the receipt of the written request for Appeal or one-page appeal form from the Complainant.

11.4 UTILIZATION REVIEW

Your 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. This program ensures that Hospital and Ambulatory Surgical Facility care is received in the most appropriate setting, and that any other specified surgery or services are medically necessary. This program is known as utilization review.

Utilization review may be undertaken:

- At least three working days before a service is provider that requires prior authorization. This is known as a prior authorization review.
- Before a hospital admission or any of the specified services that require prior authorization. This is known as admission review.
- During a hospital stay. This is known as continued stay review.
- Following discharge from a hospital or after any services are performed. This is known as a retrospective review.

11.4.1 Prior Authorization

Certain services require prior authorization in order to be covered. Typically, Your Provder will request Prior Authorization on Your behalf. Failure to obtain Prior Authorization may result in a reduction or denial of benefits under this Agreement.

The Scott and White Health Plan Health Services Division has the responsibility of issuing Prior Authorization.
For a complete list of Health Care Services subject to Prior Authorization, visit Our website at www.swhp.org or call Us at the contact number shown in the Toll Free Notice.

11.4.2 Prior Authorization Review

You are always responsible for initiating prior authorization review. **There are penalties for some services if prior authorization review is not performed.**

Note: These penalties are not counted toward the deductible or Your Out-of-Pocket Maximum.

To initiate prior authorization review, instruct Your Physician to call SWHP at least three working days prior to any admission or scheduled date of proposed service that require pre-authorization. Remember, You are responsible for making sure Your Physician calls. If SWHP determines that the admission or surgery is not Medically Necessary or Experimental or Investigational, You and Your Physician will be notified by telephone within twenty four hours after You file Your request for prior authorization review. Subject to the notice requirements and prior to the issuance of an adverse determination, if We question the Medical Necessity of appropriateness or the Experimental or Investigational nature of a service, We will give the Physician who ordered it a reasonable opportunity to discuss with Our physician Your treatment plan and the clinical basis of Our determination. You and Your Physician will be sent a written notice within three 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; and description of the procedure for the complaint and appeal process, including Your right and the procedure to appeal to an independent review organization. If You have a life-threatening condition, the notice will include a description of Your right to an immediate review by an independent review organization and the procedures to obtain that review. For an Emergency admission or procedure, We must be notified within 48 hours of the admission or procedure or as soon as reasonably possible. We may take into account whether or not Your condition was severe enough to prevent You from notifying us, or whether or not a member of Your family was available to notice Us for You.

Under state and federal law, group health plans and health plan issuers offering group insurance coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or Newborn child to less than 48 hours following an uncomplicated vaginal delivery, or less than 96 hours following an uncomplicated cesarean section, or require that a provider obtain Utilization Review from the plan for prescribing a length of stay not in excess of the above periods.

11.4.3 Admission Review

If prior authorization review is not performed, We will determine at the time of admission if the hospital admission or specified non-Emergency outpatient surgery or diagnostic procedure is Medically Necessary.

11.4.4 Continued Stay Review

We also will determine if a continued hospital or skilled nursing facility stay is Medically Necessary. We will provide notice of Our determination within twenty four hours by either telephone or electronic transmission to the provider of record followed by written notice within three working days to You or Your provider of record. If We are approving or denying post stabilization care subsequent to Emergency treatment or care related to a life threatening condition, We will notify the treating Physician or other provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case to exceed one hour after the request for approval is made.

We will determine if the use of prescription drugs or intravenous infusions is Medically Necessary. We will provide notice of Our determination no later than the 30th day before the date on which the provision of prescription drug or intravenous infusion will be discontinued.

11.4.5 Retrospective Review

If neither prior authorization review, nor admission review nor continued stay review was performed, We will use retrospective review to determine if a scheduled or an Emergency admission to a hospital or any surgery at a hospital or ambulatory surgical center or an outpatient surgery or a diagnostic procedure was Medically Necessary.

In the event services are determined to be Medically Necessary, benefits will be provided as described in the Plan. If it is determined that a hospital stay or any other service was not Medically Necessary, You are responsible for payment of the charges for those services. We will provide notice of Our adverse determination in writing to You and the provider of record within a reasonable period, but not later than 30 days after the date on which the claim is received, provided We may extend the 30-day period for up to 15 days if: We determine that an extension is necessary due to matters beyond Our control; and We notify You and the provider of record within the initial 30 day period, of circumstances requiring the extension and the date by which We expect to make a determination. If the period is extended because of Your failure or the failure or the provider of record to submit the information necessary to make the determination, the period for making the determination is tolled from the date We send Our notice of the extension to You or the provider until the earlier of: the date You or the provider responds to Our request; or the date by which the specified information was to have been submitted.

11.4.6 Appeal of Adverse Determination

Our determination that treatment or services You requested or received are not Medically Necessary or appropriate or are Experimental or Investigational, based on Our Utilization Review standards is an "adverse determination", which means that Your request for coverage of the treatment or service is denied. You, a person acting on Your behalf, or Your Physician may appeal the adverse determination to Us orally or in writing in accordance with Our internal appeal procedures. If We are notified orally, We will send a one-page form to use for making a written appeal.

Within five working days of receipt of the written request, We will acknowledge the request and advise if additional documents are needed to consider Your appeal. We will provide Our decision on Your appeal no later than thirty days after the later of the date We receive Your appeal or the date any additional information We request is provided order to consider Your appeal. Appeals involving the denial of emergency are or continued hospitalization shall be based on the medical immediacy of the condition, procedures, or treatment under review, not to exceed one working day from when We receive all information necessary to complete the appeal.

If Your appeal is denied, Our notice will include a clean and concise statement of the clinical basis for the denial and Your right to seek review of the denial from an independent review organization and the procedures for obtaining that review.

If you have a life-threatening condition or in circumstances involving prescription drugs or intravenous infusions, You have the right to an immediate review by an independent review organization and You are not required to first request an internal review by Us.

11.4.7 Review by Independent Review Organization (IRO)

If We deny Your appeal of an adverse determination, You have the right to request Us to refer Your appeal to an IRO. We will pay for the IRO review and We will comply with the IRO's determination regarding the Medical Necessity or appropriateness of the treatment or services or the Experimental or Investigation nature of such treatment or services.

11.5 <u>VOLUNTARY BINDING ARBITRATION</u>

If You are enrolled in a plan provided by Your employer that is subject to ERISA, any dispute involving an adverse determination must be appealed under claims procedure rules outlined above. After the Member has followed the appeal procedures, any dispute regarding an adverse determination may be submitted to voluntary binding arbitration, if both parties agree.

For a Member enrolled in an Employer plan subject to ERISA, any dispute regarding an adverse benefit determination, or any dispute which does not involve an adverse determination; or for a Member enrolled in an Employer plan not subject to ERISA, any dispute, may be subject to binding arbitration if:

- the mediation or arbitration will be conducted pursuant to the applicable commercial rules of the American Arbitration Association and applicable Texas statutes governing mediation and arbitration; and
- will be binding if both parties agree to mediation or arbitrations; and
- mediation or arbitration will occur in the county where the Member, or if applicable the beneficiary resides; and
- if the amount in dispute exceeds the jurisdictional limits of the small claims court.

Under this coverage, if binding arbitration is agreed to by both parties, the arbitration findings will be final and binding. We will pay the cost of arbitration. Any disputes regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

12. MISCELLANEOUS PROVISIONS

12.1 CONFIDENTIALITY

In accordance with applicable law, any data or information pertaining to the diagnosis, Treatment, or health of You or Your Covered Dependent or to an application obtained from You or Your Covered Dependent or from any physician or provider by Health Plan shall be held in confidence and shall not be disclosed to any person except: (1) to the extent that it may be necessary to carry out purposes required by or to administer this Agreement with regard to the provision of Health Care Services, payment of Health Care Services, and Health Plan operations; or (2) upon You or Your Covered Dependent's express authorization; or (3) pursuant to a law or in the event of claim or court order for the production of evidence or to discovery thereof; or (4) in the event of claim or litigation between You or Your Covered Dependent and Health Plan wherein such data or information is pertinent, or (5) bona fide medical research or studies by Health Plan. Health Plan shall be entitled to claim the same privilege against such disclosures as the physician or provider who furnishes such information to it is entitled to claim.

12.2 INDEPENDENT AGENTS

12.2.1 Health Plan's Participating Providers are independent contractors. Health Plan is not an agent of any Participating Provider, nor is any Participating Provider an agent of the Health Plan.

12.2.2 Participating Providers shall make reasonable efforts to maintain an appropriate patient relationship with Members to whom they are providing care. Likewise, You and Your Covered Dependents shall make reasonable efforts to maintain an appropriate patient relationship with the Participating Providers who are providing such care.

12.2.3 No Contract Holder or Member, in such capacity, is an agent or representative of Health Plan or its Participating Providers. No Contract Holder or Member shall be liable for any acts or omissions of any Participating Provider or its agents or employees.

12.2.4 The determination of whether any Treatment is a covered benefit under this Agreement shall be made by Health Plan according to the terms and conditions of this Agreement. The fact that Treatment has been prescribed or authorized by a Participating Provider does not necessarily mean that it is covered under this Agreement.

12.3 CHANGES IN COVERAGE

During the term of this Agreement, changes in coverage are not allowed unless approved in writing by Health Plan or authorized according to the terms stated in this Agreement. Any retroactive changes in eligibility or coverage by a Group for any of its Members must be approved by the Health Plan, and the liability of Health Plan to refund Premiums for any Member whose coverage is terminated or changed to a different category shall be no greater than two months premium paid by or on behalf of the Member. Health Plan may consider any amounts paid for Covered Services for any period for which the Member's premium was refunded as a Required Payment.

12.4 ENTIRE AGREEMENT

This Agreement, attachments, Group's application, and Your completed and accepted Enrollment Application(s) constitute the entire contract between the parties, and all oral representations and warranties have been incorporated into this Agreement. No agent or other person, except the Executive Director of Health Plan, has the authority to waive any conditions or restrictions of this Agreement, to extend the time for making a payment, or to bind Health Plan by making any promise or representation, or by giving or receiving any information. No changes to this Agreement shall be valid unless in writing and signed by the Executive Director of Health Plan. However, Health Plan may adopt policies, procedures and rules to promote the orderly and efficient administration of this Agreement.

12.5 SEVERABILITY

In the event of the unenforceability or invalidity of any section or provision of this Agreement, such section or provision shall be enforceable in part to the fullest extent permitted by law, and such invalidity or unenforceability shall not otherwise affect any other section of this Agreement, and this Agreement shall otherwise remain in full force and effect.

12.6 MODIFICATION OF TERMS

During the term of this Agreement and without Your consent or concurrence, this Agreement shall be subject to amendment, modification or termination in accordance with any provision hereof; by mutual agreement between Health Plan and Contract Holder; or as required by law. By electing coverage pursuant to this Agreement or by accepting benefits hereunder, You and Contract Holders agree to all terms, conditions and provisions hereof.

12.7 NOT A WAIVER

The failure of Health Plan to enforce any provision of this Agreement shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, the failure to enforce any remedy arising from a default under the terms of this Agreement shall not be deemed or construed to be a waiver of such default.

12.8 VENUE

Any action at law or in equity, including any suit to enforce any of the terms, conditions, rights or privileges under this Agreement, shall be brought in a court in or for Bell County, Texas.

12.9 RECOVERY

If any action at law or in equity is brought to enforce or interpret the provisions of this Agreement, the prevailing party shall be entitled to recover its costs and expenses associated with such action (including, but not limited to, reasonable attorney's fees), in addition to any other relief to which the party may be entitled. Health Plan is also entitled to recover from Contract Holder, Subscriber or Member any overpayment or other inappropriate payment, including, but not limited to, a payment for non-Covered Services or services rendered to a person who was ineligible for group coverage at the time services were provided (collectively, “Excess Payments”). Failure by the Contract Holder, Subscriber or Member to remit any Excess Payments to Scott and White Health Plan may result in legal action by Scott and White Health Plan.

12.10 NOTICE

With the exception of electronic notices sent pursuant to subparagraph 6.1.1 of this Agreement, any notice under this Agreement shall be given by United States Mail, postage prepaid, addressed as follows:

If to Health Plan:
Scott and White Health Plan
1206 West Campus Dr.
Temple, Texas 76502

If to You:
To the latest address provided by You to Contract Holder.

If to a Contract Holder:
To the latest address provided by the Contract Holder.

12.11 INCONTESTABILITY

All statements made by You on the Enrollment Application shall be considered representations and not warranties. The statements are considered to be truthful and are made to the best of Your knowledge and belief. A statement may not be used in a contest to void, cancel or non-renew an enrollee's coverage or reduce benefits unless:

1. it is in a written enrollment application signed by You, and
2. a signed copy of the enrollment application is or has been furnished to You.

This Agreement may only be contested because of fraud or intentional misrepresentation of material fact on the Enrollment Application. If the Group has 50 or less employees, the misrepresentation shall be other than a misrepresentation related to health status. If Health Plan determines that You made an intentional material misrepresentation of health status on the application, Health Plan may increase the Group premium to the appropriate level. Health Plan must provide Group sixty (60) days prior written notice of any such premium rate change.

12.12 PROOF OF COVERAGE

Health Plan will provide You with proof of coverage under this Agreement. Such evidence shall consist of an original copy of this Agreement and an identification card as described below. You will also be provided with a current roster of Participating Providers as well as additional educational material regarding the Health Plan and the services provided
under this Agreement.

12.13 IDENTIFICATION CARD

Health Plan shall issue an identification card which will provide information regarding the type of coverage held and such other information as required by law or relevant regulations. Such cards are the property of the Health Plan and are for identification purposes only. Possession of a Health Plan identification card confers no right to services or other benefits under this Agreement. To be entitled to such services or benefits the holder of the card must, in fact, be a Member on whose behalf all Required Payments under this Agreement have actually been paid. Any person receiving services or other benefits to which the person is not then entitled pursuant to the provisions of this Agreement shall be subject to charges at the providers' then prevailing rates. If You permit the use of a Health Plan identification card by any other person, such card may be retained by Health Plan, and all rights of You and Your Dependents, covered pursuant to this Agreement, shall be terminated sixteen (16) days after written notice.

12.14 CONFORMITY WITH STATE LAW

If it is determined by a regulatory or judicial body that any provision of this Agreement that is not in conformity with the insurance laws of the state of Texas, this Agreement shall not be rendered invalid, but instead will be construed and applied as if it were in full compliance with the insurance laws of the state of Texas.

12.15 OFFICE OF FOREIGN ASSETS CONTROL (OFAC) NOTICE

Notwithstanding any other provisions of this Agreement or any requirement of Texas law, Health Plan shall not be liable to pay any claim, provide any benefit, or take any other action to the extent that such payment, provision of benefit, or action would be in violation of any economic or trade sanctions of the United States of America, including, but not limited to, policies and regulations administered and enforced by the United States Treasury's Office of Foreign Assets Control (OFAC).

DESCRIPTION OF BENEFITS

13. WHAT'S COVERED?

To understand the benefits available under this Plan, You and Your Covered Dependents should first review this Description of Benefits and the Schedule of Benefits.

The Description of Benefits will help identify what types of services are covered, when and how each benefit will be covered, and how You and Your Covered Dependents can receive Health Care Services. The Section entitled Exclusions and Limitations describes the types of illness, sickness and services that are not covered by this Agreement.

You and Your Covered Dependent's entitlement to Health Care Services is contingent upon such services being determined as Medically Necessary and prescribed or ordered by, a Participating Physician or Participating Provider. Health Care Services are also contingent upon all definitions, terms, conditions, and limitations on Health Care Services set forth in all parts of this Agreement being met. In order to receive these Health Care Services, You must pay the Copayments specified in the Schedule of Benefits and any amendments and riders to this Agreement. Except for Emergency Care Services, approved out-of-network services and Health Care Services provided to a Covered Dependent child under a Qualified Medical Support Order who is outside the Service Area, all of the benefits are to be provided by Participating Physician and Participating Providers. You may select a Primary Care Physician for You and Your Eligible Dependents. Services provided for treatment of Alzheimer's disease do not require proof of organic disease. Treatment of congenital defect of newborns will be treated on the same basis as any other covered illness or injury. Treatment of hearing and screenings for children through age 17 are covered.

13.1 COPAYMENTS

The Schedule of Benefits identifies Your Copayments, and other expenses You are responsible to pay. Some benefits have copayments that are applied differently than a typical copayment. The office visit Copayment in the Schedule of Benefits is for an Office Visit only. Additional Health Care Services provided during an office visit may be subject to an additional Copayment. If special copayment rules apply, those rules will be explained in that specific benefit section.

13.2 OUT-OF-POCKET MAXIMUM

If the amount of qualifying Out-of-Pocket Expenses You pay during a Calendar Year exceeds the Out-of-Pocket Maximum shown on the Schedule of Benefits, Covered Services obtained after reaching the Out-of-Pocket Maximum will be covered at 100% and not be subject to Copayments.

13.3 BENEFIT LIMITATIONS

Certain benefits under this Agreement are subject to benefit limitations. If You or Your Covered Dependent meets or exceeds a given benefit limitation during the Plan Year, such enrollee will not be eligible for Covered Services for that particular service for the remainder of the Plan Year in which the benefit limitation was met or exceeded.

13.4 CASE GUIDANCE PROGRAM

Health Plan has in place Case Guidance Programs for Members with chronic conditions or complex care needs that require ongoing education and mentoring or a complicated plan of care requiring multiple services and providers. A nurse case manager will work with You, Your family or significant other and physician to provide assistance and to coordinate the services necessary to meet your care needs to achieve the best possible outcomes and the

greatest value for your health care benefits.

If You, or Your Covered Dependent, has a health condition or disease state for which Health Plan operates a Case Guidance program, You may be contacted by Health Plan or Health Plan's designated case guidance vendor and offered the opportunity to participate in case guidance.

Participation in Case Guidance is strictly voluntary.

13.5 PRIOR AUTHORIZATION REQUIREMENTS

Certain services require prior authorization in order to be covered. Typically, your Provider will request Prior Authorization on your behalf.

13.5.1 SERVICES REQUIRING PRIOR AUTHORIZATION

Some procedures and surgeries require Prior Authorization. Failure to obtain Prior Authorization may result in a reduction or denial of benefits under this Agreement.

The Scott and White Health Plan Health Services Division has the responsibility of issuing Prior Authorization

For a complete list of Health Care Services subject to Prior Authorization, visit Our website at www.swhp.org or call Us at the contact information shown in the Toll-Free Notice. Failure to obtain Prior Authorization will result in a 50% reduction in benefits.

13.6 BENEFITS

13.6.1 ESSENTIAL HEALTH BENEFITS AND BASIC HEALTH CARE SERVICERS

You and Your Covered Dependents are entitled to the following medically necessary Essential Health Benefits and Basic Health Care Services without being subject to Annual or Lifetime limitations.

- Ambulatory patient services, including:
  - Primary care and specialist physician services;
  - Outpatient services by other providers;
  - Home health services;
- Emergency services
  - Emergency services as required by the insurance code
- Hospitalization
  - Inpatient hospital services, including room and board, general nursing care, meals and special diets when medically necessary, use of operating room and related facilities, use of intensive care unit and services, x-ray services, laboratory and other diagnostic tests, drugs, medications, biologicals, anesthesia and oxygen services, special duty nursing when medically necessary, radiation therapy, inhalation therapy, administration of whole blood and blood plasma, and short-term rehabilitation therapy services in the acute hospital setting.
    - Inpatient physician care services, including services performed, prescribed, or supervised by preventive, referral and consultative health care services.
    - Outpatient hospital services, including treatment services, ambulatory surgery services; diagnostic services, including laboratory, radiology, and imaging services, rehabilitation therapy, and radiation therapy.
    - Maternity and newborn care, including prenatal services

    - Mental health and substance use disorder services, including behavioral health treatment
    - Prescription drugs
- Rehabilitative and habilitative services and devices, including
    - Outpatient rehabilitation therapies including physical therapy, speech therapy, manipulative, and occupational therapy
- Laboratory services, including
    - Diagnostic services, including laboratory, imaging and radiologic services;
    - Therapeutic radiology services
- Preventive and wellness services and chronic disease management, including
    - Periodic health examinations for adults as required by the insurance code §1271.153;
    - Immunizations for children as required by the insurance code §1367.053;
    - Cancer screening as required in the insurance code Chapter 1356 relating to mammography;
    - Cancer screening as required in the insurance code Chapter 1362 relating to screening of prostate cancer;
    - Cancer screening as required in the insurance code Chapter 1363 relating to screening for colorectal cancer;
    - Immunizations for adults in accordance with the United States Department of Health and Human Services Centers for Disease Control Recommended Adult Immunization Schedule by Age Group and Medical Conditions, or its successor
- Pediatric services, including
    - Oral and vision care;
    - Well-child care from birth as required in the insurance code §1271.154;
    - Eye and ear examinations for children through age 17, to determine the need for vision and hearing in accordance with established medical guidelines

If a Covered Service is an Essential Health Benefit, We will not apply annual or lifetime dollar limits to that service.

The remainder of this Agreement describes the Covered Services We will provide, which may or may not be considered Essential Health Benefits.

13.6.2 MEDICAL SERVICES

You and Your Covered Dependents are entitled to the Medically Necessary professional services of Participating Physicians and Participating Providers on an inpatient and outpatient basis. Medical Necessity is determined by a Participating Provider, subject to the review of the Health Plan Medical Director.

Examples of covered medical services may include, but are not limited to, the following:

- physical exams for medical or diagnostic purposes (other than preventive exams),
- newborn hearing screenings, and necessary diagnostic follow-up care,
- office visits,
- consultations by specialists,
- diagnostic procedures including lab and x-ray,
- treatment for diseases of the eye,
- outpatient surgery,
- dialysis,
- injections
- chemotherapy and radiation therapy for cancer,

- allergy tests and
- home health care

13.6.2.1 OTHER OUTPATIENT SERVICES

Medical Services that are not specifically listed in the description above may result in separate additional copayments or limits, if so listed in the Schedule of Benefits.

13.6.2.2 COPAYMENTS

Medical Services are subject to the applicable Copayment listed in the Schedule of Benefits. For Medical Services provided during an Office Visit to a Participating Physician or Provider, You or Your Covered Dependent may be responsible for both an office visit Copayment and a Copayment for the other Medical Services rendered in connection with the Office Visit. This is particularly true when You are subject to a percentage Copayment and may vary depending upon Your Physician or Provider's method of billing.

13.6.3 PREVENTIVE CARE SERVICES

You and Your Covered Dependents are entitled to the Preventive Services of Participating Physicians and Participating Providers without being subject to a Copayment.

You and Your Covered Dependents may access preventative Health Care Services and health education programs as determined by Health Plan.

13.6.3.1 COVERED PREVENTIVE SERVICES

You and Your Covered Dependents are entitled to the Preventive Care Services of Participating Physicians and Participating Providers without being subject to a Copayment. Preventive Care Services obtained from non-Participating Providers will be subject to applicable copayment listed in the Schedule of Benefits.

You and Your Covered Dependents may access Preventative Care Services and health education programs as determined by Health Plan. Under the Affordable Care Act, certain preventive services from Participating Providers are paid at 100% (at no cost to the member), depending on the billing and diagnosis.

The determination of whether a service is a Preventive Care Service may be influenced by the type of service for which your Physician or Provider bills the Health Plan. Specifically (1) if a recommended preventive service is billed separately from an office visit, then a plan may impose cost-sharing requirements with respect to the office visit, (2) if a recommended preventive service is not billed separately from an office visit and the primary purpose of the office visit is the delivery of a preventive service, then a plan may not impose cost-sharing requirements with respect to the office visit, and (3) if a recommended preventive service is not billed separately from an office visit and the primary purpose of the office visit is not the delivery of a preventive service, then Health Plan may impose cost-sharing requirements with respect to the office visit.

Coverage of Counseling for a particular condition or disease as a Preventive Care Service does not equate to treatment of that particular condition or disease. While the counseling visit may be considered to be a Preventive Care Service and thus not subject to Copays, the treatment of such condition or disease will be subject to appropriate Copays, and to the Exclusions and Limitations provisions of the Health Plan.

These services fall under four broad categories as shown below. These listings will be updated as required by federal or state law.

Services with an "A" or "B" rating from the United States Preventive Services Task Force.

- **Screening for abdominal aortic aneurysm** - a one-time screening for abdominal aortic aneurysm (AAA) by ultrasonography in men age 65 to 75, who have smoked.
- **Screening and counseling to reduce alcohol misuse -** screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings.
- **Aspirin to prevent CVD: men -** the use of aspirin for men age 45 to 79 years, when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.
- **Aspirin to prevent CVD: women -** the use of aspirin for women age 55 to 79 years, when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.
- **Asprin to prevent preeclampsia-** the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia
- **Screening for bacteriuria -** screening for asymptomatic bacteriuria with urine culture for pregnant women at the later of 12 to 16 weeks' gestation or at the first prenatal visit.
- **Screening for high blood pressure -** screening for high blood pressure in adults age 18 and older.
- **Counseling and testing related to BRCA screening -** women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes, who are referred for genetic counseling and evaluation for BRCA testing.
- **Screening for breast cancer (mammography) -** annual low-dose mammography for women, with or without clinical breast examination (CBE), for women age 35 and older. Low-dose mammography means the x-ray examination of the breast using equipment dedicated specifically for mammography, including an x-ray tube, filter, compression devise, screens, films and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.
- **Chemoprevention of breast cancer -** clinicians discussion of chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention. For women, age 35 and older, without a prior diagnosis, but who are at increased risk for breast cancer and at low risk for adverse medication effects, a clinician should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene. These risk-reducing medications are covered as preventive services, which qualify for the waiver of applicable cost-sharing requirements, only if used for prevention. They are not considered preventive if used for the treatment of a Member already diagnosed with breast cancer.
- **Interventions to support breast feeding -** interventions during pregnancy and after birth to promote and support breastfeeding.
- **Screening for Human Papillomavirus and cervical cancer (Pap Smear) -** diagnostic examination for early detection of cervical cancer, including the provider's charge for administration of the test, for any covered female age 18 or older, not to exceed one per Year for: a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration (FDA), alone or in combination with a test approved by the FDA for the detection of the human papillomavirus. A screening test must be performed in accordance with the guidelines adopted by the American College of Obstetricians and Gynecologists or another similar national organization of medical professionals recognized by the Insurance Commissioner.

- **Screening for chlamydial infection: non-pregnant women -** screening for chlamydial infection for all sexually active non-pregnant women age 24 and younger and for older non-pregnant women who are at increased risk.
- **Screening for chlamydial infection: pregnant** women **-** screening for chlamydial infection for all pregnant women age 24 and younger and for older pregnant women who are at increased risk.
- **Screening for cholesterol abnormalities: men 35 and older -** screening for men age 35 and older for lipid disorders.
- **Screening for cholesterol abnormalities: men younger 35 -** screening for men age 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease.
- **Screening for cholesterol abnormalities: women 45 and older -** screening for women age 45 and older for lipid disorders if they are at increased risk for coronary heart disease.
- **Screening for cholesterol abnormalities: women younger than 45 -** screening for women age 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease.
- **Screening for colorectal cancer -** screening for detection of colorectal cancer for a Member at least 50 years of age and at normal risk for developing cancer, limited to: an annual fecal occult blood test and a flexible sigmoidoscopy once every five years; or a colonoscopy once every ten years.
- **Chemoprevention of dental caries -** primary care clinicians prescription for oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride.
- **Screening for depression: adults -** screening of adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.
- **Screening for depression: adolescents -** screening of adolescents (11 to 18 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.
- **Screening for diabetes -** Screening for abnormal blood glucose as part of cardiovascular risk assessment in adults age 40 to 70 who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.
- **Counseling for a healthy diet and physical activity -** intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.
- **Supplementation with folic acid -** a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid for all women planning on or capable of pregnancy.
- **Screening for gonorrhea: women –** screening for all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors).
- **Prophylactic medication for gonorrhea: newborns -** prophylactic ocular topical medication for all newborns against gonococcal ophthalmia neonatorum.
- **Screening for hearing loss -** screening test for hearing loss for a child from birth through the date the child is 30 days old; and Medically Necessary diagnostic follow-up care to the screening test for a child from birth through the date the child is 24 months old.
- **Screening for hemoglobinopathies -** screening for sickle cell disease in newborns.

- **Screening for hepatitis B -** screening for hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit.
- **Screening for hepatitis B: nonpregnant adolescents and adults-** screening for hepatitis B virus (HBV) infection in person at high risk for infection
- **Screening for hepatitis C -** screening for hepatitis C virus (HCV) infection in persons at high risk for infection and a one-time screening for HCV infection to adults born between 1945 and 1965.
- **Screening for HIV -** screening for human immunodeficiency virus (HIV) in all adolescents and adults at increased risk for HIV infection.
- **Screening for HIV:** pregnant women – screening for all pregnant women for human immunodeficiency virus (HIV), including those who present in labor, who are untested and whose status is unknown.
- **Screening for congenital hypothyroidism -** screening for congenital hypothyroidism (CH) in newborns.
- **Screening for iron deficiency anemia -** screening for iron deficiency anemia in asymptomatic pregnant women.
- **Iron supplementation in children -** routine iron supplementation for asymptomatic children age 6 to 12 months who are at increased risk for iron deficiency anemia.
- **Screening and counseling for obesity: adults –** screening for all adult patients for obesity and intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.
- **Screening and counseling for obesity:** children **–** screening for children age 6 years and older for obesity and referral to comprehensive, intensive behavioral interventions to promote improvement in weight status.
- **Screening for osteoporosis –** screening for women age 65 and older or a qualified individual for medically accepted bone mass measurement to detect low bone mass and to determine the Member's risk of osteoporosis and fractures associated with osteoporosis. A "qualified individual" is: a postmenopausal woman who is not receiving estrogen replacement therapy; an individual with vertebral abnormalities, primary hyperparathyroidison, or a history of bone fractures; or an individual who is receiving long-term glucocorticoid therapy or being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.
- **Screening for PKU -** screening for phenylketonuria (PKU) in newborns.
- **Screening for Rh incompatibility: first pregnancy visit -** Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.
- **Screening for Rh incompatibility: 24 to 28 weeks gestation -** repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.
- **Counseling for STIs -** high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs.
- **Screening for syphilis: non-pregnant persons –** screening for persons at increased risk for syphilis infection.
- **Screening for syphilis: pregnant women -** screening for all pregnant women for syphilis infection.
- **Counseling for tobacco use -** clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.

- **Counseling for tobacco use -** clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling for those who smoke.
- **Tobacco use intervention –** clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.
- **Screening for visual acuity in children -** screening to detect amblyopia, strabismus, and defects in visual acuity in children younger than 5 years old.
- **Screening for lung cancer-** annual screening for lunch cancer with low-dose tomography in adults ages 55 to 80 years who have a 30 day per year smoking history and currently smoke or have within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.
- **Counseling for skin cancer-** counseling for children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolent radiation to reduce risk for skin cancer.
- **Fall prevention in older adults: exercise or physical therapy –** exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.
- **Fall prevention in older adults: vitamin D** – vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.
- **Screening for critical congenital heart disease**: screening for critical congenital heart disease with pulse oximetry for newborns.

Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Immunizations for Children ages 0 through 6 years:

- Hepatitis B
- Rotavirus
- Diptheria, Tetanus, Pertussis
- Haemophilus influenza type b conjugate (Hib)
- Pneumococcal conjugate and pneumococcal polysaccharide (PPSV)
- Inactivated poliovirus (IPV)
- Influenza (seasonal), including H1N1 influenza
- Measles, mumps, and rubella (MMR)
- Varicella
- Hepatitis A (HepA)
- Meningococcal
- Polio
- Any other immunization required by law for the child

Immunizations for Children ages 7 through 18 years:

- Tetanus, Diptheria, Pertusis (Td/Tdap)
- Human papillomavirus (HPV)
- Meningococcal
- Influenza (seasonal)
- Pneumococcal polysaccharide (PPSV) and pneumococcal conjugate

- Hepatitis A (HepA)
- Hepatitis B
- Inactivated poliovirus (IPV)
- Measles, mumps, and rubella (MMR Varicella
- Varicella

Immunizations for adults over age 18:

- Tetanus, Diptheria, Pertusis (Td/Tdap)
- Human papillomavirus (HPV)
- Varicella
- Herpes zoster
- Measles, mumps, and rubella (MMR)
- Influenza (seasonal)
- Pneumococcal polysaccharide (PPSV)
- Hepatitis A (HepA)
- Hepatitis B
- Meningococcal
- Haemophilus influenza type b conjugate (Hib)
- Pneumococcal conjugate

Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. Covered Services are listed in the Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care and the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children.

- **Preventive Physical Exams at Recommended Intervals**
    - Measurements – length, height, weight, head circumference, weight for length, body mass index, blood pressure
- **Sensory Screening**
    - Vision
    - Hearing
- **Developmental/Behavioral Assessment**
    - Developmental Screening
    - Autism Screening at the ages of 18 and 24 months, and as otherwise required by federal law
    - Developmental Surveillance
    - Psychosocial/Behavioral Assessment
    - Alcohol and Drug Use Assessment
- **Procedures**
    - Newborn Metabolic/Hemoglobin Screening
    - Immunization
    - Hematocrit or Hemoglobin
    - Lead Screening
    - Tuberculin Test
    - Dyslipidemia Screening
    - Sexually Transmitted Infection (STI) Screening
    - Cervical Dysplasia Screening
    - Critical Congenital Heart Disease Screening

- **Oral Health**
    - Risk Assessment and possible oral fluoride supplementation

Preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.

- **Annual well-woman preventive care visit** for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. When appropriate, this visit can include other covered Adult Preventive Care Services. 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. Screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation.
- **High-risk human papillomavirus DNA testing** in women with normal cytology results, beginning at 30 years of age and occurring no more frequently than once every three years.
- **Annual counseling on sexually transmitted infections** for all sexually active women.
- **Annual screening and counseling for human immune-deficiency virus infection** for all sexually active women.
- **Prescripted FDA-approved contraceptive methods, sterilization procedures and patient education and counseling** for all women with reproductive capacity, including Injectable Drugs and implants, intra-uterine devices, diaphragms, and the professional services associated with them.
- **Comprehensive lactation support and counseling** by a trained provider during pregnancy and/or in the postpartum period and rental of breastfeeding equipment.
- **Annual screening and counseling for women for interpersonal and domestic violence.**

13.6.3.2 PROSTATE CANCER SCREENING EXAM

You and Your Covered Dependents, if male, are eligible for an annual screening exam to detect prostate cancer. The benefits provided under this subparagraph include the following once per Calendar Year: (1) a physical examination to detect prostate cancer, (2) a prostate-specific antigen test for a male Member who is at least 50 years of age with no symptoms or who is at least 40 years of age and has a family history of prostate cancer or another prostate cancer risk factor.

13.6.3.3 PHENYLKETONURIA (PKU) OR HERITABLE METABOLIC DISEASE

Coverage for formulas to treat phenylketonuria (PKU) or a heritable metabolic disease are available to You or Your Covered Dependent as prescribed by a Participating Physician.

13.6.4 HOSPITAL SERVICES

You and Your Covered Dependents are entitled to the Medically Necessary services of any Participating Hospital to which You or Your Covered Dependent may be admitted by a Participating Physician or Participating Provider. In the event You or a Covered Dependent are admitted to a non-Participating Hospital by a Participating Physician or Participating Provider to whom You or Your Covered Dependent were referred in accordance with Health Plan procedures, the services of the non-Participating Hospital will be covered on the same basis as admission to a Health Plan Hospital, provided admission to the non-Participating Hospital was approved in accordance with this Agreement. Health Plan will cover the cost of a semi-private room, or the equivalent thereof, for covered hospital admissions for routine acute care. For more intense levels of care, that level of care which is Medically Necessary will be covered. Medically necessary services for an inpatient stay following a mastectomy shall be covered under this provision.

Examples of covered hospital services may include, but are not limited to, the following:

- semi-private room,
- inpatient meals and special diets, , when medically necessary,

- inpatient medications and biologicals,
- intensive care units,
- nursing care, including special duty nursing, when medically necessary,
- short term rehabilitation therapy services in the acute hospital setting
- inpatient lab, x-ray and other diagnostic tests,
- skilled nursing facility care,
- inpatient medical supplies and dressings,
- anesthesia,
- inpatient oxygen,
- operating room and recovery room,
- inpatient physical therapy,
- inpatient radiation therapy,
- inpatient inhalation therapy,
- administration of whole blood and blood plasma.

13.6.5 EMERGENCY CARE SERVICES

13.6.5.1 QUALIFICATION OF EMERGENCY SERVICES

Medically Necessary Emergency Care is covered by this Agreement, including the treatment and stabilization of an emergency medical condition. However, only those conditions meeting the terms of the definition of Emergency Care will qualify. Health Plan will provide for any medical screening examination or other evaluation required by Texas or federal law that takes place in a hospital emergency facility or comparable facility, and that is necessary to determine whether an emergency medical condition exists. Medically Necessary Emergency Care received from a non-participating Physician or non-Participating Provider will be fully reimbursed according to the terms of the Health Care Agreement at the usual and customary or agreed upon rate, except for Copayments, and charges for non-covered services.

13.6.5.2 URGENT CARE SERVICES

Urgent Care services provide for the immediate treatment of a medical condition that requires prompt medical attention but where a brief time lapse before receiving services will not endanger life or permanent health. Member shall be required to pay the Copayment stated in the Schedule of Benefits for Treatment administered at an Urgent Care Facility. Unless designated and recognized by Health Plan as an Urgent Care Facility, neither a hospital nor an emergency room will be considered an Urgent Care Facility.

13.6.5.3 EMERGENCY TRANSPORTATION SERVICES

Emergency transportation, when and to the extent it is Medically Necessary, is covered when transportation in any other vehicle would endanger the patient's health. Health Plan will not cover air transportation if ground transportation is medically appropriate and more economical. If these conditions are met, Health Plan will cover ambulance transportation to the closest appropriate hospital or skilled nursing facility.

13.6.5.4 EMERGENCY MEDICAL SERVICES

Emergency medical services provided by ambulance personnel for which transport is unnecessary or is declined by Member will be subject to the copayment listed in the Schedule of Benefits. If the ambulance transports the Member after receiving emergency medical services from ambulance personnel, the Emergency Medical Services Copayment is waived.

13.6.5.5 TRANSPORTATION TO PARTICIPATING FACILITY AFTER STABILIZATION

Once You or Your Covered Dependent’s condition is stabilized and as medically appropriate, Health Plan may require transfer to a Participating Hospital to appropriately manage patient's care. Where stabilization of an emergency medical condition originates in a hospital emergency facility or comparable facility, Treatment following such stabilization may require approval by Health Plan. The treating physician or provider must make the request for post-stabilization care. Health Plan will approve or deny such request within the time appropriate to the circumstances relating to the delivery of services and the condition of the patient, but in no event to exceed

one hour from the time of the request.

13.6.5.6 EMERGENCY CARE COVERAGE EXCEPTIONS/LIMITATIONS

Health Plan will not cover any expenses involving non-emergent/non-urgent Treatments performed or prescribed by non-Participating Physicians or non-Participating Providers, either inside or outside of the Service Area, and for which Health Plan has not authorized an out-of-network referral. Complications of those Treatments will not be covered prior to the date Health Plan arranges for patient's transfer to a Participating Physician or Participating Provider. In no event shall Health Plan cover any Treatments which are excluded from coverage under this Agreement or complications of those Treatments.

13.6.5.7 HOSPITALIZATION AT OTHER THAN PARTICIPATING HOSPITAL

If You or Your Covered Dependent is hospitalized as the result of an Emergency admission at other than a Participating Hospital, in order for the hospital stay to be covered You must notify Health Plan within twenty-four (24) hours of admission or as soon thereafter as it is reasonably possible, and Health Plan shall provide information about its obligations under this Agreement. Failure to provide notification may result in denial of payment unless it is shown not to have been reasonably possible to give such notice.

13.6.6 MENTAL HEALTH CARE

Medically Necessary Inpatient and Outpatient Treatment of Your or Your Covered Dependent's mental illness and emotional disorders are determined by a Participating Physician or Participating Provider. Services provided for the Outpatient Mental Health Care and Inpatient Mental Health Care listed below are limited to those services which, in the judgment of a Participating Physician, meet or exceed Treatment goals as set forth in the Individual Treatment Plan within the benefits described below. Covered services include the following:

13.6.6.1 OUTPATIENT MENTAL HEALTH CARE

For the Treatment of mental illness, You or Your Covered Dependents are entitled to outpatient diagnostic and therapeutic services provided by Participating Psychiatrists and other Health Professionals.

13.6.6.2 INPATIENT MENTAL HEALTH CARE

For the Treatment of mental illness, You or Your Covered Dependents are entitled to inpatient diagnostic and therapeutic services provided by Participating Mental Health Provider.

13.6.6.3 COPAYMENTS ON MENTAL HEALTH CARE

For outpatient mental health care, You or Your Covered Dependents are required to pay Copayment for each outpatient mental health care visit to or by a Health Professional as stated in the Schedule of Benefits.

For inpatient mental health care, You or Your Covered Dependents are required to pay Copayment for each day of inpatient mental health care with a Participating Provider as stated in the Schedule of Benefits.

13.6.6.4 PSYCHIATRIC DAY TREATMENT FACILITY

Psychiatric Day Treatment Facility services are available for Medically Necessary mental health evaluations, diagnostic and therapeutic services, as shall be recommended by a Participating Physician in lieu of hospitalization upon a referral to such facility, if any, with which Health Plan may maintain an agreement for the provision of such services. In order to be considered for coverage, the Participating Physician attending a member must certify that treatment at such facility is in lieu of hospitalization.

13.6.6.5 RESIDENTIAL AND STABILIZATION MENTAL HEALTH TREATMENT

Alternative mental health Treatment benefits are available for Medically Necessary Treatment of mental and emotional disorders, including mental health evaluations, diagnostic and therapeutic services in a Residential Treatment Center for Children and Adolescents or a Crisis Stabilization Unit as shall be prescribed by a Participating Physician in lieu of hospitalization upon a referral to such facility, if any, with which Health Plan may maintain an agreement for the provision of such services in Health Plan's Service Area.

13.6.6.6 QUALIFICATION OF RESIDENTIAL AND STABILIZATION MENTAL HEALTH TREATMENT

The above alternative mental health Treatment benefits may be covered by Health Plan under the following conditions:

1) as determined by a Participating Physician specializing in psychiatry, You or Your Covered Dependents have a serious mental illness which substantially impairs thought, perception of reality, emotional process, or judgment or grossly impairs behavior as manifested by recent disturbed behavior and which would otherwise necessitate confinement in a hospital if such care and Treatment were not available through a Crisis Stabilization Unit or Residential Treatment Center for Children and Adolescents;
2) the services rendered for which benefits are to be paid must be based on an Individual Treatment Plan; and
3) providers of services for which benefits are to be paid must be licensed or operated by the appropriate state agency or board to provide those services, be located within the Service Area, and be designated by Health Plan as an approved provider with which Health Plan has entered into an agreement for the provision of such services.

13.6.7 TREATMENT FOR CHEMICAL DEPENDENCY

13.6.7.1 TREATMENT FOR CHEMICAL DEPENDENCY

You or Your Covered Dependents are entitled to Medically Necessary care and Treatment for Chemical Dependency on the same basis as physical illness generally, subject to the Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers, adopted by the Texas Department of Insurance.

13.6.7.2 COPAYMENTS FOR CHEMICAL DEPENDENCY

You or Your Covered Dependents are required to pay the same Copayments for Outpatient Treatment for Chemical Dependency as for other outpatient benefits provided under this Agreement. You or Your Covered Dependents are required to pay the same Copayments for Inpatient Treatment for Chemical Dependency as for other inpatient benefits provided under this Agreement.

13.6.8 REHABILITATIVE AND HABILITATIVE THERAPY

13.6.8.1 REHABILITATIVE THERAPY

As recommended by a Participating Physician as Medically Necessary, outpatient rehabilitative and habilitative therapy services are available for services for physical, inhalation, speech, hearing, manipulative, and occupational therapies. Rehabilitation and services that, in the opinion of the Participating Physician are Medically Necessary, shall not be denied, limited or terminated as long as they meet or exceed Treatment goals for You or Your Covered Dependent in accordance with an Individual Treatment Plan. For a physical disability, treatment goals may include maintenance of functioning, prevention of deterioration, or slowing of further deterioration.

13.6.8.2 EARLY CHILDHOOD INTERVENTION SERVICES

Medically Necessary Covered Rehabilitative Therapy Services provided to a Covered Dependent under the age of 18 in accordance with an individualized family service plan issued by the Interagency Council on Early Childhood Intervention will be covered.

13.6.8.3 MANIPULATIVE THERAPY

You or Your Covered Dependents are eligible for outpatient manipulative therapy. Manipulative therapy services are those within the scope of rehabilitative care, including those services provided by a Chiropractor or other provider licensed to provide the service, that are supportive or necessary to help Members achieve the same physical state as before an injury or illness, and that are determined to be Medically Necessary. The services are generally furnished for the diagnosis and/or treatment of neuromusculoskeletal condition associated with an injury or illness, including the following:

- Examinations

- Manipulations
- Conjunctive Physiotherapy

13.6.9 HOME HEALTH SERVICES

Home health services consist of Medically Necessary nursing care that is recommended by a Physician, approved in advance by the Medical Director, and provided by a licensed home health care agency. These services are available when they are an essential part of an active Individual Treatment Plan, when there is a defined goal expected to be attained and You or Your Covered Dependent are required to remain at home for medical reasons. The Physician and Medical Director shall determine the conditions under which all Medically Necessary services shall be provided. Examples of such conditions include, but are not limited to, the following: duration of care; setting, such as inpatient institutional care rather than home care; type of care, such as nursing care or physical therapy; and frequency of care, such as daily or weekly. Home health services shall not be covered for Custodial Care or primarily for convenience, as determined by the Medical Director.

Rehabilitative and Habilitative Therapy Services provided in the Home Health Services setting are subject to the Home Health Rehabilitative and Habilitative Therapy Copayments and Limits as stated in the Schedule of Benefits.

Subject to any limits on the maximum number of days for which a Copayment is required, You are required to pay a Copayment for each day of Home Health Services as stated in the schedule of benefits.

13.6.10 HOME INFUSION THERAPY BENEFIT

As recommended by a Participating Physician and approved by the Medical Director as Medically Necessary, Home Infusion Therapy services are available for high technology services, including line care, chemotherapy, pain management infusion and antibiotic, antiviral or antifungal therapy. Included within the Home Infusion Therapy benefit are administrative and professional pharmacy services and all necessary supplies and equipment to perform the home infusion. Not included in the Home Infusion Therapy benefit are medical professional services (physician, nursing, etc.), enteral formula, and covered durable medical equipment not related to the home infusion therapy some of which may be covered under other provision of this Agreement, and subject to additional copayments.

13.6.10.1 COPAYMENTS FOR HOME INFUSION THERAPY BENEFITS

Subject to any limits on the maximum number of days for which a Copayment is required, You are required to pay a Copayment for each day of Home Infusion Therapy as stated in the schedule of benefits.

13.6.11 HOSPICE SERVICES

Hospice services consist of Medically Necessary Hospice care that is recommended by a designated Participating Physician, approved in advance by the Medical Director, and provided by a licensed Hospice agency with which Health Plan has arranged for You or Your Covered Dependent's care and Treatment.

13.6.11.1 COPAYMENTS FOR HOSPICE BENEFITS

Subject to any limits on the maximum number of days for which a Copayment is required, You are required to pay a Copayment for each day of Hospice Services as stated in the schedule of benefits.

13.6.12 MATERNITY SERVICES

13.6.12.1 MATERNITY SERVICES

Maternity services include physician obstetrical care, labor and delivery services, hospital room and board and the care of complicated pregnancies in conjunction with the delivery of a child or children by You or Your Covered Dependent. Routine deliveries are to be under the care of a Participating Physician at a Participating Hospital.

13.6.12.2 INPATIENT MATERNITY SERVICES

Coverage includes a minimum of forty-eight (48) hours of inpatient care to a mother and her newborn child following an uncomplicated vaginal delivery and ninety-six (96) hours of inpatient care to a mother and her newborn following an uncomplicated delivery by caesarean section, if such inpatient care is determined to be Medically Necessary by a Participating Physician or is requested by the mother.

The determination whether a delivery is complicated shall be made by the Participating Physician. If the decision is made to discharge a mother or newborn child from inpatient care before the expiration of the above time frames, Health Plan shall provide coverage for timely post-delivery care, to be provided by a Participating Physician, registered nurse or other appropriate Health Care Professional, and may be provided at the mother's home, a health care provider's office, health care facility or other appropriate location. The mother has the option to have the care provided in the mother's home. The timeliness of the care shall be determined in accordance with recognized medical standards for that care.

13.6.12.3 DELIVERY AS EMERGENCY CARE

In the event You or Your Covered Dependent delivers at a non-Participating Hospital, a routine delivery, that does not meet the definition of Emergency Care, shall not be considered Emergency Care, and will not be a Covered Service.

13.6.12.4 COPAYMENTS FOR MATERNITY SERVICES

You are NOT required to pay a Copayment for outpatient visits to a Health Professional for prenatal visits. Prenatal visits are considered to be Well Woman care, and as such are covered as Preventive Care services, and are not subject to a copayment.. Copayments are required for each day of inpatient services for the mother, and for each day of inpatient services for the newborn, for the amount and days as stated in the Schedule of Benefits.

13.6.13 FAMILY PLANNING SERVICES

13.6.13.1 FAMILY PLANNING SERVICES

Family planning and services relating to the diagnosis of infertility shall be provided as Medically Necessary and as prescribed and authorized by a Participating Physician. Examples of such services include:

- counseling,
- sex education instruction in accordance with medically acceptable standards,
- diagnostic procedures to determine the cause of infertility,(NOTE: Treatment of infertility is not a Covered Service under this provision);
- vasectomies, and
- laparoscopies.

13.6.14 DURABLE MEDICAL EQUIPMENT/ORTHOTICS/PROSTHETIC DEVICES

Medically Necessary durable medical equipment or Prosthetic Devices or Orthotic Devices may be covered under this Agreement. The Medical Director shall determine the conditions under which such equipment and appliances shall be covered. The conditions include, but are not limited to the following: the length of time covered, the equipment covered, the supplier, and the basis of coverage; i.e., rental, purchase, or loan.

13.6.14.1 CONSUMABLE SUPPLIES

Consumable supplies associated with the use of covered durable medical equipment and prosthetic medical appliances are covered under this Agreement only to the extent that such supplies are required in order to use the specific piece of durable medical equipment or prosthetic medical appliance. Repair, maintenance, and cleaning due to abnormal wear and tear or abuse is Your responsibility.

13.6.14.2 DURABLE MEDICAL EQUIPMENT

Durable Medical Equipment may be covered under this Agreement if determined as Medically Necessary by the Medical Director. Ostomy supplies are considered Durable Medical Equipment for purposes of this Provision. Rented or loaned equipment must be returned in satisfactory condition and You are responsible for cleaning and repair required due to abnormal wear and tear or abuse. Coverage for rented or loaned equipment is limited to the amount such equipment would have cost if purchased by Health Plan from a Participating DME provider. Health Plan shall have no liability for installation, maintenance or operation of such equipment for home-based use. Health Plan shall provide coverage for durable medical equipment as specified in the Schedule of Benefits.

13.6.14.3 PROSTHETIC DEVICES

Prosthetic Devices may be covered under the conditions determined by the Medical Director and as are Medically Necessary to replace defective parts of the body following injury or illness. Health Plan shall cover the initial device, replacement of the device if replacement is not due to misuse or loss of the device, and normal repairs. Prosthetic device coverage is limited to the most appropriate model of prosthetic device that adequately meets Your needs as determined by your Participating Provider. For Prosthetics, Health Plan shall provide coverage subject to the applicable Copayments, specified in the Schedule of Benefits. Health Plan shall provide coverage for prosthetic medical appliances as specified in the Schedule of Benefits.

13.6.14.4 HEARING AIDS

We provide coverage for the cost of one hearing aid per hearing impaired ear every 36 months. This coverage also includes services related to a covered hearing aid device prescribed by a licensed audiologist, hearing instrument specialist, or an ear, nose, and throat (ENT) doctor, including:

- The initial hearing aid evaluation
- Fitting and adjustments
- Qualifying supplies such as ear molds

Coverage is subject to all of the requirements of the health plan and doesn't include replacement hearing aid batteries.

13.6.14.5 ORTHOTIC DEVICES

Medically Necessary Orthotic Devices may be covered under this Agreement. Health Plan shall cover the initial device, replacement of the device if replacement is not due to misuse or loss of the device and normal repairs. Orthotic device coverage is limited to the most appropriate model of orthotic device that adequately meets Your needs as determined by your Participating Provider. Health Plan shall provide coverage for Orthotic Devices subject to the applicable Copayments specified in the Schedule of Benefits.

13.6.15 <u>COVERAGE OF PRESCRIPTION DRUGS</u>

You and Your Covered Dependents shall be eligible to receive prescription drugs on the following basis:

13.6.15.1 COVERED DRUGS, PHARMACEUTICALS AND OTHER MEDICATIONS

The only covered drugs, pharmaceuticals or other medications (herein collectively referred to as "drug" or "drugs") covered hereunder are those which, under Federal or State law, may be dispensed only pursuant to an order from a licensed Health Professional with appropriate law enforcement agency registrations; which are prescribed by:

a) a Network Health Professional, or

b) in connection with emergency Treatment, a Health Professional in attendance on You or Your Covered Dependent at an emergency facility, or

c) by a Referral Health Professional to whom You or Your Covered Dependent has been referred by a Network Health Professional; which are used for the Treatment of an illness or injury covered under this Agreement;

d) filled through a Health Plan Network Pharmacy in accordance with this Agreement.

As medically appropriate, the Medical Director may require the substitution of any drug for another drug or form of Treatment which, upon the recommendations of the Pharmacy and Therapeutics Committee or expedited review subcommittee, and the Medical Director's professional judgement, provides equal or better results at at a lower cost. Special dietary formulas for individuals with phenylketonuria or other heritable diseases are also covered under this prescription drug benefit. Heritable diseases are inherited diseases that may result in mental or physical retardation or death. Phenylketonuria is an inherited condition that may cause severe mental retardation if not treated.

13.6.15.2 COVERAGE FOR OFF-LABEL USE OF DRUGS

Drugs prescribed to treat You, or Your Covered Dependent's, covered chronic, disabling or life-threatening illness are covered under this prescription drug benefit if the drug has been approved by the Food and Drug Administration for at least one indication and is recognized for treatment of the indication for which the drug is prescribed in either a prescription drug reference compendium or substantially accepted peer reviewed medical literature. Coverage of the drug includes coverage of medically necessary services associated with the administration of the drug, but does not include coverage for experimental drugs not otherwise approved for any indication by the Food and Drug Administration or coverage for a drug that the Food and Drug Administration has not approved, or peer reviewed medical literature has not deemed as a medically accepted use for the proposed indication..

13.6.15.3 EVIDENCE BASED FORMULARY DEVELOPMENT

Health Plan provides coverage for prescription drugs in accordance with an evidence based formulary developed by physicians and pharmacists comprising the Pharmacy and Therapeutics Committee. A formulary is a list of drugs for which Health Plan provides coverage. The Pharmacy and Therapeutics Committee meets at least quarterly to review the scientific evidence, economic data, and a wide range of other information about drugs for potential formulary placement and coverage. Based upon that review, the committee selects the drugs it believes to be the safest and most effective of those drugs which meet the desired goals of providing appropriate therapy at the most reasonable cost. Once such determination is made, the Health Plan may contract with the manufacturer of the drugs for rebates. The committee will not select a drug for the formulary until enough clinical evidence is available to allow the committee to determine the drug's comparable safety and effectiveness. The committee determines which drugs to add or delete, supply and dosage limitations, sequence of use, and all other aspects about the Health Plan formulary. When necessary, a subcommittee may conduct an expedited review of a particular drug and make formulary determinations.

13.6.15.4 REQUEST FOR FORMULARY INFORMATION

You or Your Covered Dependent may contact the Health Plan to find out if a specific drug is on the formulary. The Health Plan must respond to Your request about the drug formulary no later than the third business day after the date of the request to disclose whether a specific drug is on the formulary. However, the presence of a drug on a drug formulary does not guarantee that Your Health Professional will prescribe the drug for a particular medical condition or mental illness.

13.6.15.5 FORMULARY LISTS

Copayments vary based upon the tier level a particular drug has been placed on by Health Plan. Drugs on the Health Plan formulary, which are preferred generic drugs, require the lowest Copayment. Drugs on the Health Plan formulary, which are preferred name brand drugs require an increased Copayment. Drugs, which are not on the preferred generic or preferred brand tiers on the Health Plan formulary, which are alternate choice drugs or other drugs for some medical conditions not treated by drugs on the preferred tiers, may not be covered by the Health Plan or may require the largest Copayment, depending on the plan of benefits selected. If a particular drug appeared on the Health Plan formulary at the beginning of Your Contract Year, Health Plan shall make such drug available at the contracted benefit level until the end of the Contract Year, regardless of whether the prescribed drug has been removed from the Health Plan's formulary.

For consideration of coverage for a non-formulary drug, one or more of the following criteria must be met:

1) the use of the formulary alternative(s) is contraindicated;

2) the formulary alternative(s) would cause or has caused adverse effects;

3) the use of the formulary alternative(s) would not be as effective as the non-formulary drug.

The prescribing Health Professional must submit a written request for prior authorization or request for an appeal to the Health Plan for consideration of coverage. If the request is denied, You and the Health Professional may appeal the denial (see UTILIZATION REVIEW REQUIREMENTS in the Evidence of Coverage).

13.6.15.6 INPATIENT PRESCRIPTION DRUGS

Prescription Drugs, including Preferred Specialty Pharmacy Drugs, administered while admitted to a Network Inpatient facility will be covered as part of Your Inpatient benefit, and no additional Copayments are required for prescription drugs so administered.

13.6.15.7 PREFERRED SPECIALTY PHARMACY DRUGS

Certain classes of Preferred Specialty Pharmacy Drugs must be dispensed from one of the Network Specialty Pharmacy providers. Such classes of Preferred Specialty Pharmacy Drugs dispensed by a Network Specialty Pharmacy provider will be subject to the formulary Copayment for Specialty Pharmacy Drugs specified in the Schedule of Benefits. Failure to obtain these specific classes of Specialty Pharmacy Drugs from the Network Specialty Pharmacy provider may result in denial of coverage for such Specialty Pharmacy Drug. You or Your Covered Dependent may contact the Health Plan to obtain a copy of the classes of Specialty Pharmacy Drugs which must be obtained from the Network Specialty Pharmacy Providers.

13.6.15.8 OFFICE OR CLINIC ADMINISTERED NON-SPECIALITY PHARMACY DRUGS

Prescription Drugs which do not meet the definition of Specialty Pharmacy Drugs and which are dispensed and administered to You or Your Covered Dependent in the office of a Network Provider or in another Outpatient setting, will be covered as a part of Your Medical Services benefit, and no additional Copayments are required for outpatient prescription drugs so dispensed and administered. These drugs may require preauthorization by a Medical Director in order to be covered as part of Your Medical Services benefit.

Specialty Pharmacy Drugs will be covered pursuant to the Outpatient Specialty Pharmacy Drugs benefit, regardless of whether or not the Specialty Pharmacy Drug is administered in the office of a Network Provider or other Outpatient setting.

13.6.15.9 AUTHORIZATION REQUIREMENTS

For certain medications, the Health Plan limits the quantity You or Your Covered Dependent can receive over a certain period to be sure that You are taking a safe amount of a drug. Coverage of certain drugs may also require a previous failure of another medication. Other drugs may be subject to other clinical restrictions. Preauthorization for some drugs may be required.

One-time prescriptions or refillable prescriptions that exceed the authorization requirement amounts in the Prescription Drug Schedule of Benefits will require preauthorization by the SWHP Medical Director.
If coverage for a particular drug or quantity of drug is denied, You and Your Health Professional may appeal the denial (see UTILIZATION REVIEW REQUIREMENTS of the Evidence of Coverage).

13.6.15.10 EXCLUSIONS

This Prescription Drug Benefit excludes the following:

a. drugs which do not require a Health Professional's order for dispensing (sometimes commonly referred to as "over-the-counter" drugs),except insulin;

b. anything which is not specified as covered or not defined as a drug, such as therapeutic devices, appliances, machines including syringes, except disposable syringes for insulin dependent Members, support garments, etc.;

c. Experimental or Investigational drugs or other drugs which, in the opinion of the Pharmacy and Therapeutics Committee or Medical Director, have not been proven to be effective NOTE: Denials based upon experimental or investigational use are considered Adverse Determinations and are subject to the Appeal of Adverse Determination and Independent Review provisions of Your Health Care Evidence of Coverage,

d. drugs not approved by the Food and Drug Administration for use in humans or for the condition being treated, dose, route, duration, and frequency being treated;

e. drugs used for cosmetic purposes;

f. drugs used for Treatments or medical conditions not covered by this Agreement;

g. drugs used primarily for the Treatment of infertility;

h. vitamins not requiring a prescription;

i. any initial or refill prescription dispensed more than one (1) year after the date of the Health Professional's order;

j. except for medical emergencies, drugs not obtained at a Network Pharmacy;

k. drugs given or administered to You or a Covered Dependent while at a hospital, skilled nursing facility, or other facility;

l. blood, blood plasma, and other blood products; except as covered by Medical beneits under this Agreement.

m. a prescription that has an over the counter alternative;

n. initial or refill prescriptions the supply of which would extend past the termination of this Agreement, even if the Health Professional's order was issued prior to termination

o. drugs for the treatment of sexual dysfunction, impotence, or inadequacy.

13.6.15.11 REFILL LIMITATIONS

Refill prescription will not be covered until either of the following events occurs You or Your Covered Dependent's existing supply is less than 25%-50% of the refill prescription amount.

This limitation will be calculated based upon the prescription being taken at the prescribed dosage and appropriate intervals.

13.6.15.12 MAINTENANCE DRUGS

In order for a drug to be considered a Maintenance Drug, the drug must appear on Health Plan's maintenance drug list.

13.6.15.13 COPAYMENTS

You must pay the Copayment per quantity and days supply dispensed per prescription as stated in the Schedule of Benefits. Copayments for prescription drugs shall be considered Out-of-Pocket Expenses for purposes of meeting Your Out-of-Pocket Maximum.

13.6.15.14 ORAL ANTICANCER MEDICATIONS

Oral anticancer medications are covered under the Preferred Specialty Drug benefit, and are subject to the lowest cost-sharing amounts applied to Specialty Drugs in the attached Schedule of Benefits.

Prescriptions for drugs included in the Oral Oncology Dispensing Program filled on or after January 1, 2016 will be restricted to a 14-day supply for the first two months of therapy. Note that for members with a flat fee co-payment, drugs included in the Oral Oncology Dispensing Program will be subject to 50% of the applicable copayment amount as listed in the schedule of benefits. Following the first four fills of a drug in the Oral Oncology Dispensing Program, at the same strength, members continuing on therapy may fill their prescription for a maximum day supply allowed per the schedule of benefits.

13.6.16 OUTPATIENT RADIOLOGICAL OR DIAGNOSTIC EXAMINATIONS

Outpatient Radiological and Diagnostic exams shall be covered as Medically Necessary and as prescribed and authorized by a Participating Physician or Provider. Examples of such services include:

- Angiograms (but not including cardiac angiograms);
- CT scans;
- MRIs;
- Myelography;
- PET scans; and
- stress tests with radioisotope imaging

13.6.16.1 COPAYMENTS FOR OUTPATIENT RADIOLOGICAL OR DIAGNOSTIC EXAMINATIONS

You are required to pay the Copayments listed in the schedule of benefits for Outpatient Radiological or Diagnostic Examinations contained in this Section.

An ultrasound or cardiac angiogram shall not be subject to a Radiological or Diagnostic Examination Copayment, but if performed in conjunction with an office visit or outpatient surgery, you will be responsible for the appropriate office visit or outpatient surgery Copayment as listed in the Schedule of Benefits.

13.6.17 BREAST RECONSTRUCTION BENEFITS

If You or a Covered Dependent has had or will have a mastectomy, coverage for Breast Reconstruction incident to mastectomy shall be provided under the same terms and conditions of this Agreement as for the mastectomy, as deemed medically appropriate by the Physician who will perform the surgery. Breast Reconstruction means surgical reconstruction of a breast and nipple areola complex to restore and achieve breast symmetry necessitated by mastectomy surgery. The term includes surgical reconstruction of a breast on which mastectomy surgery has been performed under the terms of this Agreement as well as surgical reconstruction of an unaffected breast to achieve or restore symmetry with such reconstructed breast. The term also includes prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy. Once symmetry has been attained, the term does not include subsequent breast surgery to affect a cosmetic change, such as cosmetic surgery to change the size and shape of the breasts. However, the term shall include Treatment for functional problems, such as functional problems with a breast implant used in the Breast Reconstruction. Symmetry means the breasts are similar, as opposed to identical, in size and shape.

13.6.18 MINIMUM INPATIENT STAY FOLLOWING MASTECTOMY

Health Plan coverage for the treatment of breast cancer includes coverage of a minimum of forty-eight (48) hours of inpatient care following a mastectomy and twenty-four (24) hours of inpatient care following a lymph node dissection for the treatment of breast cancer unless You or Your Covered Dependent, and the attending physician determine that a shorter period of inpatient care is appropriate.

13.6.19 TREATMENT FOR CRANIOFACIAL ABNORMALITIES OF A CHILD

Coverage includes 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, infection or disease. Cosmetic surgery is an excluded service to the extent it is not necessary 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, infection or disease .

13.6.20 DIABETIC SUPPLIES, EQUIPMENT AND SELF-MANAGEMENT TRAINING

If You or a Covered Dependent has been diagnosed with insulin dependent diabetes, non-insulin dependent diabetes, or abnormal elevated blood glucose levels induced by pregnancy or another medical condition, as Medically Necessary and prescribed by a Physician or Health Professional, You or Your Eligible Dependent are eligible for coverage for Diabetic Supplies, Diabetic Equipment, and Diabetic Self-Management Training under this Agreement.

Coverage for such Treatment shall be provided on the same basis as other analogous chronic medical conditions are covered, including, but not limited to the applicable Copayments. Coverage shall also be provided for new or improved Diabetic Supplies or Diabetic Equipment, upon approval of the United States Food and Drug Administration, as Medically Necessary and prescribed by a Physician or Health Professional.

13.6.20.1 COVERAGE OF DIABETIC SUPPLIES UNDER PRESCRIPTION DRUG BENEFITS (AS APPROPRIATE)

Test strips for blood glucose monitors shall be provided according to the copayment levels described in the Schedule of Benefits. Insulin, syringes, oral agents available with a prescription, and Glucagon Emergency Kits shall be provided according to the terms of the Prescription Drug Benefit, except no annual dollar Maximum Benefit limitation shall apply. If Your Agreement does not include the Prescription Drug Benefit, insulin, syringes, oral agents available with a prescription, and Glucagon Emergency Kits shall be provided according to the following subparagraph.

13.6.20.2 COPAYMENTS FOR DIABETIC EQUIPMENT AND SUPPLIES

Diabetic Equipment and Diabetic Supplies shall be provided according to the terms of this Agreement. Diabetic Supplies shall be covered in quantities as stated in the Schedule of Benefits. Health Plan will not cover a renewal of a Diabetic Supply until You or Your Covered Dependent's existing supply will be depleted in less than 10 days. You are required to pay Copayments for Diabetic Equipment, Diabetic Supplies, and Diabetic Self-Management Trainings as stated in the Schedule of Benefits.

13.6.21 BENEFITS FOR TREATMENT AND DIAGNOSIS OF CONDITIONS AFFECTING TEMPOROMANDIBULAR JOINT

Coverage for Medically Necessary diagnostic or surgical treatment of conditions affecting the temporomandibular joint, including the jaw and craniomandibular joint is available to You or Your Covered Dependent, where the condition is the result of an accident, a trauma, a congenital defect, a developmental defect or a pathology. Dental services are excluded from coverage under this Agreement.

13.6.22 TRANSPLANT SERVICES

Covered transplants, using human tissue and FDA approved artificial devices only, if determined Medically Necessary and approved by the Medical Director as not Experimental or not Investigational for the Member's condition may include:

- kidney transplants;
- cornea transplants;
- liver transplants;

- bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease, and Wiskott-Aldrich syndrome;
- heart;
- heart-lung;
- lung;
- pancreas;
- pancreas-kidney.

Donor/procurement costs for covered transplants for matching, removal, and transportation of the organ are covered if:

a. the recipient of the organ is You or Your Covered Dependent, and
b. the donor/procurements costs are not covered by the donor's Health Benefit Plan.

If the donor's Health Benefit Plan does not cover donor/procurement costs, such costs will be covered. You are required to pay the same Copayments for transplant services as for other benefits provided under this Agreement.

13.6.23 ACQUIRED BRAIN INJURY

Subject to applicable Copayments, the following services that are medically necessary as a result of an Acquired Brain Injury to You or Your Covered Dependent will be covered:

- Cognitive Rehabilitation Therapy,
- Cognitive communication therapy,
- Neurocognitive Therapy,
- Neurocognitive Rehabilitation,
- Neurobehavioral Testing,
- Neurobehavioral Treatment,
- Neurophysiological Testing
- Neurophysiological Treatment,
- Neuropsychological Treatment,
- Neuropsychological Testing,
- Psychophysiological Testing,
- Psychophysiological Treatment,
- Neurofeedback Therapy,
- Remediation required for and related to the Treatment of an Acquired Brain Injury,
- Post-acute Transition Services; and
- Community Reintegration Services, including Outpatient Day Treatment Services or other Post-Acute Care Treatment Services.

Coverage may be provided for the reasonable expenses of appropriate Post-Acute Care Treatment Services related to periodic reevaluation on an enrollee who has incurred an Acquired Brain Injury, and has been unresponsive to Treatment but later becomes responsive to treatment. The Medical Director may determine the reasonableness of a reevaluation based upon one or more of the following factors:

1. cost;
2. time passed since the previous evaluation
3. difference in the expertise of the Provider performing the evalution
4. changes in technology, and
5. advances in medicine

13.6.23.1 COPAYMENTS FOR ACQUIRED BRAIN INJURY SERVICES

Copayments for Covered Services for Treatment of Acquired Brain Injury Services shall be the same as the Copayment for Covered Services similar to the Treatment for the Acquired Brain Injury service.

13.6.24 AUTISM SPECTRUM DISORDER SERVICES

Coverage for generally recognized services prescribed to enrollees diagnosed with Autism Spectrum Disorder, is provided, from the date of diagnosis, provided the diagnosis is made before the Covered Person's 10th birthday. in accordance to a Treatment plan recommended by the enrollee's Primary Care Physician.

As used in this provision, "generally recognized services" may include services such as:

1. evaluation and assessment services;
2. Applied Behavior Analysis;
3. behavior training and behavior management;
4. speech, occupational, or physicial therapy; or
5. medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder

Autism Spectrum Disorder services must be provided by Participating Provider, which for purposes of this benefit may include:

- a health care practitioner who is licensed, certified of registered by an appropriate agency of Texas;
- a provider whose professional credential is recognized and accepted by an appropriate agency of the United States;
- a provider who is certified as a provider under the TRICARE military health system; or
- an individual acting under the supervision of a health care practitioner described under paragraph 1.

13.6.24.1 COPAYMENTS FOR AUTISM SPECTRUM DISORDER SERVICES

You will pay the same Copayments for the treatment of Autism Spectrum Disorder that are consistent with any other coverage under the health benefit plan.

13.6.25 TELEMEDICINE

We will not exclude coverage for telemedicine medical service or a telehealth service under the plan because the service is not provided through a face-to-face consultation. You are required to pay Copayments for Telemedicine as required for other medical benefits.

13.6.26 AMINO ACID-BASED ELEMENTAL FORMULAS

As ordered by a Physician, Medically Necessary Amino Acid-Based Elemental Formulas may be covered under this Agreement. Health Plan shall provide coverage for these benefits up to the maximum benefit per Calendar Year specified in the Schedule of Benefits.

13.6.26.1 COVERAGE FOR AMINO ACID-BASED ELEMENTAL FORMULAS

Regardless of the formula delivery method, Medically Necessary Amino Acid-Based Elemental Formulas provided under the written order of a treating Physician is covered for treatment or diagnosis of:

1) Immunoglogulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
2) Severe food protein-induced entercolitis syndrome;
3) Eosinophilic disorders, as evidenced by the results of a biopsy; and
4) Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length and motility of the gastrointestinal tract.

Medically necessary services associated with the administration of the formula are also covered.

13.6.26.2 COPAYMENTS AND LIMITATIONS ON AMINO ACID-BASED ELEMENTAL FORMULAS

You or Your covered Dependents are required to pay the Copayments as stated in the Schedule of Benefits for Amino Acid-Based Elemental Formulas. Benefits for Amino Acid-Based Elemental Formulas shall be limited to the Calendar Year maximum as stated in the Schedule of Benefits.

13.6.27 CARDIOVASCULAR DISEASE SCREENING FOR HIGH RISK INDIVIDUALS

Certain cardiovascular disease screening tests for high-risk individuals may be covered under this Agreement. Health Plan shall provide coverage for these benefits up to the maximum benefit per Calendar Year specified in the Schedule of Benefits.

13.6.27.1 COVERAGE FOR CARDIOVASCULAR DISEASE SCREENING

You or Your Covered Dependent may be eligible for the cardiovascular disease screening test under this provision if You or Your Covered Dependent is a male between the ages of 45 and 76, or a female between the ages of 55 and 76, and is either:

1) Diabetic; or
2) Has a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediated or higher.

The screening test for which You or Your Covered Dependent may be eligible is one of the following noninvasive tests for atherosclerosis and abnormal artery structure:

1) CT scan measuring coronary artery calcification; or
2) Ultrasonography measuring carotid intima-media thickness and plaque.

Such screening test must be performed by a Participating Provider.

13.6.27.2 COPAYMENTS AND LIMITATIONS ON CARDIOVASCULAR DISEASE SCREENING

You or Your Covered Dependents are required to pay the Copayments as stated in the Schedule of Benefits for cardiovascular screening tests. Benefits for cardiovascular screening tests shall be limited to the Benefit Maximum every 5 years as stated in the Schedule of Benefits.

13.6.28 ROUTINE PATIENT CARE COSTS FOR CLINICAL TRIALS

Subject to the terms of this Agreement and the Exclusions and Limitations Provisions herein, You or Your Covered Dependent may be covered for Routine Patient Care Costs in connection with You or Your Covered Dependent's, participation in 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:

A. Federally funded trials. The study or investigation is approved or funded by one or more of the following:
   - the Centers of Disease Control and Prevention of the United State Department of Health and Human Services;
   - the National Institutes of Health;
   - the Agency for Health Care Research and Quality;
   - the Centers for Medicare and Medicaid Services;
   - a cooperative group or center of any of the entities described in classes i)-iv) of the Department of Defense or the Department of Veteran Affairs;
   - a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of health for care support grants;
   - an institutional review board of an institution in this state that has an agreement with the Office of Human Research protections of the United States Department of Health and Human Services;
   - any of the following, if the study or investigation conducted by the Department of Health and Human Services determines to be comparable to the system of peer review of studies and investigations used by the National Institute of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:

i. the United States Department of Defense
ii. the United States Department of Veterans Affairs; or
iii. the United States Department of Energy.

B. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

C. The study or investigation is a drug trail that is exempt from having such an investigational new drug application
- the United States Food and Drug Administration;
- the United States Department of Defense;
- the United States Department of Veterans Affairs, or;
- an institutional review board of an institution in this state that has an agreement with the Office of Human Research Protections of the United States Department of Health and Human Services.

We are not required to reimburse the Research Institution conducting the clinical trial for the Routine Patient Care Cost provided through the Research Institution unless the Research Institution, and each Provider providing routine patient care through the Research Institution, agrees to accept reimbursement 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.

This provision does not 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.

13.6.28.1 COPAYMENTS AND LIMITATIONS ON COVERAGE FOR ROUTINE PATIENT CARE COSTS
We do not provide benefits for routine patient care services provided by Non-Network Providers.

You or Your Covered Dependents are required to pay the Copayments as stated in the Schedule of Benefits for Routine Patient Care Costs.

13.6.28.2 CANCELLATION OR NONRENEWAL PROHIBITED
We may not cancel or refuse to renew coverage under this Agreement solely because You or Your Covered Dependent participates in a clinical trial.

13.6.29 VISION SERVICES

13.6.29.1 VISION

Annual Eye Exam
The following coverage is provided for a Covered Person: An annual eye exam conducted by a licensed ophthalmologist or optometrist. An updated list of Participating Providers for vision services may be found on Health Plan's website, www.swhp.org.

13.6.29.2 PEDIATRIC VISION BENEFITS
Your Covered Dependent Children age 18 and under are entitled to eye exams and prescription eyewear when such eyewear is prescribed by a Participating Physician or participating optometrist and is obtained at a Health Plan participating optical dispensary. This benefit consists of:
- one comprehensive eye examination that focuses on eyes and overall wellness every Calendar Year:
- for prescription glasses,
  - glass or plastic single vision, lined bifocal, lined trifocal, or lenticular lenses once every calendar year, (including fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses, polycarbonate prescription lenses with scratch resistant coating, low vision items, ultraviolet protective coating, polycarbonate lenses, blended segment lenses, intermediate vision lenses,

standard progressives, premium progressives, photochromic glass lenses, plastic photosensitive lenses, polarized lenses, standard antireflective coating, premium AR coating, ultra AR coating, or Hi-indent lenses); and
    - frames once every calendar year;
- low vision services; or
- contact lenses once every calendar year.;; including contact lenses for the medical conditions of Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders, and Irregular Astigmatism.
- Low Vision Services- after pre-authorization is received, benefits will be provided for one comprehensive low vision evaluation every 5 years, with a maximum charge of $300, maximum low vision aid allowance of $600 with a lifetime maximum of $1,200 for items such as high-power spectacles, magnifiers, and telescopes; and follow up care. Four visits will be provided in any five year period, with a maximum charge of $100 each visit. Participating providers will obtain the necessary pre-authorization for these services.

The following are not covered: lenses, tints or coating not listed, supplies, eyewear not requiring a prescription or not prescribed by a Health Plan participating provider, and eyewear obtained at optical dispensaries not designated by Health Plan.

You are required to pay Copayments for Pediatric Vision Benefits as stated in the Schedule of Benefits.

13.6.30 DENTAL SERVICES

Dental services are not provided except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; or dental care or treatment necessary due to congenital disease or anomaly.

13.6.31 OVARIAN CANCER SCREENING

You and Your Covered Dependents are eligible for benefits for an annual medically recognized diagnostic test for the early detection of ovarian cancer, including a CA-125 blood test. This benefit is available to covered members who are female and age 18 or older.

13.7 OUT-OF-NETWORK REFERRALS

Except for Emergency Care Services, all HMO benefit level services under this Agreement must be provided by Participating Physicians, Participating Providers, or Participating Hospitals, unless a referral to a non-Participating Physician, Provider or Hospital is authorized by a Participating Physician or Participating Provider and Medical Director due to there not being a qualified Participating Provider In-Network. Even with a referral from a Participating Provider to a non-Participating Provider, if there was another Participating Provider that could have performed the Covered Service, such referral will be paid at the POS benefit level. If an out-of-network referral is authorized, Health Plan provides services only to the extent such services are covered under this Agreement. Each out-of-network referral is subject to separate review and approval. For example, an authorization for Treatment by a particular non-Participating Physician does not also authorize hospitalization in a hospital which is not a Participating Hospital or referral to another physician by the non-Participating Physician. In cases involving a non-emergency, Health Plan will not cover at the HMO benefit level any expenses associated with Treatments performed or prescribed by non-Participating Physicians, Provider, or Hospitals, either inside or outside of the Service Area, for which Health Plan has not authorized an out-of-network referral. Complications of such non-authorized Treatments will not be covered at the HMO benefit level prior to the date Health Plan arranges for You or Your Covered Dependent's transfer to Participating Physicians, Participating Providers, or a Participating Hospital. In no event shall Health Plan cover any Treatments which are excluded from coverage under this Agreement or complications of those Treatments.

13.7.1 OUT-OF-POCKET EXPENSES FOR REFERRALS

You are required to pay the HMO benefit level Copayments, as applicable, for referral Treatments as would be required for other benefits provided under this Agreement. For example, if a referral to a non-Participating Hospital is authorized, You will be required to pay the same HMO benefit level Copayments, if any, as You would for admission to a Participating Hospital.

14. EXCLUSIONS AND LIMITATIONS

The Health Care Services under this Agreement shall not include or shall be limited by the following:

14.1 Abortions
Elective abortions, which are not necessary to preserve Your, or Your Covered Dependent's, health are excluded.

14.2 Breast Implants
Non-Medically Necessary implantation of breast augmentation devices, removal of breast implants, and replacement of breast implants are excluded.

14.3 Chiropractic Services
Services for chiropractic care are limited to those described in the Manipulative Therapy provision of this Agreement.

14.4 Cosmetic or Reconstructive Procedures or Treatments
Unless otherwise covered under this Agreement, cosmetic or reconstructive procedures or other Treatments which improve or modify a Member's appearance are excluded. Examples of excluded procedures include, but are not limited to, liposuction, abdominoplasty, blepharoplasty, face lifts, osteotomies, correction of malocclusions, rhinoplasties, and mammoplasties. The only exceptions to this exclusion include certain procedures determined as Medically Necessary and approved by the Medical Director which are required solely because of any of the following: (1) an accidental bodily injury; (2) disease of the breast tissue; (3) a congenital or birth defect which was present upon birth; or (4) surgical Treatment of an illness. As medically appropriate and at the discretion of the Medical Director, any Treatment which would result in a cosmetic benefit may be delayed until such time as You or Your Covered Dependent has completed other alternative, more conservative Treatments recommended by the Medical Director.

14.5 Court-Ordered Care
Health Care Services provided solely because of the order of a court or administrative body, which Health Care Services would otherwise not be covered under this Agreement, are excluded.

14.6 Custodial Care
Custodial Care as follows is excluded:

- Any service, supply, care or Treatment that the Medical Director determines to be incurred for rest, domiciliary, convalescent or Custodial Care;
- Any assistance with activities of daily living which include activities such as walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking drugs; or
- Any Care that can be performed safely and effectively by a person who does not require a license or certification or the presence of a supervisory nurse. Such services will not be Covered Services no matter who provides, prescribes, recommends or performs those services. The fact that certain Covered Services are provided while You or Your Covered Dependent are receiving Custodial Care does not require the Health Plan to cover Custodial Care.

14.7 Dental Care
All dental care is excluded, except for congenital or accidental injury.

14.8 Disaster or Epidemic
In the event of a major disaster or epidemic, services shall be provided insofar as practical, according to the best judgment of Health Professionals and within the limitations of facilities and personnel available; but neither Health Plan, nor any Health Professional shall have any liability for delay or failure to provide or to arrange for services due to a lack of available facilities or personnel.

14.9 Elective Treatment or Elective Surgery

Elective Treatments or Elective Surgery, and complications of Elective Treatments or Elective Surgery, are excluded.

14.10 Exceeding Benefit Limits

Any Services provided to an Enrollee who has exceeded the Lifetime Maximum or any Annual Benefit Maximum is excluded from Coverage.

14.11 Experimental or Investigational Treatment

Any Treatments that are considered to be Experimental or Investigational are excluded, but may be appealed under the Appeal of Adverse Determination provision of this Agreement. This exclusion does not apply to routine patient care costs for enrollees in clinical trials pursuant to Section 13.5.28 of this Agreement.

14.12 Family Member (Services Provided by)

Treatments or services furnished by a Physician or Provider who is related to You, or Your Covered Dependent, by blood or marriage, and who ordinarily dwells in Your household, or any services or supplies for which You would have no legal obligation to pay in the absence of this Agreement or any similar coverage; or for which no charge or a different charge is usually made in the absence of health care coverage, are excluded.

14.13 Family Planning Treatment

The reversal of an elective sterilization procedure and male condoms are excluded.

14.14 Genetic Testing

Genetic tests are excluded unless approved by the FDA and approved by the Medical Director.

14.15 Household Equipment

The purchase or rental of household equipment which has a customary purpose other than medical, such as, but not limited to: exercise cycles, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows, mattresses or waterbeds is excluded.

14.16 Household Fixtures

Fixtures, including, but not limited to, the purchase or rental of escalators or elevators, saunas, swimming pools or other household fixtures are excluded.

14.17 Illegal Acts

Services for any condition caused by a Member's commission of, or attempt to commit, an illegal act.

14.18 Infertility Diagnosis and Treatment

Unless covered by a rider, the following infertility services are not covered:

- in vitro fertilization unless covered by a rider;
- artificial insemination;
- gamete intrafallopian transfer;
- zygote intrafallopian transfer, and similar procedures;
- drugs whose primary purpose is the Treatment of infertility;
- reversal of voluntarily induced sterility;
- surrogate parent services and fertilization;
- donor egg or sperm;
- abortions unless determined to be Medically Necessary or required to preserve the life of the mother.

14.19 Mental Health

Services for mental illness or disorders are limited to those services described in Mental Health Care and

Treatment for Chemical Dependency provisions of this Agreement.

14.20 Miscellaneous

Artificial aids, corrective appliances (other than those provided as Orthotic Devices), and non-prescribed, medical supplies, such as batteries (other than batteries for diabetes equipment and supplies), condoms, syringes (except for insulin syringes), dentures, eyeglasses and corrective lenses, unless covered by Rider, are excluded.

14.21 Non-Covered Benefits/Services

Treatments, which are excluded from coverage under this Agreement and complications of such Treatments, are excluded.

14.22 Non-Payment for Excess Charges

No payment will be made for any portion of the charge for a service or supply in excess of the Allowed Amount for such service or supply.

14.23 Personal Comfort Items

Personal items, comfort items, food products, guest meals, accommodations, telephone charges, travel expenses, private rooms unless Medically Necessary, take home supplies, barber and beauty services, radio, television or videos of procedures, vitamins, minerals, dietary supplements and similar products except to the extent specifically listed as covered under this Agreement, are excluded.

14.24 Physical and Mental Exams

Physical, psychiatric, psychological, other testing or examinations and reports for the following are excluded:

- obtaining or maintaining employment,
- obtaining or maintaining licenses of any type,
- obtaining or maintaining insurance
- otherwise relating to insurance purposes and the like;
- educational purposes,
- services for non-medically necessary special education and developmental programs,
- premarital and pre-adoptive purposes by court order,
- relating to any judicial or administrative proceeding,
- medical research.

14.25 Pregnancy Induced under a Surrogate Parenting Agreement

Services for conditions of pregnancy for a surrogate parent when the surrogate is a Covered Person are covered, but when compensation is obtained for the surrogacy, Health Plan shall have a lien on such compensation to recover Our medical expense. A surrogate parent is a woman who agrees to become pregnant with the intent of surrendering custody of the child to another person.

14.26 Refractive Keratotomy

Radial Keratotomy and other refractive eye surgery is excluded.

14.27 Reimbursement

Health Plan shall not pay any provider or reimburse Member for any Health Care Service for which Member would have no obligation to pay in the absence of coverage under this Agreement.

14.28 Routine Foot Care

Services for routine foot care, including, but not limited to, trimming of corns, calluses and nails, except those services related to systemic conditions are excluded.

14.29 Speech and Hearing Loss

Unless covered by a rider, services for the loss or impairment of speech or hearing are limited to those

rehabilitative services described in the Rehabilitative Therapy provision.

14.30 Storage of Bodily Fluids and Body Parts

Long term storage (longer than 6 months) of blood and blood products is excluded. Storage of semen, ova, bone marrow, stem cells, DNA, or any other bodily fluid or body part is excluded unless approved by Medical Director.

14.31 Therapies and Treatments

The following therapies and treatments are not covered: Equine therapy, cranial sacral therapy, recreational therapy, exercise programs, hypnotherapy, music therapy, reading therapy, sensory integration therapy, vision therapy, vision training, orthoptic therapy, orthoptic training, behavioral vision therapy, visual intergration, vision therapy, orthotrispy, massage therapy, and oral allergy therapy.

14.32 Transplants

Organ and bone marrow transplants and associated donor/procurement costs for You or Your Covered Dependent are excluded except to the extent specifically listed as covered in this Agreement.

14.33 Treatment Received in State or Federal Facilities or Institutions

No payment will be made for services, except Emergency Care, received in Federal facilities or for any items or services provided in any institutions operated by any state, government or agency when Member has no legal obligation to pay for such items or services; except, however, payment will be made to the extent required by law provided such care is approved in advance by a Participating Physician or Participating Provider and Medical Director.

14.34 Unauthorized Services

Non-emergency Health Care Services which are not provided, ordered, prescribed or authorized by a Participating Physician or Participating Provider are excluded.

14.35 Vision Corrective Surgery, including Laser Application

Traditional or laser surgery for the purposes of correcting visual acuity is excluded.

14.36 War, Insurrection or Riot

Treatment for Injuries or sickness as a result of war, riot, civil insurrection, or act of terrorism are excluded.

14.37 Weight Reduction

Weight reduction programs, food supplements, services, supplies, surgeries including but not limited to Gastric Bypass, gastric stapling, Vertical Banding, or gym memberships, even if the participant has medical conditions that might be helped by weight loss; or even prescribed by a physician are not covered.

SMALL EMPLOYER HMO/POINT OF SERVICE SCHEDULE OF BENEFITS

Description	HMO Copayment /Deductible	Point of Service Copayment/ Deductible
Calendar Year Deductible Applies to Out-of-Pocket Maximum The Calendar Year Deductible will be indexed annually based on applicable federal guidelines. **Family deductible is embedded** Any individual Covered Person can receive benefits after that Covered Person has satisfied his or her Calendar Year Deductible. The entire Family Deductible must be satisfied before benefits are payable for an individual Covered Person.	**Individual/Family** $2,000/$6,000	
Calendar Year Point of Service (POS) Deductible Applies to Out-of-Pocket Maximum **Family deductible is cumulative**		**Individual/Family** $4,000/$8,000
Failure to Pre-Authorize Service Penalty		50% reduction in payable benefits or $500, whichever is less
Amounts above Allowed Amount		Member will be responsible for amounts above rate Allowed Amount. Member may be billed for POS benefits above Allowed Amount. Amounts above the Allowed Amount will not be applied towards the Out-of-Pocket Maximum
Out-of-Pocket Maximum (Calendar Year) **No carryover will be allowed.** The maximum amount of Out-of-Pocket Expenses to be incurred by You or Your Covered Dependents. NOTE: The following shall not be considered Out-of-Pocket Expenses for purposes of meeting the Out-of-Pocket Maximum • Amount above the Allowed Amount • Usual and Customary rate • Failure to Pre-Authorize penalty	**Individual/Family** $7,150/$14,300 Once the Out-of-Pocket Maximum shown above is reached, Covered Services will be covered at 100%.	**Individual/Family** $21,450/$42,900 Once the Out-of-Pocket Maximum shown above is reached, Covered Services will be covered at 100% of the Allowed Amount. Covered Services received as an HMO Benefit will not be applied to the POS Out-of-Pocket Maximum
Medical Services that are not Preventive Care Services Copayment for each outpatient visit to or by a Primary Care Physician	$40 copay	50% after deductible

Description	HMO Copayment /Deductible	Point of Service Copayment/ Deductible
Copayment for each outpatient visit to or by a Participating Physician other than a Primary Care Physician	$75 copay	50% after deductible
Copayment/Coinsurance for each non-emergency outpatient visit to or by a Physician other than a Specialist	$40 copay	50% after deductible
Copayment/Coinsurance for each non-emergency outpatient visit to or by a Specialist	$75 copay	50% after deductible
Copayment per vial of serum for allergy treatments	$40 copay	50% after deductible
Copayment for outpatient surgery performed in a hospital without admission	30% after deductible	50% after deductible
Copayment for Outpatient Diagnostic Procedure	30% after deductible	50% after deductible
Copayment for other Outpatient Services	30% after deductible	50% after deductible
Preventive Care Services	No Charge	50% after deductible
Hospital Services Copayment for each day of inpatient services.	$250 per stay + 30% after deductible	50% after deductible
Maximum number of day per admission for which Copayment is due	Unlimited Days	Unlimited Days
Copayment for other inpatient Services	30% after deductible	50% after deductible
Skilled Nursing Facility **Copayment for each day of skilled nursing facility.**	$250 per stay + 30% after deductible	50% after deductible
Maximum number of Skilled Nursing Facility days per Year covered by Health Plan	25 visit(s) per year	25 visit(s) per year
Emergency Care Services Copayment for each episode of Emergency Care Copayment waived if episode results in hospitalization for the same condition within 24 hours	$500 + 30% after deductible	Emergency care covered at HMO benefit level, until stabilization.
Copayment for Diagnostic Procedures in conjunction with Emergency Care Services	30% after deductible	
Urgent Care Services Copayment for Treatment received at an Urgent Care facility	$75 copay	Emergency care covered at HMO benefit level, until stabilization.
Copayment for Diagnostic Procedures in conjunction with Urgent Care Services	30% after deductible	
Emergency Transportation Services Copayment for Emergency Transportation Services	30% after deductible	Emergency care covered at HMO benefit level, until stabilization.

Description	HMO Copayment /Deductible	Point of Service Copayment/ Deductible
Outpatient Mental Health Care Copayment for each outpatient mental health care visit to or by a Health Professional	Same as other outpatient medical services	50% after deductible
Inpatient Mental Health Care Copayment for each day of inpatient service, Psychiatric Day Treatment Facility service, and alternative mental health Treatment benefits.	Same as inpatient services	50% after deductible
Number of inpatient days per Calendar Year for which the above Copayments are due	Unlimited Days	Unlimited Days
Treatment for Chemical Dependency Copayment for each outpatient chemical dependency visit to or by a Participating Provider	Same as other outpatient medical services	50% after deductible
Copayment for each day of inpatient chemical dependency services	Same as inpatient medical services	50% after deductible
Maximum number of days per admission for which Copayment is due	Unlimited Days	Unlimited Days
Rehabilitative Therapy Copayment for each outpatient therapy visit to or by a Participating Provider other than a Primary Care Physician. Limit of 35 visits per year.	$75 copay	50% after deductible
Habilitative Therapy Copayment for each outpatient therapy visit to or by a Participating Provider other than a Primary Care Physician. Limit of 35 visits per year.	$75 copay	50% after deductible
Manipulative Therapy Copayment for each outpatient therapy visit to or by a Participating Provider other than a Primary Care Physician. Limit of 35 visits per year.	Same as rehabilitative therapy	Same as rehabilitative therapy
Home Health Services Copayment for each home health visit to or by a Participating Provider other than a Primary Care Physician	30% after deductible	50% after deductible
Maximum number of days of Home Health Services for which Copayment is due	60 visits per year	60 visits per year
Home Infusion Therapy Benefit Copayment for each day of home infusion therapy NOTE: Specialty Pharmacy Drugs administered through home infusion will be subject to the applicable Specialty Drug copayment	30% after deductible	50% after deductible

Description	HMO Copayment /Deductible	Point of Service Copayment/ Deductible
Maximum number of days of Home Infusion Therapy services for which Copayment is due	365 Days	365 Days
Hospice Services Copayment for each day of Hospice Services	30% after deductible	50% after deductible
Maximum number of days per Hospice admission for which Copayment is due	365 Days	365 Days
Maternity Services Copayment for each outpatient visit to or by a Participating Provider other than a Primary Care Physician. Prenatal visits are considered preventive care and no copayment is charged for HMO benefit levels	$75 copay	
Copayment/Coinsurance for each non-emergency outpatient visit to or by a Physician other than a Specialist		50% after deductible
Copayment/Coinsurance for each non-emergency visit to or by a Specialist		50% after deductible
Copayment for Diagnostic Procedures in conjunction with Maternity Services	30% after deductible	50% after deductible
Copayment for each day of inpatient service	$250 per stay + 30% after deductible	50% after deductible
Maximum number of days per admission for which copayment is due	Unlimited Days	Unlimited Days
Family Planning Services Copayment for each outpatient visit to or by a Participating Provider other than a Primary Care Physician	$75 copay	
Copayment/Coinsurance for each non-emergency outpatient visit to or by a Physician other than a Specialist		50% after deductible
Copayment/Coinsurance for each non-emergency outpatient visit to or by a Specialist		50% after deductible
Copayment for Outpatient Diagnostic Procedures in conjunction with Family Planning Services	30% after deductible	50% after deductible
Copayment for each day of inpatient services	$250 per stay + 30% after deductible	50% after deductible
Maximum number of days per admission for which a Copayment is due	Unlimited Days	Unlimited Days
DME/Orthotics/Prosthetic Devices Copayment for Durable Medical Equipment, Orthotic and Prosthetic Devices and all other related covered services	30% after deductible	50% after deductible
Copayment on Durable Medical Equipment	30% after deductible	50% after deductible
Copayment for Orthotic Devices and Prosthetic Devices	30% after deductible	50% after deductible

Description	HMO Copayment /Deductible	Point of Service Copayment/ Deductible
Copayment for each outpatient visit to or by a Participating Provider other than a Primary Care Physician	$75 copay	
Copayment for each non-emergency outpatient visit to our by a Physician other than a Specialist		50% after deductible
Copayment for each non-emergency outpatient visit to or by a Specialist		50% after deductible
Hearing Aids	30% after deductible	50% after deductible
Prescription Drug Program Prescription Copayment, Coinsurance, and Deductible apply to the Out of Pocket Maximum		
Preferred Generic Drugs	$5 copay	50% after deductible
Preferred Brand Drugs	$50 copay	50% after deductible
Non-preferred generic drugs and non-preferred brand drugs	$100 copay	50% after deductible
Preferred Specialty Drugs	$150 copay	50% after deductible
Maintenance Prescriptions Available when obtained through a Baylor Scott & White Pharmacy or when using the mail order prescription service.	Generic and brand preferred and non-preferred copayments will be 2 times the applicable amount indicated above 90 day supply maximum.	
Prescription Deductible You are required to pay a Deductible for out-of-pocket expenses prior to receiving coverage for covered prescription drugs	None	None
Outpatient Radiological or Diagnostic Examination Member is required to pay a Copayment for Outpatient radiological/Diagnostic examinations described below		
Angiograms, CT scans, MRI, Myelography, PET scans, stress test with radioisotope imaging	$250 copay	50% after deductible
Breast Reconstruction Benefits Copayment for Breast Reconstruction Benefits	Same as for other benefits	Same as for other POS benefits
Inpatient Stay following Mastectomy	Same as for other inpatient health care services	Same as for other POS inpatient health care services
Treatment of Craniofacial Abnormalities of a Child	Same as of other benefits	Same as for other POS benefits
Diabetic Supplies, Equipment, Copayment for Diabetic Equipment and Diabetic Supplies	Same as prescription drugs or durable medical equipment and supplies, as appropriate	Same as POS prescription drugs or durable medical equipment and supplies, as appropriate
Diabetic Supplies, Equipment, and Self-Management Training Copayment for Preferred Level test strips for blood glucose monitors	30% after deductible	50% after deductible

Description	HMO Copayment /Deductible	Point of Service Copayment/ Deductible
Copayment for Non-Preferred Level test strips for blood glucose monitors	30% after deductible	50% after deductible
Copayment for Diabetic Equipment and Diabetic Supplies	30% after deductible	50% after deductible
Copayment for Diabetes Self-Management Training	$75 copay	50% after deductible
Treatment and Diagnoses of Conditions affecting Temporomandibular Joint	Same as for other benefits	Same as for other POS benefits
Transplant Services	Same as for other benefits	Same as for other POS benefits
Acquired Brain Injury	Same as for other similar benefits	Same as for other similar POS benefits
Autism Spectrum Disorder Copayment for each visit to or by a Health Professional for generally recognized services prescribed by enrollee's Primary Care Physician	Same as for other similar benefits	Same as for other similar POS benefits
Amino Acid-Based Elemental Formulas Copayment for Amino Acid Based Elemental Formulas	30% after deductible	50% after deductible
Cardiovascular Disease Screening Test Copayment for CT scans measuring coronary artery calcification (once every five years)	Same as other CT scans	Same as other CT scans after POS deductible
Copayment for Ultrasonography measuring carotid intima-media thickness and plaque	Same as other Ultrasound	Same as other Ultrasound after POS deductible
Routine Patient Care Costs for Clinical Trial Copayments for Routine Patient Care Cost by Enrollee in Clinical Trial	Same as for other benefits	Same as for other POS benefits
Vision All Ages	$75 copay Maximum of one eye examination per year	50% after deductible Maximum of one eye examination per year
Pediatric Vision Services	$75 copay	50% after deductible
Copayment for single vision eyewear. Subject to maximum of one pair of glasses per Calendar Year	$75 copay Subject to a maximum benefit of $300 per Calendar Year.	50% after deductible Subject to a maximum benefit of $300 per Calendar Year

Description	HMO Copayment /Deductible	Point of Service Copayment/ Deductible
Copayment for bifocals or trifocals. Subject to a maximum of one pair of glasses per Calendar Year	$75 copay Subject to a maximum benefit of $300 per Calendar Year.	50% after deductible Subject to a maximum benefit of $300 per Calendar Year.
Copayment for contact lenses	$75 copay	50% after deductible
Out of Network Referrals You are required to pay the same Copayments and Deductibles, as applicable, for referral Treatment as for other benefits provided under this Agreement	Same as other benefits	

English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Spanish:
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Vietnamese:
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800 321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

Chinese:
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-321-7947（TTY：1-800-735-2989）。Scott & White Health Plan 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

Korean:
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-800-321-7947 (TTY: 1-800-735-2989) 번으로 전화해 주십시오. Scott & White Health Plan 은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다.

Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-321-7947 (رقم هاتف الصم والبكم: 1-800-735-2989).
يلتزم Scott & White Health Plan بقوانين الحقوق المدنية الفدرالية المعمول بها ولا يميز على أساس العرق أو اللون أو الأصل الوطني أو السن أو الإعاقة أو الجنس.

Urdu:
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-800-321-7947 (TTY: 1-800-735-2989).
Scott & White Health Plan ل باقطا لاو قرہشی قافی وقحقوق ےک اے ہ اتر کل یمعتی کن ینہ اور یہ کہ نسل، رنگ ، قومیت، عمر، معذوری یا جنس کی بنیاد پر امتیاز نہیں کرتا۔

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-321-7947 (TTY: 1-800-735-2989). Sumusunod ang Scott & White Health Plan sa mga naaangkop na Pederal na batas sa karapatang sibil at hindi nandidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian.

French:
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-321-7947 (ATS : 1-800-735-2989). Scott & White Health Plan respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.

Hindi:
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-321-7947 (TTY: 1-800-735-2989) पर कॉल करें।
Scott & White Health Plan लागू होने योग्य संघीय नागरिक अधिकार क़ानून का पालन करता है और जाति, रंग, राष्ट्रीय मूल, आयु, विकलांगता, या लिंग के आधार पर भेदभाव नहीं करता है।

Persian:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با(1-800-321-7947 (TTY: 1-800-735-2989 تماس بگیرید.
Scott & White Health Plan از قوانین حقوق مدنی فدرال مربوطه تبعیت می کند و هیچگونه تبعیضی بر اساس نژاد، رنگ پوست، اصلیت ملیتی، سن، ناتوانی یا جنسیت افراد قایل نمی شود.

German:
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.

Gujarati:
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan લાગુ પડતા સમવાયી નાગરિક અધિકાર કાયદા સાથે સુસંગત છે અને જાતિ, રંગ, રાષ્ટ્રીય મૂળ, ઉંમર, અશક્તતા અથવા લિંગના આધારે ભેદભાવ રાખવામાં આવતો નથી.

Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-321-7947 (телетайп: 1-800-735-2989). Scott & White Health Plan соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.

Japanese:
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-321-7947 (TTY:1-800-735-2989）まで、お電話にてご連絡ください。Scott & White Health Plan は適用される連邦公民権法を遵守し、人種、肌の色、出身国、年齢、障害または性別に基づく差別をいたしません。

Laotian:
ໂປດຊາບ: ຖ້າ ວ່າ ທ່ານ ເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍ ເຫຼືອດ້ານພາສາ, ໂດ ຍ ບໍ່ ເສັ ຽ ຄ່ າ ໄດ ້ ພ ້ ອ ມ ໃ ຫ ້ ທ ່ ານ. ໂທຣ 1-800-321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan ປະຕິ ບັ ດ ຕາ ມ ກົ ດ ໝ າ ຍ ວ ່ າ ດ ້ ວ ຍ ສິ ດ ທິ ພົ ນ ລະ ເ ມ ື ອ ງ ຂ ອ ງ ສ ັ ຖ ບ ານ ກ າ ງ ທ ີ ່ ບ ໍ ່ ຈ ໍ າ ແ ນ ກ ຊ ົ ນ ເ ຜ ົ ່ າ ພ ັ ນ ธ ุ ์ ຜ ິ ວ ໜ ັ ງ, ສ ີ ຜ ົ ວ, ຊ າ ດ ກ ໍ າ ເ ນ ີ ດ, ອ າ ຍ ຸ, ຄ ວ າ ມ ພ ິ ກ ານ, ຫ ຼ ື ເ ພ ດ.