LARGE GROUP
HEALTH MAINTENANCE ORGANIZATION
HEALTH CARE
EVIDENCE OF COVERAGE
with Point of Service Benefits

This Consumer Choice of Benefits 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 insurance agent to discover which state-mandated benefits are excluded in this Evidence of Coverage.

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

Corporate Office
1206 West Campus Drive
Temple, TX 76502
254-298-3000
800-321-7947

Evidence of Coverage

Scott & White Care Plans (herein called "Issuer")

This Evidence of Coverage, Group's application, Your completed and accepted Enrollment Application, Schedule of Benefits, any Riders, along with any attachments and amendments to those documents constitute the entire Agreement between the parties. No agent or other person, except the Chief Executive Officer of the Issuer, has the authority to waive any conditions or restrictions of the Agreement, to extend the time for making a payment, or to bind the Issuer by making any promise or representation, or by giving or receiving any information.

In consideration of the Group's application, completed and accepted Enrollment Application and timely payment of the Required Payments, the Issuer agrees to provide or arrange to provide the covered benefits as described in this Evidence of Coverage.

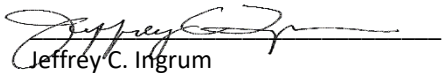
In consideration of the Issuer providing or arranging to provide the covered benefits specified in this Evidence of Coverage and subject to the terms, the Subscriber and the Contract Holder promise to pay all Required Payments when due and abide by all the terms of the Agreement and comply with all applicable local, state and federal laws.

The initial rates agreed upon by the Group and the Issuer are effective during the initial year from and after the Effective Date of the Agreement. Thereafter, the Issuer reserves the right to change rates upon sixty (60) days' notice prior to renewal.

The coverage provided under this Evidence of Coverage is Health Maintenance Organization (HMO) coverage with Point of Service (POS) benefits for Non-Participating Providers and not indemnity insurance.

The Issuer hereby certifies that it has issued a health care benefit plan (herein called the "Plan") for the Subscriber and any Covered Dependent(s). The Effective Date of coverage under the Agreement shall be as indicated on the Member's Identification Card and as confirmed by the Issuer. The Agreement shall continue in effect for one (1) year from the Effective Date until terminated in accordance with the terms of the **Termination of Coverage** section of this Evidence of Coverage.

The Issuer does not discriminate based on race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the Plan, including enrollment and benefit determinations.



Jeffrey C. Ingrum
President and Chief Executive Officer
Scott & White Care Plans
1206 West Campus Drive
Temple, Texas 76502

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Scott & White Care Plans
To get information or file a complaint with your insurance company or HMO:

Call: Customer Service at 254-298-3000
Toll-free: 800-321-7947
Online: swhp.org
Email: SWHPAPPEALSANDGRIEVANCES@BSWHealth.org
Mail: 1206 West Campus Drive, Temple, TX 76502

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:

Call with a question: 800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Scott & White Care Plans
Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Customer Service at 254-298-3000
Teléfono gratuito: 800-321-7947
En línea: swhp.org
Correo electrónico: SWHPAPPEALSANDGRIEVANCES@BSWHealth.org
Dirección postal: 1206 West Campus Drive, Temple, TX 76502

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

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Introduction

In this Evidence of Coverage, "We", "Us" and "Our" means the Issuer. "You" are the Subscriber whose Enrollment Application has been accepted by Us. The word "Member" means You and any Covered Dependents under the Plan.

This Evidence of Coverage will explain:

- Member rights and responsibilities, and Our rights and responsibilities;
- Covered benefits and how to receive them; and
- Costs the Subscriber will be responsible for paying.

The defined terms in this Evidence of Coverage are capitalized and shown in the appropriate provision, or in the **Definitions** section of this Evidence of Coverage.

Please read this Evidence of Coverage completely and carefully, particularly any sections relevant to Member special health care needs.

Important Contact Information

Resource	Contact Information	Accessible Hours
Website	swhp.org	24 hours a day 7 days a week
Mailing Address	1206 West Campus Drive Temple, Texas 76502	24 hours a day 7 days a week
Customer Service	800-321-7947 TTY Line 711	Monday – Friday 7:00 am – 7:00 pm CT

Customer Service can:

- Identify the Member Service Area;
- Provide Members with information about Participating Providers;
- Assist Members with concerns about Participating Providers;
- Provide Claim forms;
- Answer Member questions on Claims;
- Provide information on the Plan's features;
- Assist Members with questions regarding covered benefits.

We have a free service to help Members who speak languages other than English. This service allows the Member and the Member's Physician to talk about the Member's medical or behavioral health concerns.

We have representatives that speak Spanish and have medical interpreters to assist with other languages.

Members who are blind, visually impaired, deaf, hard of hearing or speech impaired may also can contact Us at 800-321-7947 (TTY 711) to arrange for oral interpretation services.

Definitions

The following defined terms shall have the specific meaning stated below and will be capitalized when used in this Evidence of Coverage.

Accidental Injury means accidental bodily injury resulting, directly and independently of all other causes, in initial necessary Treatment provided by a Physician or Health Professional.

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.

Adverse Determination means a determination by a Utilization Review agent made on behalf of the Issuer that the health care provided or proposed to be provided to a Member is not Medically Necessary or appropriate; or that the service is Experimental or Investigational. The term does not include a denial of health care due to the failure to request prospective or concurrent Utilization Review. The term includes rescissions of coverage as described in Your coverage document.

Age of Ineligibility means the age at which dependents are no longer eligible for coverage, subject to the definition of Eligible Dependent. The age of ineligibility will be 26.

Agreement is the legal contract between the Issuer, Subscriber, and Contract Holder and includes this Evidence of Coverage, Group's application, Enrollment Application, Schedule of Benefits, and Riders along with any attachments and amendments to those documents.

Allowed Amount means the amount the Plan will pay for covered benefits. The allowed amount is based upon a percentage of the amount that would be paid under Medicare for a given benefit. A contracted provider will hold the Member harmless for payment of the cost of covered benefits over the allowed amount.

Allowable Expense means a necessary reasonable and customary item of expense for health care; when the item of expense is covered at least in part by Medicare.

The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an allowable expense under the above definition unless the Member's stay in a private room is Medically Necessary either in terms of generally accepted medical practices or as specifically defined by the Issuer.

When benefits are reduced under Medicare because a Member does not comply with Medicare's provisions, the amount of such reduction will be considered an allowable expense. Examples of such provisions are those related to second surgical opinion or precertification of admission or health care.

Ambulance means a vehicle superficially designed, equipped and licensed for transporting the sick and/or injured.

Ambulatory Surgical Center means a Facility not located on the premises of a Hospital which provides specialty Outpatient Surgical Treatment. It does not include individual or group practice offices of private Physicians or Health Professionals, unless the offices have a distinct part used solely for Outpatient Surgical Treatment on a regular and organized basis.

Amino Acid-Based Elemental Formulas means complete nutrition formulas designed for Members who have an immune response to allergens found in whole foods or formulas compose of whole proteins, fats, and/or

carbohydrates. Amino Acid-Based Elemental Formulas are made from individual (single) nonallergenic amino acids (building blocks of proteins) broken down to their "elemental level" so that they can be easily absorbed and digested.

Appeal is an oral or written request for the Issuer to reverse a previous denial determination.

Autism Spectrum Disorder means a Neurobiological Disorder that is characterized by social and communication difficulties and included the previously used diagnoses such as Autism Disorder, Asperger's Syndrome, or Pervasive Development Disorder – Not Otherwise Specified.

Behavioral Health Provider means a Physician or Health Professional who provides benefits for Mental Health Care, Serious Mental Illness or Chemical Dependency.

Calendar Year means the twelve (12) month period from January 1 through December 31.

Chemical Dependency means the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance. Chemical Dependency Treatment Center means a Facility which provides a program for the Treatment of Chemical Dependency pursuant to a written Treatment plan approved and monitored by a Behavioral Health Provider and which the Facility is also:

- Affiliated with a Hospital under a contractual agreement with an established system for patient referral;
- Accredited as such a Facility by the Joint Commission on Accreditation of Healthcare Organizations;
- Licensed 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 state agency having legal authority to so license, certify, or approve.

Chemotherapy means any medication used to directly treat cancer. Medications used as supportive therapy (i.e., anti-nausea, etc.) are not included in this definition. A list of these medications will be maintained by the Pharmacy and Therapeutics Committee.

Claim means a request for payment that the Member or the Member's Participating Provider submits to the Issuer when benefits are provided by the Participating Provider. Claims typically include proof of loss or evidence of a claim, which includes the form on which the claim is made, bills and statements reflecting benefits and their respective charges provided to a Member, and correct diagnosis codes and procedure codes for the benefits.

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

Cognitive Rehabilitation Therapy means therapy designed to address therapeutic cognitive activities, based on an assessment and understanding, reading, writing, and verbal expression of information.

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

Complainant means a Member, Physician, Health Professional or other person designated to act on behalf of a Member, who files a Complaint.

Complaint is an oral or written expression of dissatisfaction with any aspect of the Issuer'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 benefit for reasons not related to Medical Necessity;
- The way a benefit 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.
- Dissatisfaction or disagreement with an Adverse Determination.

Complications of Pregnancy means conditions, requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as:

- acute nephritis;
- nephrosis;
- cardiac decompensation;
- missed abortion; and
- similar medical and surgical conditions of comparable severity.

Complications of Pregnancy does not include:

- false labor;
- occasional spotting;
- physician prescribed rest during the period of pregnancy;
- morning sickness;
- hyperemesis gravidarum;
- pre-eclampsia; and
- similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

Contract Date means the date on which the Agreement is executed. The Contract Date may not be the date coverage for the Plan commences.

Contract Holder means the person or entity with whom the Issuer has entered into an Agreement to provide health care. Under this Evidence of Coverage, the Group is the Contract Holder.

Copayment means the dollar amount of the cost of covered benefits, if any, shown in the Schedule of Benefits payable by the Member to a Participating Provider, when those benefits are obtained from that Participating Provider.

Cost Sharing means the Copayment, Deductible and any amounts exceeding benefit limits that a Member will incur as an expense for covered benefits. Specific cost sharing amounts for covered benefits can be found on the Schedule of Benefits.

Cosmetic, Reconstructive, or Plastic Surgery means surgery that:

- Can be expected or is intended to improve the physical appearance of a Member;
- Is performed for psychological purposes; or
- Restores form but does not correct or materially restore a bodily function.

Covered Dependent means a member of the Covered Employee's family who is eligible and has been enrolled by the Issuer under this Plan.

Covered Employee is the Eligible Employee whose Application has been accepted by the Issuer for coverage under the Plan.

Covered Prescription Drugs means those medications prescribed by a Physician that, under state or federal law, may be dispensed only by a Prescription Order for a Medically Necessary condition, and active ingredient(s) is/are FDA approved Legend Drug(s) or insulin.

Creditable Coverage means any group health coverage or individual health coverage, including 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.

Crisis Stabilization Unit or Facility means an institution which is appropriately licensed and accredited as a Crisis Stabilization Unit or Facility for the provision of Mental Health Care and Serious Mental Illness Treatment to Members who are demonstrating an acute psychiatric crisis of moderate to severe proportions.

Cryotherapy also known as cold therapy, is the Treatment of pain and/or inflammation by lowering the temperature of the skin over the affected area.

Custodial Care means care designed principally to assist a Member in engaging in the activities of daily living, or 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. This includes the health care related activities that people generally do themselves, such as placement of eye drops. Custodial care is normally, but not necessarily, provided in a nursing home, convalescent Hospital, or rest home or similar institution.

Deductible means the dollar amount, if any, shown in the Schedule of Benefits payable by the Member for covered benefits before the Plan provides payment for those benefits under this Evidence of Coverage.

Diabetes 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 diabetes complications. As new or improved diabetes equipment becomes available and is approved by the United States Food and Drug Administration, such equipment shall be covered if determined to be Medically Necessary and appropriate by a Participating Provider through a written order.

Diabetes Self-Management Training means any of the following training or instruction by a Participating Provider following the initial diagnosis of diabetes:

- Instruction in the care and management of the condition;
- Nutritional counseling;
- Counseling in the proper use of Diabetes 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 Treatment for diabetes.

Diabetes 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. As new or improved diabetes supplies become available and are approved by the United States Food and Drug Administration, such supplies shall be covered if determined to be Medically Necessary and appropriate by a Participating Provider through a written order.

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 Member 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 Durable Medical Equipment.

Effective Date means the date the coverage for You and/or Your Covered Dependent(s) begins. It may be different from the Contract Date.

Eligible Dependent means a member of the Subscriber's family who falls within one of the following categories:

- Subscriber's current spouse as defined by Texas law;
- A child of the Subscriber's current spouse who is:
    - An applicant for coverage during the Open Enrollment Period; and
    - Under the Age of Ineligibility; or
    - Over the Age of Ineligibility who is:
        - Incapable of self-sustaining employment by reason of physical disability or mental incapacity; and
        - Chiefly dependent upon the Subscriber for support and maintenance.
- Subscriber's Son or Daughter who is:
    - An applicant for coverage during the Open Enrollment Period; and
    - Under the Age of Ineligibility; or
    - Over the Age of Ineligibility who is:
        - Incapable of self-sustaining employment by reason of physical disability or mental incapacity; and
        - Chiefly dependent upon the Subscriber for support and maintenance.
- Subscriber's grandson or granddaughter who is:
    - An applicant for coverage during the Open Enrollment Period;
    - A dependent of the Subscriber for federal tax purposes at the time of application of coverage for the grandchild is made;
    - Unmarried; and
    - Under the Age of Ineligibility; or
    - Over the Age of Ineligibility who is:
        - Incapable of self-sustaining employment by reason of physical disability or mental incapacity; and
        - Chiefly dependent upon the Subscriber for support and maintenance;
- Any child for whom the Subscriber is obligated to provide health coverage by a Qualified Medical Support Order pursuant to the terms of that order.

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 Plan. The term does not include:

- an employee who works on a part-time, temporary, seasonal or substitute basis; or
- an employee who is covered under:
    - another health benefit plan;
    - 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.

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

Emergency Care is 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:

- Placing his or her health in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious disfigurement;
- In the case of a pregnant woman, serious jeopardy to the health of the fetus; or
- In the case of a woman having contractions, there is inadequate time to affect 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.

Employee means an individual employed by an Employer.

Employer means Group.

Enrollment Application is the document which must be completed by or on behalf of a person applying for coverage. The enrollment application along with any attachments and amendments is part of the entire Agreement between the Subscriber, Contract Holder and the Issuer.

Essential Health Benefits is the term used to describe health benefits that are comprised of general categories and covered items and services within those categories, as defined by Section 1302(b) of the Patient Protection and Affordable Care Act (PPACA).

Evidence of Coverage is the term used to describe this document which, along with any attachments and amendments, is part of the entire Agreement between the Subscriber, Contract Holder and the Issuer. This Evidence of Coverage describes the benefits covered by the Plan.

Experimental or **Investigational** means, in the opinion of the Medical Director, Treatment that has not been proven successful in improving the health outcomes of Members, in making such determinations, the Medical Director will rely on:

- Well designed and well conducted investigations published in recognized peer reviewed medical literature, such as the New England Journal of Medicine or the Journal of Clinical Oncology, when such papers report conclusive findings of controlled or randomized trials. The Medical Director shall consider the quality of the body of studies and the consistency of the results in evaluating the evidence;
- Communications about the Treatment that have been provided to Members as part of an informed consent;
- Communications about the procedure or Treatment that have been provided from the Physician studying the Treatment to the institution or government sponsoring the study;
- Documents or records from the institutional review board of the Hospital or institution studying the Treatment;
- Regulations and other communication and publications issued by the Food and Drug Administration and the Department of Health and Human Services; and
- The Member's medical records.

As used above "peer reviewed medical literature" means one or more U.S. scientific publications which require that manuscripts be submitted to acknowledged experts inside or outside the editorial office for the considered opinions

or recommendations regarding publication of the manuscript. In addition, in order to qualify as peer reviewed medical literature, the manuscript must have been reviewed by acknowledged experts before publication.

Treatments referred to as "experimental", "experimental trial", "investigational", "investigational trial", "trial", "study", "controlled study", "controlled trial", or concludes with "promising" or "further studies are needed" and any of terms of similar meaning shall be Experimental or Investigational.

Extended Care Expense means the Allowed Amount of charges incurred for Medically Necessary benefits provided by a Skilled Nursing Facility, a Home Health Agency, or a Hospice.

Facility means a health care or residential treatment center licensed by the state in which it operates to provide medical inpatient Treatment, outpatient Treatment, partial hospitalization, residential or day Treatment. Facility also means a treatment center for the diagnosis and/or Treatment of Chemical Dependency or Mental Illness.

Freestanding Emergency Medical Care Facility is a Facility, licensed under Health and Safety Code Chapter 254 (concerning Freestanding Emergency Medical Care Facilities), structurally separate and distinct from a Hospital, that receives a Member and provides Emergency Care as defined in Insurance Code §843.002.

Formulary means the list that identifies those Prescription Drugs for which coverage may be available under this Plan. Members may determine the tier assigned to each Prescription Drug by visiting the Our website at swhp.org or by calling Us at 800-321-7947.

Grace Period means a period of thirty (30) days after a Premium Due Date, during which Premiums may be paid to the Issuer without lapse of the Subscriber or Covered Dependent's coverage, if any, under this Evidence of Coverage. If payment is not received within thirty (30) days, coverage will be terminated, and the Subscriber will be responsible for any cost of benefits received during the grace period.

Group means Your Employer which is the party contracting with the Issuer 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.

Health Professional means health care professionals, licensed in the State of Texas (or, in the case of Treatment rendered on referral, licensed in the state in which that care is provided). Health Professional includes a Doctor of Dentistry, a Doctor of Podiatry, a Doctor of Optometry, a Doctor or Chiropractic, a Doctor or 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 Counselor and Family Therapist, and other practitioners of the healing arts as specified in the Texas Insurance Code.

Heritable Metabolic Disease means an inherited disease that may result in mental or physical retardation or death.

Home Health Agency means a business that provides Home Health Care and is licensed, approved, or certified by the appropriate agency of the state in which it is located or be certified by Medicare as a supplier of Home Health Care.

Home Health Care means benefits that are provided under the Plan during a visit by a Home Health Agency to Members confined at home due to a sickness or injury requiring skilled health care on an intermittent, part-time basis.

Home Infusion Therapy means the administration of fluids, nutrition, or medication (including all additives and Chemotherapy) by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting. Home Infusion Therapy shall include:

- Drugs and IV solutions;
- Pharmacy compounding and dispensing services;
- All equipment and ancillary supplies necessitated by the defined therapy;
- Delivery services;
- Patient and family education; and
- Nursing services.

Over-the-counter products which do not require a Participating Provider's prescription, including but not limited to standard nutritional formulations used for enteral nutrition therapy, are not included within this definition.

Hospice means a Facility or agency primarily engaged in providing skilled nursing care and other therapeutic care for terminally ill patients and which is:

- Licensed in accordance with state law (where the state law provides for such licensing); or
- Certified by Medicare as a supplier of Hospice Care.

Hospice Care means benefits that are provided under the Plan by a Hospice to a Member confined at home or in a Hospice Facility due to a terminal sickness or terminal injury requiring skilled health care.

Hospital means a short-term acute care Facility which:

- Is duly licensed as a Hospital by the state in which it is located and meets the standards established for such licensing, including those either accredited by the Joint Commission on Accreditation of Healthcare Organizations or is certified as a Hospital Provider under Medicare;
- Is primarily engaged in providing inpatient diagnostic and therapeutic care for the diagnosis, Treatment, and care of injured and sick persons by or under the supervision of Physicians or Behavioral Health Provider for compensation from its patients;
- Has organized departments of medicine and major surgery, either on its premises or in facilities available to the Hospital on a contractual prearranged basis, and maintains clinical records on all patients;
- Provides 24-hour nursing care by or under the supervision of a registered nurse; and
- Is not, other than incidentally, a Skilled Nursing Facility, nursing home, Custodial Care home, health resort, spa or sanitarium, place for rest, place for the aged, place for the Treatment of Chemical Dependency, Hospice, or place for the provision of rehabilitative care.

Identification Card or ID Card means the card provided to the Member by the Issuer indicating pertinent information applicable to the Member’s coverage.

Inpatient Hospital Expense means the Allowed Amount incurred for the Medically Necessary care of a Member, if benefits are:

- Furnished at the direction or prescription of a Physician, Behavioral Health Provider or Health Professional; and
- Provided by a Hospital or a Chemical Dependency Treatment Center; and
- Furnished to and used by the Member during an inpatient Hospital admission.

Inpatient Hospital Expense shall include:

- Room accommodation charges.
- All other usual Hospital care, including Prescription Drugs and medications, which are Medically Necessary and consistent with the condition of the Member.
    - Not included are personal items or comfort items, including, but not limited to, TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, or hot tubs.

- Medically Necessary Mental Health Care or Treatment of Serious Mental Illness or Treatment of Serious Mental Illness in a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, or a Residential Treatment Center for Children and Adolescents, in lieu of hospitalization, shall be Inpatient Hospital Expense.

Independent Review Organization or IRO means an organization which provides external review of Adverse Determinations as administered by the Department of Health and Human Services.

Infertility means the inability to conceive after sexual relations without contraceptives for the period of one (1) year, or if 35 years or older, inability to conceive after six (6) months; or maintain a pregnancy until fetal viability.

Issuer means Scott & White Care Plans; also referred to as "We", "Us" and "Our".

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

Legend Drug means a drug that federal law prohibits dispensing without a written prescription.

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.

Maintenance Prescription Drug means medication prescribed for a chronic, long-term condition and is taken on a regular, recurring basis.

Manipulative Therapy within the scope of rehabilitative care, includes benefits provided by a chiropractor or other provider licensed to provide the benefit, that is supportive or necessary to help Members achieve the same physical state as before an injury or illness, and that is determined to be Medically Necessary.

Mammography means the X-ray examination of the breast using equipment dedicated specifically for Mammography.

Mammography, Breast Tomosynthesis means a radiologic Mammography procedure that involves the acquisition of projection images over a stationary breast to produce cross-sectional digital three-dimensional images of the breast from which applicable breast cancer screening diagnoses may be determined.

Mammography, Diagnostic means an imaging examination designed to evaluate a subjective or objective abnormality detected by a Physician in a breast; an abnormality seen by a Physician on a screening mammogram; an abnormality previously identified by a Physician as probably benign in a breast for which follow-up imaging is recommended by a Physician; or an individual with a personal history of breast cancer.

Mammography, Digital means Mammography creating breast images that are stored as digital pictures.

Mammography, Low Dose means the X-ray examination of the breast using equipment dedicated specifically for Mammography, including an X-ray tube, filter, compression device, and screens, with an average radiation exposure delivery of less than one rad mid-breast and with two views for each breast.

Maximum Out of Pocket means the total dollar amount of Out of Pocket Expenses which a Member is required to pay for covered benefits during a Plan Year. Maximum Out of Pocket does not apply to any Treatments which are not Medically Necessary or not a covered benefit.

Medical Benefits refers to Medically Necessary covered benefits which are included in the **Medical Benefits** section of this Evidence of Coverage, any amendments or Riders thereto, and which are performed, prescribed or authorized by a Participating Provider, Participating Hospital, or a referral Physician.

Medical Director means any Physician designated by the Issuer who shall have responsibilities for assuring the continuity, availability and accessibility of covered benefits. 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 a Treatment is Experimental or Investigational.

Medical-Surgical Expense means the Allowed Amount incurred for Medically Necessary care of a Member, provided the benefits are:

- Furnished by or at the direction or prescription of a Physician, Behavioral Health Provider or Health Professional; and
- Not an excluded Inpatient Hospital Expense or Extended Care Expense in the Plan.

A benefit is furnished by or at the direction of a Physician, Behavioral Health Provider or Health Professional if the benefit is:

- Provided by a person employed by the directing Physician, Behavioral Health Provider or Health Professional; and
- Provided at the usual place of business of the directing Physician, Behavioral Health Provider or Health Professional; and
- Billed to the patient by the directing Physician, Behavioral Health Provider or Health Professional.

An expense shall have been incurred on the date the benefit was provided for which the charge is made.

Medically Necessary or Medical Necessity means those health care services which, in the opinion of the Member's Participating Provider or Participating Health Professional, 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:

- in accordance with the generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease, and;
- not primarily for the convenience of the Member, Participating Provider, a physician or any other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's illness, injury, or disease**.**

Medication Synchronization Plan means a plan established for the purpose of synchronizing the filling or refilling of multiple prescriptions.

Medicare means Title XVII of the Social Security Act, and amendments thereto.

Member means You and/or Your Covered Dependent(s).

Mental Health Care means any of the following:

- The diagnosis or Treatment of a mental disease, disorder, or condition listed in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM), as revised, or any other diagnostic coding system used by Us, whether the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin;
- The diagnosis or Treatment of any symptom, condition, disease, or disorder by a Physician, Behavioral Health Provider or Health Professional (or by any person working under the direction or supervision of a Physician, Behavioral Health Provider or Health Professional) resulting from:
    - Individual, group, family, or conjoint psychotherapy,

- Counseling,
- Psychoanalysis,
- Psychological testing and assessment,
- The administration or monitoring of psychotropic drugs, or
- Hospital visits or consultations in a Facility.

- Electroconvulsive Treatment;
- Psychotropic drugs; or,
- Any of the services listed above, performed in or by a Participating Provider.

Minimum Essential Coverage means health coverage that is recognized as coverage that meets substantially all requirements under federal law pertaining to adequate individual, group or government health insurance coverage. For additional information on whether coverage is recognized as "Minimum Essential Coverage", please contact the Issuer at 800-321-7947 or visit www.cms.gov.

Minimum Group Size means the minimum number of Eligible Employees required to be employed by the Employer in order to avoid termination of the Agreement. The minimum group size is two Eligible Employees.

Name Brand Prescription Drug means a Prescription Drug that has no generic equivalent or a Prescription Drug that is the innovator or original formulation for which the generic equivalent forms exist.

Neonatal Intensive Care Unit or NICU is also referred to as a special care nursery or intensive care nursery. Admission into NICU generally occurs but is not limited to when the newborn is born prematurely, if difficulty occurs during delivery, or the newborn shows signs of a medical problem after the delivery.

Network means Participating Providers that have contracted with the Issuer to provide covered benefits to Members.

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 interview of a Member, a Member's family, or others.

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

Neurobiological Disorder means an illness of the nervous system caused by genetic, metabolic, or other biological factors.

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

Neurocognitive Therapy means therapy designed to address neurological deficits in informational processing and to facilitate the development of higher-level cognitive abilities.

Neurophysiological Testing means evaluation of the functions of the nervous system.

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

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

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

Non-Participating Provider means a Hospital, Physician, Behavioral Health Provider, Health Professional, Urgent Care Facility or Pharmacy who has not contracted with the Issuer to provide benefits to Members of the Plan. We strongly encourage Members to use Participating Providers to assure the highest quality and lowest cost. Use of a Non-Participating Provider may result in additional charges to the Member that are not covered under the Plan. Requests for benefits performed by a Non-Participating Provider may be denied if there is a Participating Provider in the Network who can provide the same or similar benefit.

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

Oral Oncology Dispensing Program means a program that temporarily limits the quantity of oral oncology medication that can be dispensed. The first 4 fills of the Prescription Drug are restricted to a 14/15-day supply until tolerability has been established. After this period, the Member may obtain the maximum day supply allowed per the Schedule of Benefits. Prescription Drugs used to treat stage 4 advanced metastatic cancer or associated conditions are not subject to step therapy or failed first attempts.

Organ Transplant means the harvesting of a solid and/or non-solid organ, gland, or tissue from one individual and reintroducing that organ, gland, or tissue into another individual.

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

Out of Pocket Expenses means the portion of covered benefits for which a Member is required to pay at the time benefits are received. Benefits which are not covered by the Plan or are not Medically Necessary, are not included in determining Out of Pocket Expenses.

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

Participating Facility means a health care or Treatment center licensed by the State of Texas as a Facility which has contracted or arranged with the Issuer to provide covered benefits to Members and is listed by the Issuer as a Participating Provider.

Participating Health Professional means a health care professional, licensed in the State of Texas (or, in the case of Treatment rendered on referral, licensed in the state in which that care is provided) who has contracted or arranged with the Issuer to provide covered benefits to Members and is listed by the Issuer as a Participating Provider.

Participating Hospital means an institution licensed by the State of Texas as a Hospital which has contracted or arranged with the Issuer to provide covered benefits to Members and is listed by the Issuer as a Participating Provider.

Participating Pharmacy means a pharmacy that has contracted with the Issuer to provide Prescription Drugs to Members.

Participating Provider means any person employed by an entity that has contracted directly or indirectly with the Issuer to provide covered benefits to Members. Participating Provider includes but is not limited to Participating

Hospitals, Participating Physicians, Participating Behavioral Health Providers, Participating Health Professionals, Participating Urgent Care Facilities, Participating Pharmacies and Participating Specialty Pharmacy Provider within the Service Area.

Participating Specialty Pharmacy Provider means a pharmacy that has contracted with the Issuer to provide Specialty Prescription Drugs to Members.

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

Participating Virtual Network Provider means a provider or Facility that has entered into an agreement with the Issuer, or with an organization contracting on the Issuer's behalf, to deliver covered benefits through live audio with video technology or audio only or online interview process.

Pharmacy Benefits refers to Medically Necessary Covered Prescription Drugs prescribed to treat a Member for an acute, chronic, disabling, or Life-Threatening Disease or Condition which are included in the **Pharmacy Benefits** section of this Evidence of Coverage, any amendments or Riders thereto, and which are prescribed by a Participating Provider and filled by a Participating Pharmacy.

Phenylketonuria or PKU means an inherited condition that may cause severe developmental deficiency, seizures or tumors, if not treated.

Physician means a person, when acting within the scope of his license to practice medicine in the State of Texas, who is a Doctor of Medicine or Doctor of Osteopathy. The terms Doctor of Medicine or Doctor of Osteopathy shall have the meaning assigned to them by the Texas Insurance Code.

Plan, Your Plan, The Plan means the covered benefits available to You and Your Covered Dependents under the terms of the Agreement.

Plan Year means the annual period that begins on the anniversary of the Plan's Effective Date.

Post-Acute Care Treatment means Treatment provided after acute care confinement and/or Treatment that is based on an assessment of the Member's physical, behavioral, or cognitive functional deficits, which includes 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.

Post-Acute Transition means care that facilitates the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

Post-Stabilization means care that is:

- Related to an emergency medical condition;
- Provided to stabilize the Member's condition; or,
- Provided to maintain the stabilized condition, or, in certain circumstances, to improve or resolve the Member's condition.

Post-Delivery Care means postpartum care provided in accordance with accepted maternal or neonatal assessment 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 trials.

Preauthorization means a form of prospective Utilization Review by the Issuer or Issuer's Utilization Review agent of health care proposed to be provided to a Member.

Premium means periodic amounts required to be paid to the Issuer for or on behalf of a Covered Employee and Covered Dependents, if any, as a condition of coverage under the Agreement.

Premium Contribution means the minimum percentage of Premium which Your Employer must pay for Your coverage.

Premium Due Date means the first day of the month or quarter for which the payment is due.

Prescription Drug means any Legend Drug that has been approved by the Food and Drug Administration (FDA), is not Experimental or Investigational, and requires a prescription written by a duly licensed Physician.

Prescription Order means an authorization for a Prescription Drug issued by a Physician, who is duly licensed to write the authorization in the ordinary course of his professional practice.

Preventive Care means the following, as further defined and interpreted by appropriate statutory, regulator, and agency guidance:

- Evidence-based items or services with an "A" or "B" rating from the U.S. Preventive Services Task Force (USPSTF);
- 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;
- Evidence-informed Preventive Care and screening for infants, children and adolescents provided by guidelines supported by the Health Resources and Services Administration (HRSA); and
- Evidence-informed Preventive Care and screening for women provided in guidelines supported by HRSA and not otherwise addressed by the USPSTF.

Primary Care Physician means a Participating Provider specializing in family medicine, community internal medicine, general medicine, geriatrics, or pediatrics selected by the Member to manage the Medical and Pharmacy Benefits which will be made available to the Member by the Issuer.

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.

Prosthetics/Orthotics Provider means a certified prosthetist that supplies both standard and customized prostheses and orthotic supplies.

Psychiatric Day Treatment Facility means an institution which is appropriately licensed and is accredited by the Joint Commission on Accreditation of Healthcare Organizations as a Psychiatric Day Treatment Facility for the provision of Mental Health Care and Serious Mental Illness services to Members for periods of time not to exceed eight hours in any 24-hour period. Any Treatment in a Psychiatric Day Treatment Facility must be certified in writing by the attending Physician or Behavioral Health Provider to be in lieu of hospitalization.

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

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

Qualified Medical Support Order means a court or administrative order which sets forth the responsibility for providing health care coverage for Eligible Dependents.

Remediation means the process(es) of restoring and improving a specific function.

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 the Agreement, including application fees, Copayments, Deductibles, Subrogation, Premiums, late fees and any other amounts specifically identified as Required Payments under the terms of the Agreement.

Research Institute means the institution or other person or entity conducting a phase I, phase II, phase III, or phase IV clinical trial.

Residential Treatment Center for Children and Adolescents means a child-care institution which is appropriately licensed and accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Association of Psychiatric Services for Children as a residential Treatment center for the provisions of Mental Health Care and Serious Mental Illness services for emotionally disturbed children and adolescents.

Rider means a supplement to the Plan that describes any additional covered benefits, changes in Member benefits or the terms of Member coverage under the Plan. We may provide Riders to Members at the time of enrollment in the Plan or at other times after that. A Rider, along with any attachments and amendments, is part of the entire Agreement between the Issuer and the Subscriber.

Routine Patient Care Costs means the costs of any Medically Necessary care provided under the Plan, without regard to whether the Member is participating in a clinical trial. Routine patient care costs do not include:

- 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;
- The cost of a service that is not a covered benefit, regardless of whether the service is required in connection with participation in a clinical trial;
- The cost or use of a service that is clearly inconsistent with widely accepted and established standards of care for a diagnosis;
- A cost associated with managing a clinical trial; or
- The cost of a service that is specifically excluded from coverage under this Evidence of Coverage.

Schedule of Benefits is a document that lists covered benefits under the Plan along with associated Cost Sharing such as Copayments and Deductibles. The Schedule of Benefits along with any attachments and amendments is part of the entire Agreement between the Subscriber and the Issuer.

Serious Mental Illness includes the following psychiatric illnesses defined by the DSM:

- Bipolar disorders (hypomanic, manic, depressive, and mixed);
- Depression in childhood and adolescence;
- Major depressive disorders (single episode or recurrent);
- Obsessive-compulsive disorders;
- Paranoid and other psychotic disorders;
- Schizoaffective disorders (bipolar or depressive); and
- Schizophrenia.

Service Area is the geographic area in which the Issuer may offer this Evidence of Coverage.

Skilled Nursing Facility means a Facility primarily engaged in providing skilled nursing care and other therapeutic care and which is:

- Licensed in accordance with state law (where the state law provides for licensing of such Facility); or
- Medicare or Medicaid eligible as a supplier of skilled inpatient nursing care.

Son or Daughter means

- A child born to You or Your current legal spouse;

- 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
- A child who has been placed with You for adoption.

Specialist Physician means a Physician or Health Professional who has entered into an agreement with the Issuer to participate as a provider of specialty care (generally, those practices other than general practice, family practice, internal medicine, pediatrics and OB/GYN).

Specialty Prescription Drug means any Prescription Drug regardless of dosage form, including orally administered anticancer medications, or a Prescription 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 guidelines determined comprehensive patient and/or Physician education; or
- Contains any dosage form with a total cost greater than $1,000 per retail maximum days' supply.

Stabilization means the point at which no material deterioration of a condition is likely, within reasonable probability, to result from or occur during the Member's transfer.

Subrogation means recovery, from a third party, of medical costs that were originally paid by the Issuer.

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 the Agreement and for or on behalf of whom the Premiums are paid by the Group.

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

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

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

Triggering Event means an event which allows an individual to apply for enrollment in coverage outside of the Open Enrollment Period.

Urgent Care Facility means any licensed Facility that provides care for the immediate Treatment only of an injury or disease, and which has contracted with the Issuer to provide Members such care.

Urgent Care means care provided for the immediate Treatment of a medical condition that requires prompt medical attention but where a brief time lapse before receiving care 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.

Usual and Customary Rate 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 care within a geographical area; and that have been negotiated with one or more Participating Provider in a geographical area for the same of similar care. The amount payable may be increased by a fixed percentage for certain services or facilities as agreed to by the Plan.

Utilization Review means a system for prospective and/or concurrent review of the Medical Necessity, appropriateness or determination that a Treatment currently provided or proposed to be provided by a Physician or Health Professional to a Member is Experimental, or Investigational. Utilization Review does not include elective requests by the Member for clarification of coverage.

Virtual Visit for Medical Benefits includes the diagnosis and Treatment of less serious medical conditions through live audio with video technology (video visits) or online interview process (E-visits) or audio only. Virtual visits provide communication of medical information in real-time between the Member and a distant Physician or Health Professional, through use of live audio with video technology or audio only or online interview process outside of a medical Facility (for example, from home or from work).

Waiting Period means the period specified by Group, but not longer than ninety (90) days, that must pass before a person becomes eligible for coverage under the Agreement.

You means the Subscriber.

Your means relating or pertaining to the Subscriber.

How the Plan Works

Our Right to Contract with Providers

We contract with providers of covered benefits as it is determined can reasonably provide them. The Issuer is not an agent of any Participating Provider, nor is any Participating Provider an agent of the Issuer. No Contract Holder or Member, in such capacity, is an agent or representative of the Issuer 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.

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. Participating Providers determine the methods and form of Treatment provided to Members. Not every form of Treatment may be provided, and even though a Member's personal beliefs or preferences may conflict with the care as offered by Participating Providers, a Member will not be entitled to any specific class of licensed provider, school of approach to such care, or otherwise be able to determine the providers who will care for the Member other than as provided by this Evidence of Coverage. This provision does not restrict the Member's right to consent or agree to any Treatment. The fact that Treatment has been prescribed or authorized by a Participating Provider does not necessarily mean that it is covered under the Agreement.

Plan Network

Members are entitled to the covered benefits specified and subject to the conditions and limitations stated in the Schedule of Benefits and this Evidence of Coverage that are Medically Necessary. Except for Emergency Care, approved referrals to Non-Participating Providers or care provided to a Covered Dependent child under a Qualified Medical Support Order who is outside the Service Area, covered benefits are available only through Participating Providers. We have no liability or obligation for any care needed or received by any Member from any other provider, Hospital, extended care Facility, or other person, institution or organization, unless Preauthorization for referral has been obtained by a Medical Director. Members can access up-to-date lists of Participating Providers and other Plan Network information by visiting Our website at swhp.org.

Primary Care Physician

Under this Plan, Members do not have to select a Primary Care Physician (PCP) but are encouraged to do so. The PCP is available to supervise and coordinate the Member's health care in the Plan Network. Should a Member decline to select a PCP, We will not assign one. Members may request to use a Specialist Physician as a PCP if the Member has a chronic, disabling, or Life-Threatening Disease or Condition. Members do not need a referral from a PCP before receiving specialist care.

A PCP may be selected from the list of Primary Care Physicians published by the Issuer. The ability to select a Participating Provider as a PCP is subject to that Physician's availability. A current, updated list of Primary Care Physicians may be found on Our website at swhp.org or by contacting Us at 800-321-7947. A female Member may select an obstetrician or gynecologist in addition to a PCP to provide Treatment that is within the scope of the provider's license.

You or Your Covered Dependents may change Your Primary Care Physician anytime.

Specialist Physician

A wide range of Specialist Physicians are included in the Plan Network.

There may be occasions however, when Members need care from a Non-Participating Provider. This could occur if a Member has a complex medical problem that cannot be taken care of by a Participating Provider. If the care You or Your Covered Dependent require is not available from Participating Providers contact Us at 800-321-7947 to receive the necessary Preauthorization for out-of-network benefits in this situation.

Participating Providers

Other than for Emergency Care, Members must choose Participating Providers within the Plan Network for all care. The Plan Network consists of Physicians, Specialist Physicians, Hospitals, and other health care facilities to serve Members throughout the Network Service Area. Refer to the provider directory or visit Our website at swhp.org to make Member selections. The list of Participating Providers may change occasionally, so make sure the providers selected are still Participating Providers at the time of service. An updated directory will be available at least annually or Members may access Our website at swhp.org for the most current listing to assist in locating a Participating Provider.

If a Member chooses a Participating Provider, the provider will bill Us, not the Member, for care provided. The provider has agreed to accept as payment in full the least of:

- The billed charges, or
- The Allowed Amount as determined by the Issuer, or
- Other contractually determined payment amounts.

The Subscriber is responsible for paying any Deductibles and Copayment amounts as set forth in the Schedule of Benefits. The Subscriber may be required to pay for limited or non-covered benefits. No Claim forms are required.

Non-Participating Providers

Except for Emergency Care, all covered benefits under this Evidence of Coverage must be provided by Participating Providers unless a Participating Provider requests a referral to a Non-Participating Provider and the referral receives Preauthorization by Our Medical Director.

If the Member requires a Medically Necessary covered benefit that is not available through a Participating Provider and We approve the Member's Participating Provider's referral, We will cover the benefit as if it were performed by a Participating Provider. The Member will be held harmless for any amounts beyond the Copayment and Deductible that the Subscriber would have paid had the Member received benefits from a Participating Provider.

Upon the request of a Participating Provider, We must approve a referral to a Non-Participating Provider within the time appropriate to the circumstances and will not exceed five (5) business days. Additionally, upon the request of a Participating Provider, We must provide for a review by a health care provider with expertise in the same specialty or a specialty similar to the type of health care provider to whom a referral is requested before We may deny the referral.

If a Non-Participating Provider referral is authorized by Us, care is only permitted to the extent such care is covered under this Evidence of Coverage and reimburse the Non-Participating Provider at the Usual and Customary or agreed upon rate, except for Copayments and charges for non-covered care.

In all cases, Medically Necessary Emergency Care received from a Non-Participating Provider will be reimbursed according to the terms of this Evidence of Coverage at the Usual and Customary or agreed upon rate, except for Copayments, and charges for non-covered care. The Member will be held harmless for any amounts beyond the Copayment or other Out of Pocket Expenses that the Subscriber would have paid had the Network included Participating Providers from whom the Member could obtain the care.

In cases involving a non-emergency, the Plan will not cover any expenses associated with Treatments performed or prescribed by Non-Participating Providers, either inside or outside of the Service Area, for which We have not authorized a Non-Participating Provider referral. Complications of such non-authorized Treatments will not be covered prior to the date We arrange for the Member's transfer to Participating Provider.

Each Non-Participating Provider referral is subject to separate review and approval by Us. For example, an authorization for Treatment by a Non-Participating Provider does not also authorize hospitalization in a Hospital which is not a Participating Hospital or referral to another Physician by the Non-Participating Provider.

Some Facility-based providers such as anesthesiologist, pathologist, and radiologists may not be included in the Plan's Network. In certain circumstances We may authorize the Member to receive Treatment from a Non-Participating Provider. The Member will not be responsible for an amount greater than the applicable Copayment and Deductible under the Plan on the initial amount determined to be payable by the Plan. A Member should contact the Issuer if the Member receives a balance bill from a Facility-based provider, Non-Participating Facility-based provider, or other Health Professional that may balance bill the Member. In order to determine the contract status of providers, Members may consult the provider directory on Our website at swhp.org or contact Us at 800-321-7947.

Continuity of Care

Except as specified in the **Medical Benefits** section of this Evidence of Coverage, if Participating Providers fail to, or become unable to, provide the covered benefits which they have agreed to provide, We agree to coordinate through Our Medical Director the provision of Medical Benefits to Members.

If You or Your Covered Dependents are receiving covered benefits from a Participating Provider whose relationship with the Issuer as a Participating Provider is terminated by the provider, We will give the Member no less than thirty (30) days' advance notice of the termination after notification from the provider. However, if a provider is terminated for reasons related to imminent harm, We will notify the Member immediately.

Except for medical incompetence or unprofessional behavior, the termination does not release the Issuer from reimbursing the Participating Provider for providing Treatment to You or Your Covered Dependents 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 includes a disability, acute condition, Life-Threatening Disease or Condition, or being past the twenty-fourth (24th) week of pregnancy. However, the Participating Provider must first identify the special circumstance and submit a request to Our Medical Director that You or Your Covered 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 Participating Provider were still under contract with Us. If the request is granted, Our obligation to pay for the services of the Participating Provider shall not exceed ninety (90) days from the date of termination or nine (9) months in the case of a terminal illness with which You or Your Covered Dependent were diagnosed at the time of the termination and shall not exceed the contract rate. If You or a Covered Dependent are past the twenty-fourth (24th) week of pregnancy at the time of termination, Our 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 (6) weeks of delivery.

Refusal to Accept Treatment

Should a Member refuse to cooperate with or accept the recommendations of Participating Providers regarding health care for that Member, Participating Providers may regard such refusal as obstructing the delivery of proper medical care. In such cases, Participating Providers shall make reasonable efforts to accommodate the Member. However, if the Participating Provider determines that no alternative acceptable to the Participating Provider exists, the Member shall be so advised. If a Member continues to refuse to follow the recommendations, then neither We

nor Our Participating Providers shall have any further responsibility under the Agreement to provide care for the condition under Treatment.

Medical Necessity

Benefits available under the Plan must be Medically Necessary as described in the **Definitions** section of this Evidence of Coverage.

Utilization Review

The Plan includes a Utilization Review program to evaluate inpatient and outpatient Hospital and Ambulatory Surgical Center admissions and specified non-emergency outpatient surgeries, diagnostic procedures and other services. This program ensures that Hospital and Ambulatory Surgical Center care is received in the most appropriate setting, and that any other specified surgery or services are Medically Necessary. Utilization Review includes all review activities and may be undertaken by:

- Preauthorization review which takes place before a service is provided that requires Preauthorization.
- Admission review which takes place before a Hospital admission or after an emergency admission.
- Continued stay review which takes place during a Hospital stay.
- Retrospective review which takes place following discharge from a Hospital or after any services are performed.

Certain benefits require Preauthorization in order to be covered. For a complete list of benefits that require Preauthorization, visit Our website at swhp.org.

We will accept requests for renewal of an existing Preauthorization beginning sixty (60) days from the date that the existing Preauthorization is set to expire. Upon receipt of a request for renewal of an existing Preauthorization, We will, to the extent possible, review the request and issue a determination indicating whether the benefit is Preauthorized before the existing authorization expires.

Preauthorization Review

To satisfy Preauthorization review requirements, the Member or Participating Provider should contact Us at the authorization phone number listed on the Member ID Card on business days between 6 a.m. and 6 p.m. CT and on Saturdays, Sundays and Holidays between 9 a.m. and 12 p.m. CT at least three (3) calendar days prior to any admission or scheduled date of a proposed benefit that requires Preauthorization. Participating Providers may Preauthorize benefits for Members, when required, but it is the Member's responsibility to ensure Preauthorization requirements are satisfied.

Subject to the notice requirements and prior to the issuance of an Adverse Determination, if We question the Medical Necessity or appropriateness of a service, We will give the Participating Provider who ordered it a reasonable opportunity to discuss with Our Medical Director the Member's Treatment plan and the clinical basis of Our determination. If We determine the proposed benefit is not Medically Necessary, the Member or Participating Provider will be notified in writing within three (3) days. The written notice will include:

- the principal reason(s) 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 the Member's rights and the procedure to Appeal to an Independent Review Organization.

For an Emergency admission or procedure, We must be notified within forty-eight (48) hours of the admission or procedure or as soon as reasonably possible. We may consider whether the Member's condition was severe enough to prevent the Member from notifying Us, or whether a family member was available to notify Us for the Member.

If the Member has a Life-Threatening Disease or Condition, including emergency Treatment or continued hospitalization, or in circumstances involving Prescription Drugs or intravenous infusions, the Member has the right to an immediate review by an Independent Review Organization and the Member is not required to first request an internal review by Us.

Admission Review

If Preauthorization 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.

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 (24) hours by either telephone or electronic transmission to the provider of record followed by written notice within three (3) working days to the Member or provider of record. If We are approving or denying Post Stabilization care subsequent to Emergency Care related to a Life-Threatening Disease or 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 Member, but in no case to exceed one (1) hour after the request for approval is made.

Retrospective Review

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 the Member and the provider of record within a reasonable period, but not later than thirty (30) days after the date on which the Claim is received, provided We may extend the 30-day period for up to fifteen (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 decision.

If the period is extended because of Your failure or the failure of the provider of record to submit the information necessary to make the determination, the period for making the determination is tolled from the date We send Our notice of the extension to 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.

Failure to Preauthorize

If any benefit requiring Preauthorization is not Preauthorized and it is determined that the benefit was not Medically Necessary, the benefit may be reduced or denied. The Member may also be charged additional amounts which will not count toward the Member's Deductible or Maximum Out of Pocket.

Prescription Drugs and Intravenous Infusions

We will determine if the use of Prescription Drugs or intravenous infusions is Medically Necessary.

Appeal of an Adverse Determination

Internal Appeal of an Adverse Determination

Our determination that the care the Member requested or received was not Medically Necessary or appropriate or was Experimental or Investigational based on Our Utilization Review standards is an Adverse Determination, which means the Member's request for coverage of the care is denied. Once We have all the information to make a decision, Our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an Adverse Determination subject to an internal Appeal.

The Member, a person acting on the Member's behalf, or the Member's Physician may request an internal Appeal of an Adverse Determination to Us orally or in writing in accordance with Our internal Appeal procedures. Members will have one hundred eighty (180) days following receipt of a notification of an Adverse Determination within which to Appeal the determination. We will acknowledge the Member's request for an internal Appeal within five (5) working days of receipt. This acknowledgment will, if necessary, inform the Member of any additional information needed before a decision can be made. A clinical peer reviewer who is a Physician or a Health Professional in the same or similar specialty as the provider, who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial Adverse Determination will perform the Appeal.

If the Member's Appeal is denied, Our notice will include a clean and concise statement of the clinical basis for the denial and the Member's right to seek review of the denial from an Independent Review Organization and the procedures for obtaining that review.

If the Member has a Life-Threatening Disease or Condition or in circumstances involving Prescription Drugs or intravenous infusions, the Member has the right to an immediate review by an Independent Review Organization and the Member is not required to first request an internal review by Us.

Adverse Determination Appeal

If the Member's Appeal relates to an Adverse Determination, We will decide the Appeal within thirty (30) calendar days of receipt of the Appeal request. Written notice of the determination will be provided to the Member, or the Member's designee, and where appropriate, the Member's Provider, within two (2) business days after the determination is made, but no later than thirty (30) calendar days after receipt of the Appeal request.

Expedited Appeal

An Appeal regarding continued or extended benefits, additional benefits provided in the course of continued Treatment, Home Health Care benefits following discharge from an inpatient Hospital admission, benefits in which a provider requests an immediate review, or any other urgent matter will be handled on an expedited basis.

The Member can additionally request an expedited Appeal for the denial of Emergency Care, continued hospitalization, Prescription Drugs for which the Member is receiving benefits through the Plan and a step therapy exception request. For an expedited Appeal, the Member's provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. The Member's provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or one (1) business day of receipt of the information necessary to conduct the Appeal.

If a Member has any questions about the Appeals procedures or the review procedure, contact Us at 800-321-7947.

Appeal of an Adverse Determination to an Independent Review Organization

An Adverse Determination means a determination by Us or Our designated Utilization Review organization that the benefits provided or proposed to be provided are not Medically Necessary or are Experimental or Investigational.

A Final Internal Adverse Determination means an Adverse Determination that has been upheld by Us at the completion of Our internal review and Appeal process. This procedure pertains only to Appeals of Adverse Determinations.

The Member or an individual acting on the Member's behalf or the Member's provider has the right to request an immediate review of Our Appeal decision by an IRO by submitting a request to Our HHS administered external review contractor, MAXIMUS, within four (4) months after receipt of the notice of the determination of the Member's Appeal. There is no cost to the Member for the independent review.

The Member will not be required to exhaust Our Appeal process before requesting an IRO if:

- the Appeal process timelines are not met; or
- in an Urgent Care situation.

Under non-urgent circumstances, the Member may request a standard external review. For Urgent Care, the Member may request an expedited external review.

The IRO examiner will contact Us upon receipt of the request for external review. For a standard external review, We will provide the examiner all documents and information used to make the final internal Adverse Determination within three (3) business days. For an expedited external review, We will provide the examiner all documents and information used to make the final internal Adverse Determination as soon as possible.

The IRO examiner will give the Member and Us written notice of the final external review decision as soon as possible, but no later than twenty (20) days after the examiner receives the request for a standard external review. For an expedited external review, the examiner will give the Member and Us the external review decision as quickly as medical circumstances require, but no later than within seventy-two (72) hours of receiving the request.

The Member may request an external review for an Adverse Determination for Prescription Drug exception requests. The IRO will issue a response to the Member or the Member's legal representative no later than seventy-two (72) hours from receipt of the Member's request. For an expedited Appeal for Prescription Drug exception requests, the IRO will issue a response to the Member or the Member's legal representative no later than twenty-four (24) hours from receipt.

Case Management Program

Case Management helps coordinate services 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 care manager will work with the Member, the Member's family, and Physician to aid and coordinate the services necessary to meet the Member's care needs to achieve the best possible outcome and the greatest value for the Member's benefits. Some of the ways a care manager can provide include:

- Help with finding medical or Behavioral Health Providers that can meet the Member's needs;
- Help with getting community resources that may be available to the Member;
- Information and resources to help Members better understand their conditions and how to better manage them; and,
- Help with learning how to navigate the healthcare system and better understand benefits.

If Members have a health condition or disease for which We operate a case management program, Members may be contacted by Us or Our designated case management vendor and offered the opportunity to participate in case management.

Disease Management Program

We have a disease management program offered to Members at no additional cost. The program helps Members with certain conditions to learn more about how to manage them. These conditions include:

- Asthma;
- Coronary Artery Disease;
- Chronic Obstructive Pulmonary Disease;
- Diabetes; and
- Heart Failure.

Participation in disease management is completely voluntary and Members may opt in or out at any time without affecting their benefits. Members who agree to participate receive phone calls from specially trained nurses, as well as helpful information in the mail.

Proof of Coverage

The Issuer will provide You with proof of coverage under the Agreement. Such evidence shall consist of an original copy of the 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 Issuer and the benefits provided under the Agreement.

Identification Card

The Identification Card (ID Card) tells Participating Providers that You and Your Covered Dependents are entitled to benefits under the Plan with Us. The ID Card offers a convenient way of providing important information specific to You and Your Dependent's coverage including, but not limited to, the following:

- Member ID;
- Any Cost-Sharing amounts that may apply to Your or Your Dependent's coverage; and
- Important telephone numbers.

Always remember to carry the Identification Card and present it to Participating Providers or Participating Pharmacies when receiving covered benefits.

Refer to the **Eligibility and Enrollment** section of this Evidence of Coverage for instructions when changes are made. Upon receipt of the change in information, We will provide a new ID Card.

Identification cards are the property of the Issuer and are for identification purposes only. Possession of an Issuer Identification Card confers no right to benefits under the Agreement. To be entitled to such benefits the holder of the card must, in fact, be a Member on whose behalf all Required Payments under the Agreement have been paid. Any person receiving benefits to which the person is not then entitled pursuant to the provisions of the Agreement shall be subject to charges at the provider's then prevailing rates. If You or Your Covered Dependent permit the use of an Issuer Identification Card by any other person, such card may be retained by Us, and all rights of You and Your dependents, covered pursuant to the Agreement, shall be terminated sixteen (16) days after written notice.

Termination of Coverage for Members

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

- Except for continuation privileges, on the date on which You and/or Your Covered Dependents cease to be eligible for coverage in accordance with the Agreement; or
- Thirty-one (31) days after written notice from Us that You have failed to pay any Required Payment when due; or

- 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 and facilities. Coverage may be terminated retroactively due to fraud or intentional misrepresentation upon thirty (30) days written notice from Us; or
- The date Group coverage terminates.

Termination or Non-Renewal of Coverage for Group

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

1. The Group fails to pay a Required Payment as required by the Agreement;
2. Fraud or intentional misrepresentation of a material fact by the Group;
3. The Group fails to comply with the terms and conditions of the Agreement;
4. The 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. We elect to cease providing coverage to all small employers or large employers in Our Service Area;
7. We elect to discontinue a coverage; or
8. The Group elects to terminate the Agreement.

Notice of Termination or Non-Renewal of Group

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

Loss of Eligibility

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

- the death of the covered Subscriber;
- the termination (other than for gross misconduct) or reduction of hours of the Subscriber's employment;
- the divorce or legal separation of the Subscriber from the Subscriber's spouse;
- the Subscriber (excluding dependents who may continue coverage under the Agreement) becomes entitled to benefits under Medicare;
- a Dependent child ceases to be a dependent child under the generally applicable requirements of the Group;
- 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.

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 Plan will be deemed to allow continuation of coverage to the extent necessary to comply with COBRA requirements. Members should contact the Employer or Group Contract Holder for verification of eligibility and to obtain procedures for obtaining benefits.

Additional Continuation Provisions

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

- Continuation of group coverage must be requested not later than the 60th day following the latter of:
    - the date the group coverage will terminate; or
    - the date the Member is given notice of the right of continuation by either the Employer or the Contract Holder.
- 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.
- Continuation coverage will continue until the earliest of:
    - if Member is not eligible for continuation coverage under COBRA nine (9) months after the date the election for continuation is made;
    - if Member is eligible for continuation coverage under COBRA, six (6) additional months following any period of continuation under COBRA;
    - the date on which failure to make payments would terminate coverage;
    - the date on which the Member is covered for benefits by another health plan; or
    - the date on which the Agreement terminates as to all Members.
- 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 the 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 the 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 the 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 the Agreement within sixty (60) days of the Subscriber's death, retirement or divorce. Coverage under the 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 the Agreement. This continuation coverage will terminate upon the earlier of the following:
    - the day a Premium is due and unpaid; or
    - the day the Covered Dependent becomes eligible for similar coverage; or
    - three (3) years from the date of the Subscriber's death, retirement or divorce.

Eligibility and Enrollment

Types of Coverage

Employee

Employee and Spouse
You and Your spouse who is an Eligible Dependent as defined in this Evidence of Coverage.

Employee and Child(ren)
You and Your child who is an Eligible Dependent as defined in this Evidence of Coverage.

Employee and Family
You and Your family who are Eligible Dependents as described in this Evidence of Coverage.

Eligibility Provisions

Eligible Employee

Except for continuation coverage, to be eligible for coverage You must be:

- An Eligible Employee of the Contract Holder; and
- Work, live or reside in the Service Area.

Eligible Dependent

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

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 Plan.

Eligible Dependents may reside inside or outside the Service Area. For a child covered under a Qualified Medical Support Order who resides outside of the Service Area, We shall not enforce any otherwise applicable provisions which deny, limit, or reduce benefits because the child resides outside the Service Area, including, but not limited to Emergency Care only while outside the Service Area. However, We may utilize an alternative delivery system to provide alternative coverage. If the coverage is not identical to coverage under this Evidence of Coverage, it shall be at least actuarially equivalent to the coverage We provide to other dependent children under this Evidence of Coverage. Eligible Dependents, not subject to a Qualified Medical Support Order, may be limited to HMO Network restrictions.

Enrollment Periods and Effective Dates of Coverage

The Effective Date is the date the coverage for a Member begins. It may be different from the Eligibility Date.

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

- a completed Enrollment Application which must be received by Us during the enrollment period, and
- payment of the Premium when due.

If You fail to pay a Required Payment when due, You may be disenrolled from the Plan, in accordance with the procedures set forth in the Agreement.

If the Group fails to pay a Required Payment when due, the Group (and its enrollees) may be disenrolled from the Plan, in accordance with the procedures set forth in the Agreement.

Initial Eligibility

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

- If You are eligible on the Contract Date and the application is received by Us prior to or within thirty-one (31) days following such date, the Effective Date for You and Your Eligible Dependents for whom an application was submitted is the Contract Date.
- If You and Your Eligible Dependents enrolled during an Open Enrollment Period, the Effective Date is the date mutually agreed to by Group and the Issuer. 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.
- If an Eligible Employee is subject to a Waiting Period, and if application is received within thirty-one (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.
- If You become eligible after the Contract Date and if Your application is received by Us within the first thirty-one (31) days following Your Eligibility Date, Your Effective Date is the first day of the month following the date You satisfy the requirements of the Agreement, unless another date is specified in the Agreement.

Late Enrollee

If Your application is not received within thirty-one (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 provision, 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.

Avoidance of Late Enrollee Designation

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

- 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
- You declined coverage under the Plan in writing, based on coverage under another health benefit plan or self-funded health benefit plan;
- You provide written proof that Your prior health benefit plan or self-funded plan:
    - Continuation coverage has been exhausted; or
    - 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
    - Was ended as a result of termination of the other plan's coverage; and
- You request to enroll no later than thirty-one (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 Issuer.

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

Dependent Special Enrollment

Newborn Child

To be an Eligible Dependent, a newborn must be a child of You or Your spouse. To make sure Your child has continued coverage, You must notify Your employer within thirty-one (31) days of birth, complete the employer's application to add the newborn child, and pay any required Premium within that thirty-one (31) day 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 Us after that 31-day period, Your newborn child will be considered a Late Enrollee and will not be eligible for coverage until the next Open Enrollment Period.

Adopted Child, Child Involved in a Suit for Adoption and a Child Placed for Adoption

To be an Eligible Dependent, an adopted child must be a child of You or Your spouse. A proposed adopted child is eligible for coverage on the same basis as a natural child during any waiting period prior to the finalization of the child's adoption. 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. To make sure Your adopted child has continued coverage, You must notify Us, either verbally or in writing, of the addition of Your child as a dependent within thirty-one (31) days. If You notify Us after that 31-day period, Your adopted child will not be eligible for coverage until the next Open Enrollment Period.

Court Ordered Dependent Child

If a court has ordered You to provide coverage for a child, written application and the required Premium must be received within thirty-one (31) days after We receive notice of the court order. The Effective Date will be the day application for coverage is received by Us and the required Premium is received. If You notify Us after the 31-day period, the dependent child will be considered a Late Enrollee.

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 thirty-one (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 thirty-one (31) days, Your spouse will be considered a Late Enrollee.

Employee or Dependent Loss of Coverage Under a Governmental Program

If You or Your dependent loses coverage under Title XIX of the Social Security Act (Medicaid) or under Chapter 62 of the Texas Health and Safety Code (CHIP) due to loss of eligibility, written enrollment and the required Premium must be received within sixty (60) days after the date on which coverage was lost. If application is not made within the initial sixty (60) days, You or Your dependent, as applicable will be considered a Late Enrollee.

Employee or Dependent Becomes Eligible for State Premium Assistance

If You or Your dependent becomes eligible for premium assistance, with respect to the Issuer, 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 sixty (60) days after the date on which You or Your dependent became eligible for premium assistance. If application is not made within the initial sixty (60) days, You or Your dependent, as applicable, will be considered a Late Enrollee.

Other Dependents

Written application must be received within thirty-one (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 thirty-one (31) days, then Your dependent will be considered a Late Enrollee.

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.

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

Employee Special Enrollment

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 thirty-one (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.

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 thirty-one (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 Issuer.

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.

Incontestability

All statements made by You on the Enrollment Application shall be considered representations and not warranties. The statements are 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:

- it is in a written Enrollment Application signed by You, and
- a signed copy of the Enrollment Application is or has been furnished to You.

The Agreement may only be contested because of fraud or intentional misrepresentation of material fact on the Enrollment Application. If the Issuer determines that You made an intentional material misrepresentation of health status on the application, the Issuer may increase the Group Premium to the appropriate level. The Issuer must provide the Group sixty (60) days prior written notice of any such Premium rate change.

Additional Requirements

During the term of the Agreement, changes in coverage are not allowed unless approved in writing by the Issuer or authorized according to the terms stated in the Agreement.

Any retroactive changes in eligibility or coverage by a Group for any of its Members must be approved by the Issuer, and the liability of Issuer to refund Premiums for any Member whose coverage is terminated or changed to a different category shall be no greater than two (2) months Premium paid by or on behalf of the Member. The Issuer may consider any amounts paid for covered benefits for any period for which the Member's Premium was refunded as a Required Payment.

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

It is Your responsibility to inform:

- 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;
- The Issuer immediately of all changes that affect administration of Your, and Your Covered Dependents, Plan benefits, including, but not limited to:
    - address changes.

The Group must inform the Issuer in writing of all enrollments, terminations, or changes as they occur on forms required by the Issuer and provide information necessary to allow the Issuer to comply with its legal obligation regarding the issuance of certificates of Creditable Coverage.

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

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

Required Payments

Allowed Amount

The Allowed Amount is the maximum amount We will pay for expenses Members incur under the Plan. We have established an Allowed Amount for Medically Necessary benefits to Members by Participating Providers. You will be responsible for expenses incurred that are limited or not a covered benefit under the Plan, Deductibles, and Copayment amounts. Participating Providers will not look to the Member for payment outside of the Member's Cost Share.

Deductibles

Except where stated otherwise, a Member must pay the Deductible shown in the Schedule of Benefits during each Plan Year before this Plan provides payments for benefits.

The individual Deductible applies to each Member. Once a Member within a family meets the individual Deductible, no further Deductible is required for the Member that has met the individual Deductible for that Plan Year. However, after Deductible payments for Members collectively total the family Deductible amount in the Schedule of Benefits in a Plan Year, no further Deductible will be required for any Member covered e for the remainder of that Plan Year.

Copayments

Some benefits Members receive under the Plan will require that a Copayment amount be paid at the time Members receive the benefits. Refer to the Schedule of Benefits for specific Plan information. The Schedule of Benefits will indicate the basis of which a Copayment amount is calculated. It may be per visit, per day, per service, or any combination thereof.

Maximum Out of Pocket

Most of the Member's payment obligations, including Deductibles and Copayment amounts are applied to the Maximum Out of Pocket.

The Member's Maximum Out of Pocket will not include:

- Cost-sharing for Non-Participating Providers, except for Emergency Care and Medically Necessary covered benefits when those benefits are not available from a Participating Provider;
- Benefits limited or excluded by the Plan;
- Expenses not covered because a benefit maximum has been reached;
- Any expenses paid by the primary plan when the Member's Plan is the secondary plan for purposes of coordination of benefits;
- Penalties applied for failure to Preauthorize.

Individual Maximum Out of Pocket

When the Maximum Out of Pocket for a Member in a Plan Year equals the "Individual" "Maximum Out of Pocket" shown on the Schedule of Benefits for that level, the Plan will provide coverage for 100% of the Allowed Amount for benefits for the remainder of the Plan Year.

Family Maximum Out of Pocket

When the Maximum Out of Pocket for all Members under the Subscriber's coverage in a Plan Year equals the "Family" "Maximum Out of Pocket" shown on the Schedule of Benefits for that level, the Plan will provide coverage for 100% of the Allowed Amount for benefits for the remainder of the Plan Year. No Member will be required to contribute more than the individual Maximum Out of Pocket to the family Maximum Out of Pocket.

Premiums

Premiums are due in the office of the Issuer, 1206 West Campus Drive, Temple, Texas 76502 on or before the date indicated in the monthly billing statement issued to Group by the Issuer. The Contract Holder is responsible for informing the Issuer of any events which render an individual enrollee ineligible for coverage under the 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 the Issuer 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 the Issuer receives notice from the Contract Holder of that covered individual's ineligibility for coverage during the first three (3) 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 the Issuer as of the date of delivery to the post office. Notice given during the first three (3) 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 the Issuer 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 Issuer received notice from the Contract Holder of that individual's ineligibility for coverage during the first three (3) 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.

Payment of Premiums for Employer plans are a personal expense to be paid for directly by the Employer on behalf of the employee and the employee's dependents. In compliance with federal guidance, the Issuer will accept third-party payment for Premium from the following entities:

- The Ryan White HIV/AIDS Program under title XXVI of the Public Health Services Act;
- Indian tribes, tribal organizations, or urban Indian organizations; and
- State and federal Government programs

Except as provided above, third-party entities shall not pay the Issuer directly for any or all a Member's Premium. Premium payments from any other party will not be credited to Your account which may result in termination or cancellation of coverage in accordance with the termination provisions of this Evidence of Coverage.

Contribution Requirements

A Group must contribute for any Subscriber who enrolls in the 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 the 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.

Premium Changes

Pursuant to Texas law, We may change rates only upon sixty (60) days prior written notice. Additionally, We will not change rates more or less frequently than annually unless otherwise allowed by federal law.

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 subrogation or coordination of benefits provisions of the Agreement, You or Your Covered Dependent must submit to the Issuer within thirty-one (31) days of receipt of such benefits or monies, the amount to which the Issuer is entitled. In the event You, Your Covered Dependents, or anyone on behalf of You or Your Covered Dependents should enter into an agreement for the payment of amounts due under the subrogation provisions, any amount due is a Required Payment.

Late Payment Fee

A late payment fee may be assessed on any Premium not received by the Issuer at its offices when due. Such late payment fee will be calculated by the Issuer 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 a Required Payment from the Group.

Grace Period and Cancellation of Coverage

If any Premium is not received by the Issuer within thirty (30) days of the due date, the Issuer may terminate coverage under the Agreement after the 30th day. During the 30-day grace period, coverage shall remain in force. However, if payment is not received, the Issuer 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.

Medical Benefits

Refer to the Schedule of Benefits for Copayment amounts and any benefit limitations that may apply for certain services.

Medical Services

Members are entitled to the Medically Necessary professional services of Participating Providers on an inpatient and outpatient basis. Medical Necessity is determined by a Participating Provider, subject to the review of Our Medical Director. Treatment of congenital defects of newborns will be treated on the same basis as any other covered illness or injury.

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

- Allergy tests;
- Allergy serum;
- Chemotherapy and radiation therapy for cancer;
- Specialist consultations;
- Diagnostic procedures including lab and X-ray;
- Dialysis;
- Home Health Care;
- Injections;
- Newborn hearing screening and necessary diagnostic follow-up care;
- Office visits;
- Outpatient surgery;
- Physical exams for medical or diagnostic purposes;
- Treatment for diseases of the eye.

Office or Clinic Administered Prescription Drugs

Prescription Drugs which do not meet the definition of Specialty Prescription Drugs and which are dispensed and administered to a Member in the office of a Participating Provider or in another outpatient setting, will be covered as a part of the Member's Medical Benefit, and no additional Copayments are required for outpatient Prescription Drugs so dispensed and administered. These Prescription Drugs may require Preauthorization by Our Medical Director in order to be covered as part of the Member's Medical Benefit.

Specialty Prescription Drugs obtained under the Medical Benefit and administered in the office of a Participating Provider or other outpatient setting may be subject to separate Copayments and may not be included in the office visit Copayment.

Telehealth Service and Virtual Visits

Network Benefits are available only when services are delivered through a Participating Virtual Network Provider. Members can find a Participating Virtual Network Provider by calling the telephone number on their ID Card or locating the Customer Service telephone number on swhp.org.

Not all medical conditions can be treated through Virtual Visits. The Participating Virtual Network Provider will identify any condition for which treatment by an in-person Physician contact is needed. Benefits do not include email, or fax and standard telephone calls, or for Telehealth Service or Telemedicine Medical Service visits that occur within medical facilities (CMS defined originating facilities).

Other Telehealth Service and Telemedicine Medical Service

Benefits include Telehealth Services and Telemedicine Medical Services. An in-person consultation is not required between the health care provider and the Member for benefits to be provided. Covered benefits provided by telemedicine and telehealth are subject to the same terms and conditions under the Evidence of Coverage as any benefit provided in-person. You may find additional information regarding Telehealth Services or Telemedicine Medical Services at swhp.org.

Emergency Care

In the case of an emergency, Members may go to a Participating Provider or a Non-Participating Provider. The Plan will provide benefits for the Emergency Care received from a Non-Participating Provider to the same extent as would have been provided if care and Treatment were provided by a Participating Provider. However, follow-up care or Treatment by a Non-Participating Provider will be treated as Network coverage only to the extent it is Medically Necessary and appropriate care or Treatment rendered before the Member can return to Participating Provider in the Service Area. If a Member receives care and Treatment for an emergency from a Non-Participating Provider, the Member should notify Us as soon as reasonably possible to receive assistance transitioning care to a Participating Provider.

Medically Necessary Emergency Care received from a Non-Participating Provider, including diagnostic imaging and laboratory providers, will be reimbursed according to the terms of this Evidence of Coverage at the Usual and Customary or agreed upon rate, except for Copayments, and charges for non-covered benefits. The Member will be held harmless for any amounts beyond the Copayment or other Out of Pocket Expenses that the Member would have paid had the Network included Participating Providers from whom the Member could obtain care.

Medically Necessary Emergency Care is provided by this Evidence of Coverage and includes the following benefits:

- An initial 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;
- Treatment and Stabilization of an emergency medical condition; and
- Post-Stabilization care originating in a Hospital emergency room, Freestanding Emergency Medical Care Facility, or comparable emergency Facility, if approved by the Us, provided that We must approve or deny coverage within the time appropriate to the circumstances relating to the delivery of care and the condition of the patient not to exceed one (1) hour of a request for approval by the treating Physician or the Hospital emergency room.

Examples of medical emergencies for which Emergency Care would be covered include but are not limited to:

- Heart attacks;
- Cardiovascular accidents;
- Poisoning;
- Loss of consciousness or breathing;
- Convulsions;
- Severe bleeding; and
- Broken bones.

Once a Member's condition is stabilized and as medically appropriate, We, upon authorization of Our Medical Director, may facilitate transportation to a Participating Facility. Where Stabilization of an emergency medical condition originates in a Hospital emergency Facility or comparable Facility, further Treatment following such Stabilization will require approval by Us.

Urgent Care

Urgent Care provides for the immediate Treatment of a medical condition that requires prompt medical attention but where a brief time lapse before receiving care will not endanger life or permanent health. Unless designated and recognized by Us as an Urgent Care Facility, neither a Hospital nor an emergency room will be considered an Urgent Care Facility.

Ambulance Transportation

Ground, Sea, or Air Ambulance transportation, when and to the extent it is Medically Necessary, is covered when transportation in any other vehicle would endanger the Member's health. We will not cover air transportation if ground transportation is medically appropriate and more economical. If these conditions are met, We will cover Ambulance transportation to the closest appropriate Hospital or Skilled Nursing Facility.

Emergency medical care 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. Subject to the paragraph above, if the Ambulance transports the Member after receiving medical care from Ambulance personnel, the Emergency Medical Services Copayment is waived.

Ground, Sea, or Air non-emergency interfacility Ambulance transport as Medically Necessary is covered when Medically Necessary and is Preauthorized by Our Medical Director. For example, the Member is discharged from an inpatient Facility and needs to be moved to a Skilled Nursing Facility.

Preventive Care

The following Preventive Care benefits from a Participating Provider that are required by Section 2713 of the Patient Protection and Affordable Care Act (PPACA) will not be subject to Copayment, Cost share, or Deductible:

(a) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF);
(b) Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention (CDC) with respect to the individual involved;
(c) Evidence-informed Preventive Care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents; and
(d) With respect to women, such additional Preventive Care and screening as provided for in comprehensive guidelines supported by HRSA.

For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening and Mammography and prevention will be considered the most current. The Preventive Care described above may change as USPSTF, CDC, and HRSA guidelines are modified.

Examples of benefits include routine annual physicals, immunizations, well-child care, cancer screening mammograms, bone density test, screening for prostate cancer and colorectal cancer, smoking cessation counseling services, and healthy diets counseling and obesity screening/counseling.

Examples of covered immunizations include diphtheria, haemophilus influenza type b, hepatitis B, measles, mumps, pertussis, rubella, tetanus, varicella, rotavirus, and any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision.

Benefits not included in items (a) through (d) above will be subject to Copayment and Deductibles.

The determination of whether a benefit is Preventive Care may be influenced by the type of care for which your Participating Provider bills Us. Specifically:

- If a recommended preventive service is billed separately from an office visit, then the Plan may impose Cost-Sharing requirements with respect to the office visit.
- 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 the preventive service, then the Plan may not impose Cost-Sharing requirements with respect to the office visit.
- 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 the Plan may impose Cost-Sharing requirements with respect to the office visit.

Coverage of counseling for a condition or disease as Preventive Care does not equate to Treatment of that condition or disease. While the counseling visit may be Preventive Care and thus not subject to a Deductible or Copayment, the Treatment of such condition or disease will be subject to appropriate Deductible and Copayment, and to the **Exclusions and Limitations** section in this Evidence of Coverage.

Routine Exams and Immunizations

Benefits for routine exams are available as Preventive Care as indicated on the Schedule of Benefits for the following:

- Well-baby care (after newborn's initial examination and discharge from the Hospital);
- Well-child care;
- Routine annual physical exam;
- Immunizations.

Benefits are not available for inpatient Hospital coverage or Medical-Surgical Coverage for routine physical examinations performed on an inpatient basis, except for the initial examination of a newborn child.

Injections for allergies are not considered immunizations under this benefit provision.

Cardiovascular Disease Screening

Benefits are available for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five (5) years when performed by a laboratory that is certified by a recognized national organization:

- Preauthorized as Medically Necessary Computed tomography (CT) scanning measuring coronary artery calcifications; or
- Ultrasonography measuring carotid intima-media thickness and plaque.

Tests are available to each Member who is:

- A male older than 45 years of age and younger than 76 years of age, or
- A female older than 55 years of age and younger than 76 years of age.

The Member must have diabetes or have a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher.

Prostate Cancer Screening Exam

Benefits are available for:

- An annual medically recognized diagnostic physical examination for the detection of prostate cancer, and
- A prostate-specific antigen test used for the detection of prostate cancer for each male Member under the Plan who is at least:
    - 50 years of age and asymptomatic; or
    - 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

Colorectal Cancer Screening Exam

For Members 50 years of age or older, benefits include medically recognized screening examinations for the detection of colorectal cancer, including a fecal occult blood test performed annually, a flexible sigmoidoscopy performed every five (5) years, a colonoscopy performed every five (5) years when evidence-based risk factors are present, and a colonoscopy performed every ten (10) years without established risk factors. Medically Necessary colonoscopy consultations are covered as Preventive Care.

Bone Mass Measurement for Osteoporosis

If a Member is a Qualified Individual, benefits are available for medically accepted bone mass measurement for the detection of low bone mass and to determine a Member's risk of osteoporosis and fractures associated with osteoporosis, as show on the Schedule of Benefits.

Qualified Individual means:

- A postmenopausal woman not receiving estrogen replacement therapy;
- An individual with:
    - Vertebral abnormalities,
    - Primary hyperparathyroidism, or
    - A history of bone fractures.
- 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.

Cancer Screening Mammography

Benefits are available for:

- Annual screening Mammography provided for female Members 35 years of age and older; and
- Diagnostic Mammography for an imaging examination designed to evaluate a subjective or objective abnormality detected by a Physician on a screening mammogram.

Screenings are provided by Low-Dose Mammography, Digital Mammography and Breast Tomosynthesis, to detect breast cancer. Refer to the **Definitions** section of this Evidence of Coverage for further explanation to Mammography procedures.

Ovarian and Cervical Cancer Screening Exam

Female Members over age 18, are eligible for a medically recognized annual diagnostic examination including:

- a Cancer Antigen 125 (CA 125) blood test, and
- a conventional Pap smear screening or a screening using liquid-based cytology methods alone or in combination with a test for the detection of the human papillomavirus, for the early detection of ovarian cancer and cervical cancer.

The well-woman examination may be performed by the Member's Primary Care Physician or designated obstetrician or gynecologist.

Hospital Services

Members are entitled to Medically Necessary benefits of any Participating Hospital to which Members may be admitted by a Participating Provider. If a Member is admitted to a Non-Participating Hospital by a Participating Provider to whom the Member was referred in accordance with Our procedures, the services of the Non-Participating Hospital will be covered on the same bases as admission to a Participating Hospital, provided admission to the Non-Participating Hospital was approved in accordance with this Evidence of Coverage.

For a service provided in a Hospital to be a covered benefit, the Hospital should be the medically appropriate setting for that service.

If a Member is hospitalized at a Non-Participating Hospital, the Member must notify Us within forty-eight (48) hours of admission or as soon as is reasonably possible, and We shall review the admission and the stay for Medical Necessity under this Evidence of Coverage. Failure to provide notification may result in denial of payment unless it is shown not to have been reasonably possible to give such notice.

Examples of Hospital benefits may include, but are not limited to the following:

- Semi-private room, or the equivalent, for routine acute care;
- Inpatient meals and special diets, when Medically Necessary;
- Inpatient medications and biologicals;
- Intensive care units;
- Nursing care, including private duty nursing, when Medically Necessary;
- Short term rehabilitation therapy services in the acute Hospital setting;
- Inpatient lab, X-ray and other diagnostic tests;
- Inpatient medical supplies and dressings;
- Anesthesia;
- Oxygen;
- Operating room and recovery room;
- Inpatient physical therapy;
- Inpatient radiation therapy;
- Inpatient inhalation therapy;
- Cost of and administration of whole blood, blood plasma, and blood plasma expanders.

Prescription Drugs administered while admitted to a Participating Hospital will be covered as part of the Member's inpatient benefit, and no additional Deductible or Copayments are required for the administered Prescription Drugs.

Skilled Nursing Facility

The Plan covers authorized inpatient care in a Skilled Nursing Facility if it meets all these conditions:

- Care is delivered under the supervision of a Participating Provider and are delivered by and require the judgment of a qualified and appropriately licensed provider, such as a registered nurse, physical therapist, occupational therapist, respiratory therapist, or speech-language pathologist.
- Services are reasonable to treat a specific health condition, illness, or injury.
- Services are expected to result in a significant and measurable improvement in the Member's medical condition or functional capabilities.
- The skilled care needed cannot be provided in a less-intense setting, such as through intermittent home health skilled nursing visits and custodial support.
- Services are supported by evidence-based medical guidelines or literature as being specific, effective and reasonable Treatment for the Member's diagnosis and physical condition.

Mental Health Care

Inpatient and outpatient benefits for mental health conditions are covered under the same terms and conditions applicable to the Plan's medical and surgical benefits and coverage. The Plan will not impose any quantitative or nonquantitative Treatment limits on such benefits that are more restrictive than those imposed on benefits for medical or surgical expenses.

Short-Term Mental Health

Medically Necessary short-term diagnostic and therapeutic treatment for mental illnesses and emotional disorders are covered when all these conditions are met:

- The mental illness or disorder being treated is listed in the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM), at the time benefits are provided;
- The initial evaluation, diagnosis, medical management and ongoing medication management of attention deficit disorder (ADD) and attention deficit hyperactivity disorder (ADHD) are also covered. Visits for medication management are not included in the maximum allowed visits.

Serious Mental Health

Medically Necessary diagnostic and therapeutic treatment for Serious Mental Illness is covered if the mental illness or emotional disorder being treated is one of the following psychiatric illnesses as defined by the most current DSM:

- Schizophrenia;
- Paranoid and other psychotic disorders;
- Bipolar disorders (hypomanic, manic, depressive, and mixed);
- Major depressive disorders (single episode or recurrent);
- Schizoaffective disorders (bipolar or depressive);
- Obsessive-compulsive disorders; and
- Depression in childhood and adolescence.

Chemical Dependency

Benefits are provided to Members for the Medically Necessary Treatment for Chemical Dependency which includes abuse of, psychological or physical dependence on, or addiction to alcohol or a controlled substance and detoxification 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.

Rehabilitative and Habilitative Therapy

Medically Necessary outpatient rehabilitative and habilitative therapy benefits are available for Medically Necessary physical, speech, hearing, Manipulative, and occupational therapies that meet the following conditions:

- The Member's Participating Provider orders such therapy services; and
- The services can be expected to meet or exceed the Treatment goals established for the Member by the Member's Participating Provider; and
- The services are given by a doctor, a licensed therapist, or chiropractor; and
- The Member is progressing toward the Treatment goals in response to participating in the therapy.

For a Member with a physical disability, Treatment goals may include maintenance of functioning or prevention of or slowing of other deterioration.

Therapies for Children with Developmental Delays

The Plan includes benefits for the Treatment of "Developmental Delays", which means a significant variation in normal development as measured by appropriate diagnostic instruments and procedures in one or more of the following areas:

- Cognitive;
- Physical;
- Communication;
- Social or Emotional; or

- Adaptive.

Treatment includes the necessary rehabilitative and habilitative therapies in accordance with an "Individualized Family Service Plan", which is the initial and ongoing Treatment plan developed and issued by the Interagency Council on Early Childhood Intervention under Chapter 73 of the Human Resources Code for a Dependent child with Developmental Delays, including:

- Occupational therapy evaluations and services;
- Physical therapy evaluations and services;
- Speech therapy evaluations and services; and
- Dietary or nutritional evaluations.

You must submit an Individualized Family Service Plan to Us before the Member receives any benefits, and again if the Individualized Family Service Plan is changed. After a child is three (3) years of age and services under the Individualized Family Service Plan are completed, the standard contractual provisions in this Evidence of Coverage and any benefit exclusions or limitations will apply.

Manipulative Therapy and Chiropractic Care

Benefits are available to Members for outpatient Manipulative Therapy from Participating Providers licensed to perform that therapy, including chiropractors. The benefits are generally furnished for the diagnosis and/or Treatment of neuromusculoskeletal conditions associated with an injury or illness, including examinations and manipulations.

Home Health Care

The Plan covers Medically Necessary Preauthorized Home Health Care consisting of:

- Skilled nursing by a registered nurse or licensed vocational nurse under the supervision of at least one registered nurse and at least one Physician;
- Physical, occupational, speech and respiratory therapy;
- The services of a home health aide under the supervision of a registered nurse; and
- The furnishing of medical equipment and supplies other than Prescription Drugs and medicines.

Home Health Care provides benefits for payment or other consideration in a patient's residence under a plan of care that is:

- Established, approved in writing, and reviewed at least every two (2) months by the attending Physician; and
- Certified by the attending Physician as necessary for medical purposes.

Home Health Care is provided unless the attending Physician certifies that hospitalization or confinement in a Skilled Nursing Facility would be required if a Treatment plan for Home Health Care were not provided.

Skilled care benefits are provided within Home Health Care from:

- A licensed Home Health Agency; or
- Private duty nursing, when Preauthorized in the following limited set of circumstances:
    - Skilled care that exceeds the capacity of periodic home care from a licensed Home Health Agency;
    - The Member's care can be safely managed in the home setting;
    - The Member's Participating Provider is willing and able to follow the Member during private duty nursing service; and
    - The care is not being used for the purpose of providing Custodial Care or for the reason of the Member or the Member's family convenience.

Home Infusion Therapy

As recommended by a Participating Provider and approved by Our Medical Director as Medically Necessary, Home Infusion Therapy is available for high technology services, including:

- Line care;
- Chemotherapy;
- Pain management infusion;
- Antibiotic, antiviral or antifungal therapy; and
- Specialty Prescription Drugs.

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 enteral formula, and covered Durable Medical Equipment, not related to the Home Infusion Therapy some of which may be covered under other provisions of this Evidence of Coverage, and subject to additional Copayments.

In some situations, the Plan may require infusions to be delivered in the home, in lieu of a Participating Provider's office or outpatient setting. These situations include when the home setting is both clinically appropriate and cost-effective.

Hospice Care

Hospice Care benefits are included under the Plan when provided by a Hospice to a Member confined at home or in a Participating Facility due to a terminal sickness or terminal injury requiring skilled care if Preauthorized and the following conditions are met:

- The benefits are provided to Member by a Participating Provider licensed by the State of Texas; and,
- The Participating Provider certified the Member has a limited life expectancy of six (6) months or less due to a terminal illness.

Hospice Care includes the provision of pain relief, symptom management and supportive benefits to terminally ill Members and their immediate families on both an outpatient and inpatient basis.

Maternity Care

The Plan provides maternity care benefits including:

- Participating Provider prenatal and postnatal obstetrical care;
- Labor and delivery services;
- Hospital room and board for the mother;
- The care of complicated pregnancies in conjunction with the delivery of a child or children by a Member. Complications of Pregnancy are treated as any other illness or sickness. Routine deliveries are to be under the care of a Participating Provider at a Participating Hospital; and
- In-home care for high-risk pregnancy.

Prenatal obstetrical care is considered well woman care and is not subject to a Copayment under Preventive Care.

Copayments are required for each day of inpatient care for the mother, and for each day of inpatient care for the newborn for the amount and days as stated in the Schedule of Benefits. The Plan covers inpatient care for the mother and newborn child in a health care Facility for a minimum of:

- forty-eight (48) hours following an uncomplicated vaginal delivery; and
- ninety-six (96) hours following an uncomplicated delivery by caesarean section.

If the Member's newborn qualifies as an Eligible Dependent and requires confinement in a Neonatal Intensive Care Unit (NICU), then any applicable Deductible and Copayment will be applied separately to the Member's newborn,

for any covered benefits associated with that confinement. This is in addition to any applicable Mother Deductible and Copayment.

Comprehensive Hospital benefits for routine nursery care of a newborn child, including newborn screening tests, including the cost and administration of the test kit, are available so long as the child qualifies as an Eligible Dependent as defined in the **Eligibility and Enrollment** section of this Evidence of Coverage.

The determination whether a delivery is complicated shall be made by the Participating Provider. If the decision is made to discharge a mother or newborn child from inpatient care before the expiration of the above time frames, The Plan shall provide coverage for timely Post-Delivery Care, to be provided by a Participating Provider, registered nurse or other appropriate Participating Health Professional and may be provided at the mother's home, Participating Provider's office, Participating Facility or other appropriate location. Post-Delivery Care means postpartum benefits provided in accordance with accepted maternal and neonatal physical assessments. The term includes:

- Parent education;
- Assistance and training in breast-feeding and bottle feeding; and
- The performance of any necessary and appropriate clinical tests.

In the event a Member 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 covered under the Plan.

Family Planning

Family Planning benefits shall be provided as Medically Necessary. Examples include:

- counseling;
- sex education instruction in accordance with medically acceptable standards;
- diagnostic procedures to determine the cause of Infertility of the Member. Treatment of Infertility is not a covered benefit under this provision;
- vasectomies and tubal ligations;
- laparoscopies.

Benefits are provided for FDA approved contraceptive methods and procedures for all women with reproductive capacity, including injectable drugs and implants, intra-uterine devices, diaphragms, and the professional services associated with them.

Durable Medical Equipment and Devices

Medically Necessary Durable Medical Equipment, Orthotic Devices, or Prosthetic Devices shall be covered under this Evidence of Coverage. The Medical Director in consultation with the treating Physician 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.

Consumable Supplies

Consumable supplies are non-durable medical supplies that:

- are usually disposable in nature;
- cannot withstand repeated use by more than one Member;
- are primarily and customarily used to serve a medical purpose;
- generally, are not useful to a Member in the absence of illness or injury; and

- may be ordered and/or prescribed by a Physician.

Consumable supplies are a covered benefit only if the supply is required in order to use with covered Durable Medical Equipment, Orthotic Device, or Prosthetic Device. Repair, maintenance, and cleaning due to abnormal wear and tear or abuse are the Member's responsibility.

Durable Medical Equipment

Durable Medical Equipment may be covered as a purchased or rented item at the discretion of the Plan. Rented or loaned equipment must be returned in satisfactory condition and the Member is 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 the Issuer from a Participating Provider. We shall have no liability for installation, maintenance or operation of such equipment for home-based use.

Orthotic Devices

The Plan provides benefits for the following Medically Necessary devices consisting of the initial device, professional services for fitting and use, and replacement of the device, if replacement is not due to misuse or loss of the device and normal repairs:

- orthopedic or corrective shoes;
- shoe inserts;
- arch supports; and
- orthotic inserts and other supportive devices including ankle braces required for recovery after surgery.

Orthotic Device coverage is limited to the most appropriate model of Orthotic Device that adequately meets the Member's needs as determined by the Member's Participating Provider, the Plan shall provide coverage for Orthotic Devices subject to the applicable Copayments specified in the Schedule of Benefits.

Prosthetic Devices

Prosthetic Devices may require Preauthorization to be covered under conditions determined by Our Medical Director as Medically Necessary to replace defective parts of the body following injury or illness. Members should contact Us to confirm whether the device requires Preauthorization. Examples of Medically Necessary covered devices including the initial device, professional services for fitting and use, and replacement of the device if replacement is not due to misuse or loss of the device, and normal repairs are:

- artificial arms, legs, hands, feet, eyes;
- breast prostheses, and surgical brassieres after mastectomy for breast cancer.

Prosthetic Device coverage is limited to the most appropriate model of Prosthetic Device that adequately meets the Member's needs as determined by the Member's Participating Provider. For Prosthetics, the Plan shall provide coverage subject to the applicable Copayments, specified in the Schedule of Benefits.

Hearing Aids and Cochlear Implants

The Plan provides the following benefits for hearing aids or cochlear implants:

- Fitting and dispensing services and the provision of ear molds as necessary to maintain optimal fit of hearing aids;
- Any Treatment related to hearing aids and cochlear implants, including coverage for habilitation and rehabilitation as necessary for educational gain; and
- For a cochlear implant, an external speech processor and controller with necessary component replacements every three (3) years.

Limitations:

- One (1) hearing aid in each ear every three (3) years for Members through the age of 18; and
- Hearing aid prescription must be written by:
    - A Physician certified as an otolaryngologist or otologist; or
    - An audiologist who:
        - is legally qualified in audiology; or
        - holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements; and who performs the exam at the written direction of a legally qualified otolaryngologist or otologist.
- When alternate hearing aids can be used, the Plan's coverage may be limited to the cost of the least expensive device that is:
    - Customarily used nationwide for Treatment, and
    - Deemed by the medical profession to be appropriate for Treatment of the condition in question. The device must meet broadly accepted standards of medical practice, considering your physical condition. Members should review the differences in the cost of alternate Treatment with their Physician. A Member and their Physician may still choose the more costly Treatment method however the Member is responsible for any charges in excess of what The Plan will cover.
- One cochlear implant in each ear with internal replacement as medically or audio logically necessary.

Coverage required under this section is subject to any provision that applies generally to coverage provided for Durable Medical Equipment benefits under the Plan, including a provision relating to Deductibles, Copayments or Preauthorization. Preauthorization may be required.

Imaging and Radiology

Imaging and radiological exams shall be covered as Medically Necessary and as prescribed and authorized by a Participating Provider. Preauthorization may be required. Examples of such services include:

- Angiography (but not including cardiac angiograms);
- CT scans;
- MRIs;
- Myelography;
- PET scans; and
- Stress tests with radioisotope imaging.

An ultrasound or cardiac angiogram shall not be subject to an imaging and radiological exam Copayment, but if performed in conjunction with an office visit or outpatient surgery, the Member will be responsible for the appropriate office visit or outpatient surgery Copayment as listed in the Schedule of Benefits.

Cosmetic, Reconstructive, or Plastic Surgery

Benefits available for Cosmetic, Reconstructive, or Plastic Surgery require Preauthorization and must meet one of the following criteria or is otherwise deemed Medically Necessary:

- Treatment provided for the correction of defects incurred in an Accidental Injury sustained by a Member;
- Treatment provided for reconstructive surgery following cancer surgery;
- Surgery performed for the Treatment or correction of a congenital defect;
- Surgery for craniofacial abnormalities to improve the function of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infection, or disease;
- Breast reconstruction following mastectomy as described below.

If a Member has had or will have a mastectomy to treat disease, trauma, or physical complications, coverage for breast reconstruction incident to mastectomy shall be provided under the same terms and conditions of this

Evidence of Coverage as for the mastectomy, as deemed medically appropriate by the Participating Provider 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 Evidence of Coverage 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 breast are similar, as opposed to identical, in size and shape.

Temporomandibular Joint Pain Dysfunction Syndrome (TMJ)

Coverage for Medically Necessary diagnostic or surgical Treatment of conditions affecting the temporomandibular joint, including the jaw and craniomandibular joint is available to Members, 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 Evidence of Coverage.

Limited Accidental Dental

The Plan provides limited coverage for dental benefits that would be excluded from coverage but are determined by Our Medical Director to be Medically Necessary and incident to and an integral part of a covered medical procedure. Examples could include the following:

- Treatment of, including removal of broken teeth as necessary to reduce a fractured jaw;
- Reconstruction of a dental ridge resulting from removal of a malignant tumor;
- Extraction of teeth prior to radiation therapy of the head and neck;
- Dentures as a result of radiation therapy of the head and neck or replacement dentures due to changes in the mouth as a result of radiation therapy of the head and neck;
- Removal of cysts of the mouth (except for cysts directly related to the teeth and their supporting structures).

The Plan provides limited coverage for initial restoration and correction of damage caused by external violent Accidental Injury to natural teeth and/or jaw if:

- The fracture, dislocation or damage results from an Accidental Injury;
- The Member seeks treatment within forty-eight (48) hours of the time of the accident or upon the Effective Date of coverage, whichever comes later;
- Restoration or replacement is completed within six (6) months of the date of the injury or upon the Effective Date of coverage, whichever comes later.

The Plan provides benefits for certain oral surgeries including maxillofacial surgical procedures that are limited to:

- Excision of neoplasm, including benign, malignant and pre-malignant lesions, tumors and non-odontogenic cysts;
- Incision and drainage of cellulitis and abscesses; and
- Surgical procedures involving accessory sinuses, salivary glands, and ducts.

The Plan provides benefits for Medically Necessary dental procedures when required to be performed in a Participating Facility for the delivery of necessary and appropriate dental care when the dental care cannot be safely provided in a dentist's office due to the Member's physical, mental, or medical condition.

Amino Acid-Based Elemental Formulas

The Plan includes benefits for Medically Necessary Amino Acid-Based Elemental Formulas as ordered by a Participating Provider.

Regardless of the formula delivery method, Amino Acid-Based Elemental Formulas provided under the written order of a Participating Provider is covered for the Treatment or diagnosis of:

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

Phenylketonuria or Heritable Metabolic Disease

Coverage for specialty dietary formulas necessary to treat Phenylketonuria or a Heritable Metabolic Disease are available to Members as prescribed by a Participating Provider. The formulas are provided to the extent this Plan provides coverage for other drugs that are available upon Physician orders. Heritable Metabolic 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.

Diabetes Care

If a Member 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 Participating Provider, Members are eligible for coverage for:

- Diabetes Self-Management Training;
- Diabetes Education;
- Diabetes Care Management;
- Diabetes Equipment; and
- Diabetes Supplies.

Coverage shall be provided on the same basis as other comparable chronic medical conditions. Benefits shall also be provided for new or improved Diabetes Supplies or Diabetes Equipment, upon approval of the United States Food and Drug Administration, as Medically Necessary and prescribed by a Participating Provider.

The Plan will not cover a renewal of Diabetes Supplies until a Member's existing supply will be depleted in less than three (3) weeks.

Organ and Tissue Transplants

Subject to the conditions described below, benefits are provided to a Member by a Participating Provider related to an organ or tissue transplant will be determined as follows, but only if all the following conditions are met:

- The transplant procedure is not Experimental or Investigational in nature;
- Donated human organs or tissue or an FDA-approved artificial device are used;
- The recipient is a Member under the Plan;
- The transplant procedure is Preauthorized as required under the Plan;
- The Member meets all the criteria used by Us to determine Medical Necessity for the transplant;
- The Member meets all the protocols and has been approved for transplant by the Participating Facility in which the transplant is performed;
- Benefits related to an organ or tissue transplant or FDA approved artificial device include, but are not limited to, imaging studies (e.g. X-rays, CT scan, MRI, scan), laboratory testing, Chemotherapy, radiation

therapy, Prescription Drugs, procurement of organs or tissues from a living or deceased donor, and complications arising from such transplant;
- Services are coordinated through Our health services department; and
- The Member uses a Preauthorized transplant network which may be different than the Member's Plan Network.

Covered transplants, using human tissue 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;
- corneal 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.

Coverage of each type of solid Organ Transplant is limited to:
- one (1) initial transplant; and
- one (1) subsequent re-transplant due to rejection.

Member transplant medical costs for the removal of organs, tissues, or bone marrow from a live donor are covered, but only to the extent that such costs are not covered by the donor's group or individual health plan, benefit contract, prepayment plan, or other arrangement for coverage of medical costs, whether on an insured or uninsured basis.

If the donor is also a Member, coverage is subject to all procedures, limitations, exclusions, Copayments and Deductibles that apply under the donor-Member's plan only if all the above conditions are met.

Acquired Brain Injury

Coverage includes:
- Cognitive Rehabilitation Therapy;
- Cognitive Communication Therapy;
- Neurocognitive Therapy and Rehabilitation;
- Neurobehavioral, Neuropsychological, Neurophysiological and Psychophysiological Testing and Treatment;
- Neurofeedback Therapy;
- Remediation;
- Post-Acute Transition and Community Reintegration Services, including Outpatient Day Treatment; and
- Post-Acute Care Treatment.

Treatment for an Acquired Brain Injury may be provided at a Hospital, an acute or post-acute rehabilitation Hospital, an assisted living Facility or any other Facility at which appropriate benefits may be provided.

Service means the work of testing, Treatment, and providing therapies to a Member with an Acquired Brain Injury.

Therapy means the scheduled remedial Treatment provided through direct interaction with the Member to improve a pathological condition resulting from an Acquired Brain Injury.

To ensure that appropriate Post-Acute-Care Treatment Service is provided, the Plan includes benefits for reasonable expenses related to periodic reevaluation of the care of a Member who:

- Has incurred an Acquired Brain Injury;
- Has been unresponsive to treatment; and
- Becomes responsive to treatment later.

Treatment goals for the Member may include the maintenance of functioning or the prevention of or slowing of further deterioration.

Benefits for the Medically Necessary Treatment of an Acquired Brain Injury will be determined on the same basis as Treatment for any other physical condition.

Autism Spectrum Disorder

Benefits are provided for generally recognized services in relation to Autism Spectrum Disorder by a Participating Provider in a Treatment plan recommended by that provider. An individual providing Treatment for Autism Spectrum Disorder must be:

- A Participating Health Professional:
    - who is licensed, certified or registered by an appropriate agency in the state of Texas;
    - whose professional credential is recognized and accepted by an appropriate agency of the United States; or
    - who is certified as a provider under the TRICARE military health system;
- An individual acting under the supervision of a Participating Health Professional described under this provision.

Generally recognized services include, but are not limited to:

- screening a child at the ages of 18 and 24 months;
- treatment to a Member from the date of diagnosis;
- evaluation and assessment services;
- applied behavior analysis;
- behavior training and management;
- speech, physical, and occupational therapy; and
- medications used to address symptoms of the Autism Spectrum Disorder.

Benefits for the Treatment of an Autism Spectrum Disorder will be determined on the same basis as Treatment for any other physical condition. Benefit limits do not apply for Autism Spectrum Disorder.

Clinical Trials – Routine Patient Care

Benefits are available to Members for Routine Patient Care Costs in connection with the Member participating 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 paragraphs:

- Federally funded trials for 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 States 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;
    - Cooperation group or centers of any of the entities described in clauses (i)-(iv) of the Department of Defense or the Department of Veteran Affairs;
    - A qualified non-government research entity identified in the guidelines issued by the National Institutes of Health for center support grants;

    - An institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services;
    - Any of the following, if the study or investigation conducted by such Department has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review of studies and investigations used by the National Institute of Health, and assured unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;
        - the United States Department of Defense;
        - the United States Department of Veterans Affairs;
        - the United States Department of Energy.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

We are not required to reimburse the Research Institute conducting the clinical trial for the Routine Patient Care Cost provided through the Research Institute unless the Research Institute and each provider providing routine patient care through the Research Institute, 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 Institute conducting the clinical trial.

We may not cancel or refuse to renew coverage solely because a Member participates in a clinical trial.

Pharmacy Benefits

Covered Prescription Drugs, Pharmaceuticals and Other Medications

The only Covered Prescription Drugs, pharmaceuticals or other medications (referred to as "drug" or "drugs") covered under this Evidence of Coverage are those which, under Federal or State law, may be dispensed following a Prescription Order from a licensed Participating Health Professional with appropriate law enforcement agency registrations, which are prescribed by:

- A Participating Provider;
- In connection with Emergency Care Treatment, a Participating Provider or Participating Health Professional in attendance to a Member at an Emergency Care Facility;
- A Participating Health Professional to whom a Member has been referred to by a Participating Provider, which is used for the Treatment of an illness or injury covered under this Evidence of Coverage; or
- Filled through a Participating Pharmacy in accordance with this Evidence of Coverage.

As medically appropriate, the Medical Director may require the substitution of any Prescription Drug for another Prescription Drug or form of Treatment which, based upon the recommendations of the Pharmacy and Therapeutics Committee, and Our Medical Director's professional judgment, provides equal or better results at a lower cost.

Benefits for Medically Necessary Covered Prescription Drugs prescribed to treat a Member for an acute, chronic, disabling, or Life-Threatening Disease or Condition are available under this Evidence of Coverage if the Prescription Drug:

- has been approved by the Food and Drug Administration (FDA) for at least one indication; and
- is recognized for Treatment of the indication for which the drug is prescribed by the following:
    - a standard reference compendium, or
    - a substantially accepted peer reviewed medical literature.

If the indication for which the Prescription Drug is prescribed is not an FDA approved indication of the Prescription Drug being prescribed, We reserve the right to exempt the Prescription Drug from coverage for that off label use.

Coverage of Prescription Drugs does not include coverage for Experimental drugs not otherwise approved for any indication by the FDA, coverage for a drug that the FDA has not approved, or Prescription Drug reference compendia or peer reviewed medical literature has not deemed as a medically accepted use for the proposed indication.

Evidence Based Formulary

We provide 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 Prescription Drugs for which We provide 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 Prescription Drugs it believes to be the safest and most effective of those Prescription Drugs which meet the desired goals of providing appropriate therapy at the most reasonable cost. Once such determination is made, We may obtain or access contracts with the manufacturer of the Prescription Drugs for rebates. The committee will not select a Prescription 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 defines this timeframe as one hundred eighty (180) days of availability. The committee determines which Prescription Drugs to add or delete, supply and dosage limitations, sequence of use, and all other aspects about Our Formulary. We will provide written notice of the modification to the Prescription Drug Formulary to the commissioner and each affected Member, not later than the 60th day before the date the modification is effective.

Request for Formulary Information

A Member may contact Us to find out if a specific Prescription Drug is on the Formulary. We must respond to the Member's request about the Prescription Drug Formulary no later than the third business day after the date of the request to disclose whether a specific Prescription Drug is on the Formulary. However, the presence of a Prescription Drug on a Formulary does not guarantee that the Member's Participating Provider will prescribe the drug for a medical condition or mental illness or that the Prescription Drug will be covered.

Formulary Lists

Copayments vary based upon the tier level a Prescription Drug has been placed on by Us. Prescription Drugs on Our Formulary, which are generic Prescription Drugs, require the lowest Copayment. Prescription Drugs on Our Formulary, which are preferred Name Brand Prescription Drugs require an increased Copayment. If the negotiated or Usual and Customary cost of a drug is less than the Copayment, the Member is only required to pay the lower cost. If the Member requires the use of generic-equivalent drugs and the Member receives a Name Brand Prescription Drug when a generic equivalent is available, then the Member will pay no more than the generic Copayment plus the difference between the cost of the generic drug and the cost of the Name Brand Prescription Drug, even when the prescription is written "dispense as written." Prescription Drugs, which are non-preferred, may not be covered by Us or may require the largest Copayment, depending on the Plan selected.

Prescription Drugs designated on the Formulary as Specialty Prescription Drugs that are dispensed at a Participating Pharmacy and self-administered or administered in the office of a Participating Provider may be covered under this Evidence of Coverage, subject to the Specialty Pharmacy Copayments, Cost Share, and Deductibles indicated in the Schedule of Benefits.

Prescription Drugs on Our Formulary may require Preauthorization by Our Medical Director or be subject to coverage requirements.

If a Prescription Drug appeared on Our Formulary at the beginning of the Member's Plan Year, We shall make such Prescription Drug available at the contracted benefit level until the end of the Plan Year, regardless of whether the Prescription Drug has been removed from Our Formulary.

Prescription Drugs not listed on Formulary may be covered if:

- The drug is not excluded from coverage;
- The drug is Medically Necessary;
- The Formulary alternatives have been tried but were insufficient to treat the Member's condition, or there are clinically significant reasons why the Formulary alternatives would not be appropriate. (This may not apply to Prescription Drugs used to treat stage 4 advanced metastatic cancer or an associated condition.)

To request coverage for a non-Formulary medication, A Member, or the prescribing Participating Provider or Participating Health Professional must submit a request for Preauthorization or request for an Appeal to the Utilization Review agent for consideration of coverage. If the request is denied, the Member and the prescribing Participating Provider or Participating Health Professional may Appeal the denial. Refer to the **Claim Filing, Complaints and Appeals Procedures** section of this Evidence of Coverage.

Specialty Prescription Drugs

Most Specialty Prescription Drugs obtained under the pharmacy benefit must be dispensed from one of the Participating Specialty Pharmacy Providers. Specialty Prescription Drugs dispensed by a Participating Specialty Pharmacy Provider will be subject to the Formulary Copayment for Specialty Prescription Drugs specified in the Schedule of Benefits. Failure to obtain Specialty Prescription Drugs from the Participating Specialty Pharmacy Provider may result in denial of coverage for the Specialty Prescription Drug. A Member may contact Us to obtain a

copy of the Specialty Prescription Drugs which must be obtained from the Participating Specialty Pharmacy Providers. Specialty Prescription Drugs may require Preauthorization by a Medical Director or be subject to coverage requirements.

Authorization Requirements

Certain medications have restrictions in place to ensure they are being used appropriately and safely. Such restrictions may include:

- Quantity limits on the amount of a Prescription Drug the Member can receive over a period;
- Step therapy requiring trial of an alternative Prescription Drug(s) before a Prescription Drug is covered. Step therapy restrictions do not apply to Prescription Drugs used to treat stage 4 metastatic cancer or associated conditions;
- Preauthorization requiring the provider to submit documentation that the Prescription Drug is Medically Necessary before a Prescription Drug is covered.

If coverage for a Prescription Drug or quantity of Prescription Drug is denied, the Member and the Member's Participating Provider or Participating Health Professional may Appeal the denial (refer to the **Claim Filing, Complaints and Appeals Procedures** section of this Evidence of Coverage). The Member's Participating Provider or Participating Health Professional may submit a request for an exception to step therapy protocol. If a step therapy exception request is not denied within seventy-two (72) hours of the request, the request will be considered granted. If the prescribing Participating Provider or Participating Health Professional feels that a denial of the step therapy exception request would result in death or serious harm, the request will be considered granted if not denied within twenty-four (24) hours of the request.

Prescription Drug Refill

Refills of a Prescription Drug will not be covered until the Member is reasonably due for a refill as calculated based upon the Prescription Drug being taken at the prescribed dosage and appropriate intervals.

Refills of prescription eye drops to treat chronic eye disease are allowed if:

- the original Prescription Order states that additional quantities of the eye drops are needed;
- the refill does not exceed the total quantity of dosage units authorized by the prescribing Participating Provider or Participating Health Professional on the original prescription, including refills; and
- the refill is dispensed on or before the last day of the prescribed dosage period; and
    - not earlier than the 21st day after the date a prescription for a 30-day supply of eye drops is dispensed;
    - not earlier than the 42nd day after the date a prescription for a 60-day supply of eye drops is dispensed;
    - not earlier than the 63rd day after the date a prescription for a 90-day supply of eye drops is dispensed.

Maintenance Prescription Drugs

Prescription Drugs taken for chronic conditions as defined by Us are designated as maintenance Prescription Drugs and will be considered for Medical Synchronization as follows:

- Meet Preauthorization criteria;
- Is used for Treatment and management of a chronic illness;
- May be prescribed with refills;
- Is a formulation that can be effectively dispensed in accordance with the Medication Synchronization Plan;
- Is not a Schedule II or III controlled substance; and
- May qualify for synchronizing refills and pro-rated Cost Sharing amounts for partial supplies of certain medications.

Copayment and Deductible

A Member must pay the Copayment for each Prescription Drug based on the quantity and days' supply dispensed as stated in the Schedule of Benefits. Any Deductible, and/or Copayments for Prescription Drugs shall be considered Out of Pocket Expenses for purposes of meeting the Member's Maximum Out of Pocket. The amount a Member pays for a Prescription Drug will not be more than the Copayment, as stated in the Schedule of Benefits, the Allowed Amount for the Prescription Drug, or the actual price of the Prescription Drug.

Oral Anticancer Medications

Oral anticancer medications, which are no less favorable than intravenously administered or injected cancer medications, are covered under the Specialty Prescription Drug benefit and are subject to the Cost Sharing amounts applied to Specialty Prescription Drugs in the Schedule of Benefits.

Prescriptions Drugs included in the Oral Oncology Dispensing Program will be restricted to a 14/15-day supply for the first two (2) months of therapy. Note that for Members with a Copayment, 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 (4) fills of a drug in the Oral Oncology Dispensing Program, Members continuing therapy may fill their prescription for a maximum day supply allowed per the Schedule of Benefits.

Discontinuance of Prescription Drugs or Intravenous Infusions

We shall provide notice of an Adverse Determination for a review of the provision of Prescription Drugs or intravenous infusions for which the Member is receiving covered benefits under the Evidence of Coverage not later than the 30th day before the date on which the provision of Prescription Drugs or intravenous infusions will be discontinued.

Exclusions and Limitations

The benefits under this Evidence of Coverage shall not include or shall be limited by the following:

Abortions
Elective abortions, non-therapeutic termination of pregnancy, including any abortion-inducing medications are excluded except where the life of the mother would be endangered if the fetus were to be carried to term or a medical emergency that places the woman in danger of serious risk of substantial impairment of a major bodily function unless an abortion is performed.

Ambulance Transportation is excluded when another mode of transportation is clinically appropriate; for stable, non-emergency conditions, unless Preauthorized; when provided for the convenience of the Member, the Member's family, Ambulance provider, Hospital, or attending Physician; where no transportation of a Member occurs. Additionally, air or sea Ambulance transportation is excluded when ground Ambulance is clinically appropriate; and to locations other an acute care Hospital. All forms of Medically Necessary ambulance transportation that are for non-emergency situations must be Preauthorized.

Assistant Surgeons are excluded unless determined to be Medically Necessary.

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

Circumcision in any male other than a newborn, age 30 days or less, is excluded unless Medically Necessary.

Chiropractic Services other than those described in the Manipulative Therapy and Chiropractic Care provision is excluded.

Colorectal Cancer Screening Exam excludes Colorguard®.

Complications of non-covered procedures
Treatment related to complication of non-covered procedures are excluded.

Cosmetic or Reconstructive Procedures or Treatment
Cosmetic, plastic, medical or surgical procedures, and cosmetic therapy and related supplies, including, but not limited to Hospital confinement, Prescription Drugs, diagnostic laboratory tests and X-rays or surgery and other reconstructive procedures, including any related prostheses, except breast prostheses after mastectomy, are excluded, unless specifically covered in the **Medical Benefits** section of this Evidence of Coverage. Among the procedures that are excluded are:

- Excision or reformation of any skin on any part of the body, removal of port wine stains, removal of superficial veins, tattoos or tattoo removal, the enlargement, reduction implantation or change in the appearance of any portion of the body unless determined to be Medically Necessary;
- Removing or altering sagging skin;
- Changing the appearance of any part of the Member's body, such as enlargement, reduction, or implantation, except for breast construction following a mastectomy;
- Hair transplants or removal;
- Peeling or abrasion of the skin;
- Any procedure that does not repair a functional disorder; and
- Rhinoplasty as associated surgery except when Medically Necessary to treat craniofacial abnormalities as described in the **Medical Benefits** section of the Evidence of Coverage.

Court Ordered Care
Benefits provided solely because of the order of a court or administrative body, which benefits would otherwise not be covered under this Evidence of Coverage are excluded.

Cryotherapy devices such as PolarCare™ are excluded.

Custodial Care as follows is excluded:

- Any services, 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 Prescription Drugs; and
- 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 benefits no matter who provides, prescribes, recommends, or performs those services. The fact that certain benefits are provided while You or Your Covered Dependent are receiving Custodial Care does not require Us to cover Custodial Care.

Dental Care
All dental care or oral surgery is excluded, except for corrective Treatment of craniofacial abnormalities or an Accidental Injury to natural teeth, or any Treatment relating to the teeth, jaw, or adjacent structures, including but not limited to:

- Cleaning of teeth;
- Any services related to crowns, bridges, fillings, or periodontics;
- Rapid palatal expanders;
- X-rays or exams;
- Dentures or dental implants;
- Dental prostheses, or shortening or lengthening of the mandible or maxillae for Members over the age of 18, correction of malocclusion, and any non-surgical dental care involved in the Treatment of temporomandibular joint pain dysfunction syndrome (TMJ), such as oral appliance and devices;
- Treatment of dental abscess or granuloma;
- Treatment of gingival tissues, other than for tumors;
- Surgery or Treatment for overbite or under bite and any malocclusion associated thereto, including those deemed congenital or development abnormalities; and
- Orthodontics, such as splints, positioners, extracting teeth, or repairing teeth.

The only dental related coverage We provide is described in the **Medical Benefits** section of this Evidence of Coverage.

Disaster or Epidemic
In the event of a major disaster or epidemic, benefits shall be provided to the extent that is practical, according to the best judgment of Participating Providers and within the limitations of facilities and personnel available; but neither the Issuer, nor any Participating Providers shall have any liability for delay or failure to provide or to arrange for services due to a lack of available facilities or personnel.

Exceeding Medical Benefit Limits
Any services provided to a Member who has exceeded a Medical Benefit maximum are excluded from coverage, regardless of authorization status, as permitted by law.

Experimental or Investigational Treatment
A Prescription Drug, device, Treatment, or procedure that is Experimental or Investigational is excluded. We consider a Prescription Drug, device, Treatment, or procedure to be Experimental or Investigational if:

- It cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time it is provided.
- It was reviewed, and approved by the treating Facility's Institutional Review Board, or similar committee, or if federal law required it is be reviewed and approved by that committee. This exclusion also applies if the informed consent form used with the Prescription Drug, device, Treatment, or procedure was or was requested by federal law to be reviewed and approved by that committee.
- Reliable evidence shows that the Prescription Drug, device, Treatment, or procedure is the subject of ongoing Phase I or Phase II clinical trials, is the research, Experimental study, or Investigational arm of ongoing Phase I or Phase II clinical trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness, or its effectiveness compared to a standard method of Treatment or diagnosis.
- The safety and/or efficacy has not been established by reliable, accepted medical evidence, or
- Reliable evidence shows that the prevailing opinion among experts is that further studies or clinical trials of the Prescription Drug, device, Treatment, or procedure are needed to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness, or its effectiveness compared to a standard method of Treatment or diagnosis.

"Reliable evidence" includes only published reports and articles in authoritative medical and scientific literature, and written protocols and informed consent forms used by the treating Facility or by another Facility studying substantially the same Prescription Drug, device, Treatment or procedure.

Additionally, any Prescription Drug, device, Treatment, or procedure that would not be used in the absence of an Experimental or Investigational drug, device, Treatment, or procedure is excluded.

Family Member (Service 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 dwells in the Member's household, or any services or supplies for which the Member would have no legal obligation to pay in the absence of this Evidence of Coverage or any similar coverage; or for which no charge or different charge is usually made in the absence of health care coverage, are excluded.

Family Planning Treatment
The reversal of an elective sterilization procedure, and condoms for males are excluded.

Foot Care (Routine)
Treatment of weak, strained or flat fee, corns, calluses, or medications for the Treatment of uncomplicated nail fungus are excluded. Corrective orthopedic shoes, arch supports, splints, or other foot care items are excluded, except as noted in the **Medical Benefits** section of this Evidence of Coverage. This will not apply to the removal of nail roots.

Genetic Testing
Genetic testing relating to pre-implantation of embryos for in-vitro fertilization is excluded, except for those required under applicable state or federal law and Medically Necessary prenatal genetic counseling. Genetic testing results or the refusal to submit to genetic testing will not be sued to reject, deny, limit, cancel, refuse to renew, increase Premiums for, or otherwise adversely affect eligibility for or coverage under this plan.

Hearing Devices
The following exclusions include hearing aid batteries or cords, temporary or disposable hearing aids, repair or replacement of hearing aids due to normal wear, loss, or damage, a hearing aid that does not meet the specifications prescribed for correction of hearing loss.

Household Equipment
The following **devices**, **equipment, and supplies** are excluded:

- Corrective shoes, shoe inserts, arch supports, and Orthotic inserts, except as provided for in the **Medical Benefits** section of this Evidence of Coverage and for the Treatment of diabetes;
- Equipment and appliances considered disposable or convenient for use in the home, such as over-the counter bandages and dressings;
- Comfort or convenience items, such as bathtub chairs, whirlpool tubs, safety grab bars, stair gliders or elevators, over-the-bed tables, bed boards, saunas, and exercise equipment;
- Environmental control equipment, such as air conditioners, purifiers, humidifiers, dehumidifiers, electrostatic machines, and heat lamps;
- Consumable medical supplies, such as over-the-counter bandages, dressings, and other disposable supplies, skin preparations, surgical leggings, elastic stockings, TED stockings, stump socks and compression garments;
- Foam cervical collars;
- Stethoscopes, sphygmomanometers, and recording or hand-held pulse oximeters;
- Hygienic or self-help items or equipment; and
- Electric, deluxe, and custom wheelchairs or auto tilt chairs.

Illegal Acts
Charges for services received as a result of injury or sickness caused by or contributed to by the Member engaging in an illegal act or occupation or by committing or attempting to commit a crime, criminal act, assault or other felonious behavior, regardless of whether charged, are excluded. For purposes of this exclusion, an act is "illegal" if it is contrary to or in violation of law, and includes, but is not limited to, operating a motor vehicle, recreational vehicle, or watercraft while intoxicated. Intoxication includes situations in which the Member has a blood alcohol content or concentration (BAC) which exceeds the applicable legal limit. This exclusion does not apply if the injury resulted from an act of domestic violence or medical condition (including both physical and mental health), or in case of emergency, the initial medical screening examination, Treatment and Stabilization of an emergency condition.

Infertility Treatment
The following Infertility services are excluded:

- in vitro fertilization unless covered by a Rider;
- artificial insemination;
- gamete intrafallopian transfer, and similar procedures;
- 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;
- any costs related to surrogate parenting, sperm banking for future use, or any assisted reproductive technology or related Treatment that is not specified in the **Medical Benefits** section of this Evidence of Coverage.

Mental Health
Services for mental illness or disorders are limited to those services described in the "Mental Health Care" provision of this Evidence of Coverage including counseling and related services. Coverage for services for or in connection with a Court Order or condition of parole or probation are subject to the same limitation.

Miscellaneous
Artificial aids, corrective appliances, other than those provided as Orthotic Devices. Non-prescribed medical supplies, such as take home and over the counter drugs, batteries, condoms, syringes (other than insulin syringes), dentures, eyeglasses and corrective lenses, unless specified in the Plan, are excluded.

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 Usual and Customary charges for such services or supply prevailing in the area in which the service or supply was received.

Orthotripsy and related procedures are excluded.

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 Evidence of Coverage, are excluded.

Pharmacy Benefit excludes the following:

- Covered drugs, devices or other pharmacy services which a Member may properly obtain at no cost through a local, state or federal government program, except if provided through Medicaid or this exclusion is specifically prohibited by law;
- "Over-the-counter" drugs which do not require a Participating Provider or Participating Health Professional's Prescription Order for dispensing. The exception is insulin and if the drug is listed on Our Formulary;
- Anything which is not specified as covered or not defined as a drug, such as therapeutic devices, appliances, support garments, glucometers, asthma spacers and machines, including syringes (except disposable syringes for insulin dependent Members) unless listed on Our Formulary;
- 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 this Evidence of Coverage;
- Drugs not approved by the Food and Drug Administration for use in humans or for the condition, dose, route, duration, and frequency being treated;
- Drugs used for cosmetic purposes;
- Drugs used for Treatments or medical conditions not covered by this Evidence of Coverage;
- Drugs used primarily for the Treatment of Infertility;
- Vitamins except if drug is listed on Our Formulary;
- Any initial or refill prescription dispensed more than one (1) year after the date of the Participating Provider or Participating Health Professional's Prescription Order;
- Except for medical emergencies, drugs not obtained at a Participating Pharmacy;
- Drugs given or administered to a Member while at a Hospital, Skilled Nursing Facility, or other Facility;
- A prescription that has an over the counter alternative;
- Initial or refill prescriptions the supply of which would extend past the termination of this Evidence of Coverage, even if the Participating Provider or Participating Health Professional's Prescription Order was issued prior to termination;
- Drugs for the Treatment of sexual dysfunction, impotence, or inadequacy; or,
- High cost drugs that are chemically similar drugs and share the same mechanism of action to an existing, approved chemical entity and offer no significant clinical benefit.

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 license 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; and
- qualifying for participation in athletic activities, such as school sports.

Surgery for Refractive Keratotomy is excluded.

Reimbursement
We shall not pay any provider or reimburse Member for any Medical Benefit or Pharmacy Benefit for which a Member would have no obligation to pay in the absence of coverage under this Evidence of Coverage.

Speech and Hearing Loss
Services for the loss or impairment of speech or hearing are limited to those rehabilitation services described in the Rehabilitation Therapy provision unless covered by a Rider.

Sports Rehabilitation refers to continued Treatment for sports related injuries to improve above and beyond normal ability to perform activities of daily living (ADLs). Sports-related rehabilitation or other similar avocational activities is excluded because it is not considered Treatment of disease. This includes, but is not limited to: baseball, pitching/throwing, cheerleading, golfing, martial arts of all types, organized football, baseball, basketball, soccer, lacrosse, swimming, track and field, etc. at a college, high school, or other school or community setting, professional and amateur tennis, professional and amateur/hobby/academic dance, and competitive weightlifting and similar activities.

Therapies and Treatments
The following therapies and Treatments are excluded: 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 integration; vision therapy; orthotripsy; oral allergy therapy; acupuncture; naturopathy; hypnotherapy or hypnotic anesthesia; Christian Science Practitioner Services; Biofeedback services, except for the Treatment of Acquired Brain Injury and for rehabilitation of Acquired Brain Injury; massage therapy, unless associated with a physical therapy modality provided by a licensed physical therapist.

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 Evidence of Coverage.

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 Provider and Preauthorized, if required, by Our Medical Director.

Unauthorized Services
Non-emergency Medical Benefits or Pharmacy Benefits which are not provided, ordered, prescribed, or authorized by a Participating Provider or Participating Health Professional are excluded.

Vision Care – Adult
Eye exercises, training, orthoptics, multiphase testing, eyeglasses, including eyeglasses and contact lenses prescribed following vision surgery, contact lenses for Members over the age of 18, except for Treatment of Keratoconus, and any other items or services for the correction of the Member's eyesight, including but not limited to orthoptics, vision training, vision therapy, radial keratotomy (RK), automated lamellar keratoplasty (ALK or LK), astigmatic

keratotomy (AK), laser vision corrective surgery and photo refractive keratectomy (PRK-laser) are excluded unless specifically provided in the **Medical Benefits** section of this Evidence of Coverage, or provided by a Rider.

Vision Care – Pediatric

- Routine eye exams do not include professional services for contact lenses;
- Laser eye surgery (LASIK) is excluded;
- Any vision service, Treatment or materials not specifically listed as a covered Medical Benefit is excluded;
- Services and materials not meeting accepted standards of optometric practice are excluded;
- Telephone consultations are excluded.

War, Insurrection or Riot

Medical Benefits or Pharmacy Benefits provided as a result of any injury or illness caused by any act of declared or undeclared war, or Member's participation in a riot or insurrection are excluded.

If the rendition of a Medical Benefit or Pharmacy Benefit is delayed or rendered impractical due to circumstances beyond the reasonable control of the Issuer, such as complete or partial destruction of facilities due to war, riot, or civil insurrection; an act of terrorism; labor dispute; government order; national, state or local state of emergency; pandemic; or the like, neither We, nor any Participating Provider, Participating Health Professional, nor any Facility shall have any liability to Members or Contract Holder.

Weight Reduction

Weight reduction programs, supplements, services, supplies, surgeries including but not limited to Gastric Bypass, gastric stapling, Vertical Banding, and gym memberships are excluded, even if the Member has medical condition or is prescribed by a Physician or Health Care Professional.

Claim Filing, Complaints and Appeal Procedures

The Issuer has the authority to review Claims in accordance with the procedures contained herein to determine if the Claims are covered by this Evidence of Coverage.

Claim Filing Procedure

Members will not ordinarily need to pay any provider or Facility for benefits provided under this Evidence of Coverage. However, if a Member receives benefits from facilities which do not routinely contract with Us, for example in case of an emergency, Members may be asked to pay that provider or Facility directly. Members are entitled to reimbursement for such payment to the extent that those benefits are covered under this Evidence of Coverage provided:

- Members submit written proof of and Claim for payment to Us at Our office;
- The written proof and Claim for payment are acceptable to Us;
- We received the written proof and Claim for payment within sixty (60) days of the date the benefits were received by the Member; and
- The Member has complied with the terms of this Evidence of Coverage.

Failure to File a Claim Within 60-Days

Failure to submit written proof of and Claim of payment within the sixty (60) day period shall not invalidate or reduce the Members entitlement to reimbursement provided it was not reasonably possible for the Member to submit such proof and Claim within the time allowed and written proof 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 benefits were received;
- Date the benefit was provided;
- Amount paid for the benefit; and
- Diagnosis for visit.

Claims for reimbursement should be sent to:

Scott & White Care Plans
Attn: Claim Department
1206 West Campus Drive, Temple, TX 76502

In no event will We have any obligation under this Evidence of Coverage if such proof of and Claim for payment is not received by Us within one (1) year of the date the benefits were provided to the Member.

Acknowledgement of Claim

Not later than the fifteenth (15th) day after receipt of Your Claim, We will acknowledge in writing receipt of the Claim; begin any investigation of the Claim; and require from the Member any necessary information, statements or forms. Additional requests for information may be made during the investigation.

Acceptance or Rejection of Claim

Not later than the fifteenth (15th) business day after receipt of all requested items and information, We will notify the Member in writing of the acceptance or rejection of the Claim and the reason, if rejected; or notify the Member that additional time is needed to process the Claim and state the reason We need additional time. If additional time

is needed to decide, We shall accept or reject the Claim no later than the forty-fifth (45th) day after the Member has been notified of the need for additional time.

Payment of Claim

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

Payment to Physician or Provider

Payment by Us to the provider or Facility providing the service to the Member shall discharge Our obligation under this section.

Physical Examination or Autopsy

We retain the right and opportunity to:

- Conduct a physical examination of a Member for whom a Claim is made when and as often as We reasonably require during the pendency of the Claim under this Evidence of Coverage; and
- In the case of a death, may require that an autopsy be conducted, unless the autopsy is prohibited by law.

Complaint Procedure

We recognize 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 Evidence of Coverage does not meet expectations. It is important that such an event be brought to the attention of Issuer. We are dedicated to addressing problems quickly, managing the delivery of benefits effectively, and preventing future Complaints and Appeals. We will not retaliate against a Member because the Member, the Member's provider, or a person acting on the Member's behalf files a Complaint or appeals a decision made by Us.

We offer Members the opportunity to file a Complaint within one hundred eighty (180) days to dispute the benefit/Claim processing. Members are required to file a Complaint in writing and can call Customer Service to begin the process. If Our resolution of the Complaint is unsatisfactory Member, the Member will be afforded the opportunity to Appeal that Complaint.

In some cases, We may ask for additional time to process a Member's Complaint. If a Member does not wish to allow additional time, We will decide a Member's Complaint based on the information We have. This may result in a denial of a Member's Complaint.

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

We 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.

The Complaint resolution letter will include the specific reason(s) for Our determination. The response letter will also 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.

Complaints concerning an emergency, or a denial of continued hospitalization are resolved no later than one (1) business day after We receive the Complaint.

Appeal of Complaints

If the Complainant is not satisfied with Our resolution of the Complaint, the Complainant will be given the opportunity to appear in person before an Appeal panel at the site of which the Member normally receives benefits or at another site agreed to by the Complainant or address a written Appeal to an Appeal panel.

We 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 Our Appeal procedures and time frames. If the Appeal is received orally, We will also enclose a one-page Appeal form, which must be returned for prompt resolution of the Appeal.

We will appoint members to the Complaint Appeal panel, which shall advise Us on the resolution of the Complaint. The Complaint Appeal panel shall be composed of one Issuer 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 Provider 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 Member may not be an employee of Issuer.

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

- any documentation to be presented to the panel Our staff;
- the specialization of any Physicians or providers consulted during the investigation; and
- the name and affiliation of each Issuer representative on the panel.

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

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

Notice of the final decision of the Issuer on the Appeal will include a statement of:

- The specific medical determination;
- The clinical basis for the Appeal's denial;
- The 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.

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

Voluntary Binding Arbitration

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 Claim 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 Determination, or any dispute which does not involve an Adverse Determination; or for a Member enrolled in a n 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.

Medicare and Subrogation

Medicare

Regardless of any other provisions of the Agreement to the contrary, on and after the first day You or Your Covered Dependent become covered under Medicare and in instances where Medicare would be the primary payor of benefits, You or Your Covered Dependent shall agree to:

1. You and Your Covered Dependent shall qualify for, and remain continuously qualified for, coverage under 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 other terms of the Agreement, and perform such acts as shall be necessary and desirable to facilitate the maximum reimbursement by Medicare, the Issuer, and Participating Providers for the services provided.

Effect on the Benefits of the Plan

The Issuer will pay the difference between the Allowable Expense and the amount paid by Medicare in accordance with the Medicare explanation of medical benefits. Benefits will be reduced proportionally whenever a reduction is required under this provision. The Issuer will then charge these amounts against any applicable benefit limitations.

Method of Payment

The Issuer will have the right, exercisable alone in its sole discretions, to pay directly to any organization making such other payments any amount it determines to be warranted in order to satisfy the intent of this provision. Amounts so paid will be deemed to be benefits under the Plan. These payments will fully discharge the Issuer from all further liability.

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, if You or Your family did not pay the Premium;
- 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.

Regardless of the foregoing, the Plan will comply with the requirements of any applicable state law.

Right to Recovery

The Plan has the right to recover benefits it has paid on the plan participant's behalf that were:

- made in error;
- due to a mistake in fact;
- incorrectly paid by the Plan during the time period of meeting any Out of Pocket Maximum for the Calendar Year.

Benefits paid because the plan participant misrepresented facts are also subject to recovery.

If the Plan provides a benefit for the plan participant that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested, or
- reduce a future benefit payment for you or your dependent by the amount of the overpayment.

If the Plan incorrectly pays benefits to you or your dependent during the time period of meeting the Out of Pocket maximum for the Calendar Year, the Plan will send you or your dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover benefits by:

- submitting a reminder letter to you or a Covered Dependent that details any outstanding balance owed to the Plan; and
- conducting courtesy calls to you or a Covered Dependent to discuss any outstanding balance owed to the Plan.

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.

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.

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:

- 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; and
- 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.

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 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.
- A plan participant authorizes the Plan to pursue, sue, compromise and settle any claim described herein, and agrees to execute a medical authorization in furtherance of the plan's prosecution of its claim.
- 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.
- 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.

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.

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.

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.

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.

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 governs 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 determines whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan. When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits equal 100 percent of the total 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 Member 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 based on 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 Member 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 Members 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 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 Member 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, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan must be responsible for the plan's compliance with this subchapter.

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

i. The plan of the parent whose birthday falls earlier in the 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 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 Member is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB must not apply between that plan and other closed panel plans.

Compliance with Federal and State Laws Concerning Confidential Information

Certain facts about health care coverage and services are needed to apply the 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.

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.

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

Member. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

General Provisions

Assignment

The Member's rights and benefits under this Plan are personal to the Member and may not be assigned in whole or in part by the Member unless otherwise specifically provided herein. We will recognize assignments of benefits to the degree this Plan is subject to Texas Insurance Code §1204.053. If this Plan is not subject to section §1204.053, We will not recognize assignment or attempted assignment of benefits. Nothing contained in the Agreement shall be construed to make Issuer liable to any third party to whom the Member may be liable for the cost of medical care, Treatment, or services.

Confidentiality

In accordance with applicable law, all records and information pertaining to the diagnosis, Treatment, or health of You or Your Covered Dependents, or to an application obtained from You or Your Covered Dependents, or received from any provider shall be held by the Issuer in confidence and shall not be disclosed to any person except:

- to the extent it is necessary to carry out the purpose of the Agreement and administer this Evidence of Coverage;
- with Your or Your Covered Dependent's express authorization; or
- when required or authorized by law, regulation or court order; or
- in the event of claim or litigation between You or Your Covered Dependents and the Issuer.

More details about how We may use or disclose Member medical information can be found in Our Notice of Privacy Practices on Our website swhp.org.

Conformity with State Law

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

Limitations on Actions

No action at law or in equity shall be brought to recover payment of a Claim under this Evidence of Coverage prior to the expiration of sixty (60) days from the date written proof of and Claim for payment, as described above, was received by Us. In no event shall such action be brought after one (1) year from such date.

Modification of Agreement Terms

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

Not a Waiver

The failure of the Issuer to enforce any provision of the Agreement shall not be deemed or construed to be a waiver of the past or future enforceability of such provision. Similarly, the Issuer's failure to pursue any remedy arising from a default with a term of the Agreement shall not be deemed or construed to be a waiver of such default.

Notice

Any notice, under the Agreement shall be given by United States Mail, postage prepaid, addressed as follows:

If to the Issuer:
Scott & White Care Plans
1206 West Campus Drive
Temple, Texas 76502

If to You:
To the latest address provided by You

If to a Contract Holder:
When We provide written notice to the Contract Holder, that notice is deemed notice to all affected Subscribers and Covered Dependents. The Group is responsible for giving notice to You.

Office of Foreign Assets Control (OFAC) Notice

Notwithstanding any other provisions of the Agreement or any requirement of Texas law, the Issuer 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).

Records

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

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

Subject to all applicable confidentiality requirements, We are entitled to receive Your or Your Covered Dependents' information from any Physician or provider of health care in connection with the administration of the Agreement. By accepting benefits under the Agreement, You authorize every Physician or provider rendering health care to You and Your Covered Dependents to disclose, as permitted by law, all information and records pertaining to You or Your Covered Dependent's care, Treatment and physical condition to Us, 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 and permit copying of such records and reports by Us or other such Physicians and providers.

Recovery

If any action at law or in equity is brought to enforce or interpret the provisions of the 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.

The Issuer is also entitled to recover from the Contract Holder, Subscriber or Member any overpayment or other inappropriate payment, including, but not limited to, a payment for non-covered benefits 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 payment to Issuer may result in legal action by Issuer.

Reporting Health Care Fraud

Our mission is to make healthcare smart and simple. Our goal is to empower Members with information to help guide their health care decisions, including how to protect themselves and the Issuer against health care fraud.

Health care fraud occurs when someone intentionally provides false or misleading information to obtain health benefits or money.

Health care fraud places a burden on both the Issuer and Members. Providers who engage in fraud may be willing to prioritize their own financial gain over quality of Treatment and diagnosis. Also, health care fraud raises the cost of health insurance for everyone.

Health care fraud can be committed by a number of people including providers, hospitals, labs, medical equipment suppliers, and even Members.

Examples of provider fraud:

- Billing for services that were not performed;
- Using a falsified diagnosis to bill tests or procedures that are not Medically Necessary;
- "Upcoding" or billing for more expensive services than the ones that were performed;
- Accepting money from another provider for Member referrals or a "kickback"; and
- Waiving a Member's Cost Share in order to bill the insurer more.

Examples of member fraud:

- Using someone else's plan coverage or ID Card;
- Falsely alleging the theft of medical equipment; and
- Reselling medical items.

We keep Member personal health data safe, and it's important that Members take steps to protect their information as well.

When a Member goes to the doctor, the Member should ask questions about the care received. Once a Member receives a medical bill from a provider, the bill should be compared to the Member's Plan explanation of benefits. If a Member has questions about what was charged, the Member should contact Us at 800-321-7947. If a Member has any questions about the Claim procedure or the review procedure, the Member should contact Us at 800-321-7947 or visit Our website at swhp.org.

We have a Special Investigations Unit (SIU) to investigate allegations of fraud. If a Member suspects fraud, report concerns to Our Special Investigations Unit:

- Email: SWHPComplianceDepartment@bswhealth.org;
- Toll-free fraud hotline: 888-484-6977; or
- Reports submitted by mail:
  Attn: Compliance Department
  Scott & White Care Plans
  1206 West Campus Drive
  Temple, TX 76502

When leaving the Issuer's SIU a message, please provide as much information as possible (names of those involved, locations, and any other details), so that We can investigate and take appropriate action. We do not trace calls and will not try to identify the caller. Reports can be made without worry of retaliation or intimidation.

Severability

In the event of the unenforceability or invalidity of any section or provision of the Agreement, such invalidity or unenforceability shall not otherwise affect any other section of the Agreement, and the Agreement shall otherwise remain in full force and effect.

Venue

The Agreement shall be governed by the laws of the State of Texas, and federal laws where applicable. Any action at law or in equity, including any suit to enforce any of the terms, conditions, rights or privileges under the Agreement, shall be brought in a court located within the SWCP Service Area.

Required Notices

Notice of Rights - 28 TAC §11.1612(c)

A health maintenance organization (HMO) provides no benefits for services you receive from out-of-network physicians or providers, with specific exceptions as described in your Evidence of Coverage and below.

You have the right to an adequate network of participating physicians or providers (known as "Network Physicians and Providers").

If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.

If your HMO approves a referral for out-of-network services because no participating physician or provider is available, or if you have received out-of-network emergency care, your HMO must, in most cases, resolve the non-participating provider's bill so that you only have to pay any applicable network copayment and deductible amounts.

You may obtain a current directory of participating providers by visiting our website at swhp.org or by calling 800-321-7947 for assistance in finding available participating providers. If you relied on materially inaccurate directory information, you may be entitled to have a claim by a non-participating provider paid as if it were from a participating provider, if you present a copy of the inaccurate directory information to the HMO, dated not more than 30 days before you received the service.

Special Toll-Free Complaint Number

To make a complaint about a private psychiatric hospital, chemical dependency treatment center, or psychiatric or chemical dependency services at a general hospital, call:

800-321-7947

Your complaint will be referred to the state agency that regulates the hospital or chemical dependency treatment center.

Mandatory Benefit Notices

This notice is to advise you of certain coverage and/or benefits provided in the plan provided by the us. This notice is required by legislation to be provided to you. If you have questions regarding this notice, call us at 800-321-7947. If you have any questions about the claim procedures or the review procedure, call us at 800-321-7947 or write to us at 1206 West Campus Drive, Temple, Texas 76502.

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy - 28 TAC §21.2106(b)(2)(3)

Coverage and/or benefits are provided to each member for reconstructive surgery after mastectomy, including:

- All stages of the reconstruction of the breast on which mastectomy has been performed;
- Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
- Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

The coverage and/or benefits must be provided in a manner determined to be appropriate in consultation with the member and the attending physician.

Deductibles and copayment amounts will be the same as those applied to other similarly covered inpatient hospital expense or medical-surgical expense, as shown on the Schedule of Benefits.

Prohibitions: We may not (a) offer the member a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above; (b) condition, limit, or deny any member's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above; or (c) reduce or limit the amount paid to the physician or provider, nor otherwise penalize, or provide a financial incentive to induce the physician or provider to provide care to a member in a manner inconsistent with the coverage and/or benefits shown above.

Mastectomy or Lymph Node Dissection - 28 TAC §21.2106(b)(1)

Minimum Inpatient Stay: If due to treatment of breast cancer, any member covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of:

- 48 hours following a mastectomy; and
- 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the member receiving the treatment and the attending physician determine that a shorter period of inpatient care is appropriate.

Prohibitions: We may not (a) deny any member eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours; (b) provide money payments or rebates to encourage any member to accept less than the minimum inpatient hours; (c) reduce or limit the amount paid to the attending physician, or otherwise penalize the physician, because the physician required a member to receive the minimum inpatient hours; or (d) provide financial or other incentives to the attending physician to encourage the physician to provide care that is less than the minimum hours.

Coverage for Tests for Detection of Colorectal Cancer - 28 TAC §21.2106(b)(6)

Benefits are provided, for each member in the plan who is 50 years of age or older and at normal risk for developing colon cancer, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include the member's choice of:

- A fecal occult blood test performed annually, and a flexible sigmoidoscopy performed every five years, or
- A colonoscopy performed every 10 years.

Coverage of Tests for Detection of Human Papillomavirus and Cervical Cancer - 28 TAC §21.2106(b)(7)

Coverage is provided, for each woman enrolled in the plan who is 18 years of age or older for expenses incurred for an annual, medically recognized diagnostic examination for the early detection of ovarian and cervical cancer. Coverage required under this section includes a CA 125 blood test and, at a minimum, a conventional pap smear screening or a screening using liquid- based cytology methods, as approved by the FDA, alone or in combination with a test approved by the FDA for the detection of the human papillomavirus.

If any member has questions concerning the above, please call us at 800-321-7947 or write to us at 1206 West Campus Drive, Temple, Texas 76502.

Examinations for Detection of Prostate Cancer - 28 TAC §21.2106(b)(4)

Benefits are provided for each male member for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include:

- A physical examination for the detection of prostate cancer; and
- A prostate-specific antigen test for each covered male who is:
    - At least 50 years of age; or
    - At least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

Inpatient Stay Following Birth of a Child - 28 TAC §21.2106(b)(5)

For each member covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

- 48 hours following an uncomplicated vaginal delivery; and
- 96 hours following an uncomplicated delivery by cesarean section.

This benefit does not require a female member who is eligible for maternity/childbirth benefits to (a) give birth in a hospital or other health care facility; or (b) remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours has expired, we will provide coverage for post-delivery care. Post-delivery care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. Care will be provided by a physician, registered nurse or other appropriately licensed health care provider, and the mother will have the option of receiving the care at her home, the health care provider's office or a health care facility.

Prohibitions: We may not (a) modify the terms of this coverage based on any member requesting less than the minimum coverage required; (b) offer the mother financial incentives or other compensation for waiver of the minimum number of hours required; (c) refuse to accept a physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians; (d) reduce payments or reimbursements below the usual and customary rate; or (e) penalize a physician for recommending inpatient care for the mother or the newborn child.

Point of Service Rider
Scott & White Care Plans

In consideration of Required Payments, We add this Point of Service (POS) Rider, and benefits it provides, to the Evidence of Coverage, Schedule of Benefits and HMO Riders (collectively, "HMO Plan"). All provisions of the HMO Plan apply to this Rider, unless this Rider provides otherwise.

POS Rider Definitions

Coinsurance means the percentage, if any, shown in the POS Schedule of Benefits, of the Usual and Customary Rate payable for benefits for which the Member is responsible.

Point of Service (POS) means an arrangement under which a Member chooses to obtain benefits through an HMO Network or a Non-Participating Provider outside the HMO Network.

POS Benefits means covered benefits provided by Non-Participating Providers, unless such benefits would otherwise be covered under the HMO Plan.

POS Deductible means the dollar amount, if any, shown in the POS Schedule of Benefits payable by the Member for covered benefits before the Plan provides payment for those benefits under the POS Rider.

POS Benefits

To understand the benefits available under this POS Rider, Members should first review the HMO Plan, this Rider and the POS Schedule of Benefits.

The HMO Plan will help identify what types of benefits are covered, when and how each benefit will be covered, and how Members can receive benefits. The section entitled **Exclusions and Limitations** of the Evidence of Coverage describes the types of illness, sickness and services that are not covered by this Agreement.

While the HMO Plan provides Members with care from Participating Providers, the POS Rider provides Members with access to care from Non-Participating Providers. The POS Schedule of Benefits identifies Your Copayments, Coinsurance and Deductibles, if any, and other expenses You are responsible to pay.

We will pay up to the Usual and Customary Rate for covered benefits incurred by Members as a direct result of injury or sickness after satisfaction of any applicable Copayments, Coinsurance and Deductibles. Coinsurance percentages are calculated from the Usual and Customary Rate for covered benefits. If a Non-Participating Provider's billed charges exceed the Usual and Customary Rate, in addition to Deductibles, Copayments and Coinsurance, You may be fully liable to the Non-Participating Provider for the difference between billed charges and the Usual and Customary Rate. Such payments will not exceed any applicable maximum shown in the POS Schedule of Benefits. All benefits are subject to the limitations and exclusions described in this Rider and the HMO Plan.

Allocation of Benefits and Limitations Between HMO and POS

In addition to benefits under the HMO Plan, this Rider provides coverage for POS benefits under the following conditions:

- If a Member does not receive Treatment from a Participating Provider, benefits may be available under this Rider.
- Covered HMO benefits and POS benefits that a Member receives do not duplicate each other.

- Members cannot receive HMO benefits and POS benefits for the same service.
- When calculating POS benefit limits, the Member's HMO benefits and POS benefits will both be allocated against the POS benefit limits.
- When calculating HMO benefit limits, the Member's HMO benefits will be included. The Member's POS benefits will not be included in calculating HMO benefit limits.

Application and Required Payments

Subject to the HMO Plan, Deductibles and Copayments paid for HMO benefits by the Member may be Out of Pocket Expenses to be applied to the Maximum Out of Pocket under the HMO Plan. Deductibles and Copayments paid for HMO benefits do not count as satisfying the Member's POS Deductible or Maximum Out of Pocket under this POS Rider.

Subject to the HMO Plan, Deductibles, Coinsurance or Copayments paid for POS benefits by the Member may be Out of Pocket Expenses to be applied to the Maximum Out of Pocket under the HMO Plan and will apply to the annual Maximum Out of Pocket limits for this POS Rider. Deductibles and Copayments paid for POS benefits also count as satisfying the Member's HMO Deductible, if any.

Claim Filing

Necessity of Filing Claims

For POS benefits, you may file a claim for reimbursement directly with Us or assign the rights and benefits of this Rider to Non-Participating Providers.

Payment to Texas Department of Human Services

All benefits paid on behalf of Your Covered Dependent children will be paid to the Texas Department of Human Services whenever:

- The Texas Department of Human Services is paying benefits under the financial and medical assistance service programs administered pursuant to the Texas Human Resources Code;
- You have possession or access to the child pursuant to a court order, or You are not entitled to access or possession of the child but are required by the court to pay child support; and
- When the claim is first submitted You notify the Issuer that the benefits must be paid directly to the Texas Department of Human Services.

Payment to a Managing Conservator

Benefits paid on behalf of a Covered Dependent child may be someone other than You, if an order issued by a court of competent jurisdiction in this or any other state names such other person the managing conservator of the Covered Dependent child.

To be entitled to receive benefits, a managing conservator must submit with the claim form, written notice that such person is the managing conservator of the child on whose behalf the claim is made and submit a certified copy of a court order establishing the person as managing conservator. This will not apply in the case of any unpaid medical bill submitted as a claim by a Participating Provider or to claims submitted by You where You have paid any portion of a medical bill that would be covered under the terms of this Agreement.

Preauthorization Penalty

For a complete list of benefits that are subject to Preauthorization, visit Our website at swhp.org or call Us at 800-321-7947. Failure to obtain Preauthorization of benefits, other than Emergency Care, will result in a penalty of the lesser of $500 or 50% reduction in benefits.

How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
  - Up to $500,000 for health benefit plans, with some exceptions.
  - Up to $300,000 for disability income benefits.
  - Up to $300,000 for long-term care insurance benefits.
  - Up to $200,000 for all other types of health insurance.
- **Life insurance:**
  - Up to $100,000 in net cash surrender or withdrawal value.
  - Up to $300,000 in death benefits.
- **Individual annuities:** Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.
- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.
- **Individual aggregate limit:** Up to $300,000 per person, regardless of the number of policies or contracts. A limit of $500,000 may apply for people with health benefit plans.
- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

To learn more about the Association and your protections, contact:	For questions about insurance, contact:
Texas Life and Health Insurance Guaranty Association 1717 West 6th Street, Suite 230 Austin, TX 78703-4776 1-800-982-6362 or www.txlifega.org	**Texas Department of Insurance** P.O. Box 12030 Austin, TX 78711 1-800-252-3439 or www.tdi.texas.gov

Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.

ATTACHMENT 2
SCOTT AND WHITE HEALTH PLAN
SERVICE AREAS

1. SERVICE AREAS

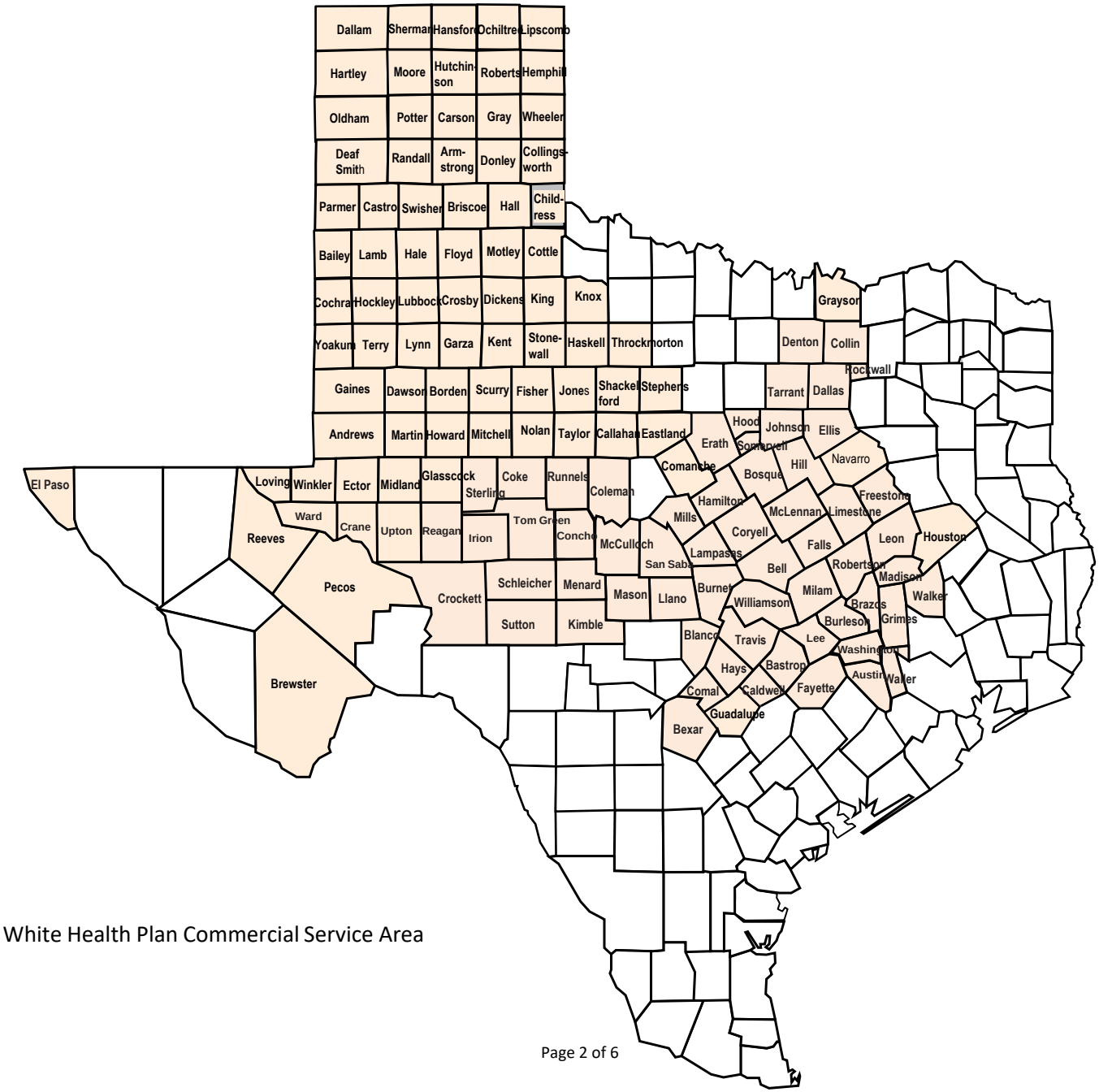
Figure 1 shows the approved Service Area of the Health Plan. Subscribers must work or reside inside of this Service Area in order to be covered by the Health Plan.

Service Area Description:
All of the following counties in central Texas: Andrews, Armstrong, Austin, Bailey, Bastrop, Bell, Bexar, Blanco, Borden, Bosque, Brazos, Brewster, Briscoe, Burleson, Burnet, Caldwell, Callahan, Carson, Castro, Childress, Cochran, Coke, Coleman, Collin, Collingsworth, Comal, Comanche, Concho, Coryell, Cottle, Crane, Crockett, Crosby, Dallam, Dallas, Dawson, Deaf Smith, Denton, Dickens, Donley, Eastland, Ector, El Paso, Ellis, Erath, Falls, Fayette, Fisher, Floyd, Freestone, Gaines, Garza, Glasscock, Gray, Grayson, Grimes, Guadalupe, Hale, Hall, Hamilton, Hansford, Hartley, Haskell, Hays, Hemphill, Hill, Hockley, Hood, Houston, Howard, Hutchinson, Irion, Johnson, Jones, Kent, Kimble, King, Knox, Lamb, Lampasas, Lee, Leon, Limestone, Lipscomb, Llano, Loving, Lubbock, Lynn, Madison, Martin, Mason, McCulloch, McLennan, Menard, Midland, Milam, Mills, Mitchell, Moore, Motley, Navarro, Nolan, Ochiltree, Oldham, Parmer, Pecos, Potter, Randall, Reagan, Reeves, Roberts, Robertson, Rockwall, Runnels, San Saba, Schleicher, Scurry, Shackelford, Sherman, Somervell, Stephens, Sterling, Stonewall, Sutton, Swisher, Tarrant, Taylor, Terry, Throckmorton, Tom Green, Travis, Upton, Walker, Waller, Ward, Washington, Wheeler, Williamson, Winkler and Yoakum counties.

2. ADMITTING HOSPITALS

Following Figure 1 is a listing of the names and addresses of the admitting hospitals in the service area.

Figure 1



Scott and White Health Plan Commercial Service Area

ADMINISTRATIVE OFFICES

SCOTT AND WHITE HEALTH PLAN
TEMPLE OFFICE
1206 West Campus Dr.
Temple, Texas 76502

ADMITTING HOSPITALS

HENDRICK MEDICAL CENTER 1900 Pine St. Abilene, TX 79601	METHODIST HOSPITAL FOR SURGERY 1701 Dallas Pkwy Addison, TX 75001	BAPTIST ST. ANTHONY HEALTH SYSTEM 1600 Wallace Amarillo, TX 79105
PHYSICIANS SURGICAL HOSPITAL 6819 Plum Creek Dr. Amarillo, TX 79124	BAYLOR ORTHOPEDIC & SPINE HOSPITAL AT ARLINGTON 707 Highlander Blvd Arlington, TX 76015	BAYLOR SCOTT & WHITE EMERGENCY HOSPITAL 26791 Highway 380 East Aubrey, TX 76227
BAYLOR SCOTT & WHITE MEDICAL CENTER–AUSTIN 5245 W. Highway 290 Austin, TX 78735	THE HOSPITAL AT WESTLAKE MEDICAL CENTER 5656 Bee Caves Road, M302 Austin, TX 78746	BALLINGER MEMORIAL HOSPITAL 608 Avenue B Ballinger, TX 76821
REAGAN MEMORIAL HOSPITAL 1300 N. Main St. Big Lake, TX 76932	HEART OF TEXAS MEMORIAL HOSPITAL 2008 Nine Road Brady, TX 76825	BAYLOR SCOTT & WHITE MEDICAL CENTER–BRENHAM 700 Medical Parkway Brenham, TX 77833
VALLEY BAPTIST MEDICAL CENTER – BROWNSVILLE 1040 West Jefferson Brownsville, TX 78520	BAYLOR SCOTT & WHITE MEDICAL CENTER–BUDA 5330 Overpass Rd Buda, TX 78610	BAYLOR SCOTT & WHITE EMERGENCY HOSPITAL BURLESON 12500 South Freeway, Suite 100 Burleson, TX 76028
GOODALL-WITCHER HOSPITAL 101 Posey Ave. Clifton, TX 76634	COLEMAN COUNTY MEDICAL CENTER 310 South Pecos Coleman, TX 76834	BAYLOR SCOTT & WHITE MEDICAL CENTER–COLLEGE STATION 700 Scott & White Drive College Station, TX 77845
BAYLOR SCOTT AND WHITE EMERGENCY HOSPITAL COLLEYVILLE 5500 Colleyville Blvd Colleyville, TX 76034	BAYLOR MEDICAL CENTER AT UPTOWN 2727 East Lemmon Avenue Dallas, TX 75204	BAYLOR RESEARCH INSTITUTE 3310 Live Oak Street, Suite 501 Dallas, TX 75204
BAYLOR SCOTT AND WHITE HEART AND VASCULAR HOSPITAL-DALLAS 621 Hall Street Dallas, TX 75246	BAYLOR T BOONE PICKENS CANCER HOSPITAL 3410 Worth Street Dallas, TX 75246	BAYLOR UNIVERSITY MEDICAL CENTER 3500 Gaston Avenue Dallas, TX 75246
CHILDREN'S MEDICAL CENTER-DALLAS 2222 Medical District Drive Dallas, TX 75235	CHILDREN'S MEDICAL CENTER-DALLAS 1935 Medical District Drive Dallas, TX 75235	CITY HOSPITAL AT WHITE ROCK 9440 Poppy Drive Dallas, TX 75218

METHODIST CHARLTON MEDICAL CENTER 3500 Wheatland Rd Dallas, TX 75237	METHODIST DALLAS MEDICAL CENTER 1441 North Beckley Ave. Dallas, TX 75203	NORTH CENTRAL SURGICAL CENTER 9301 North Central Expressway, Suite 100 Dallas, TX 75231
OUR CHILDREN'S HOUSE 1340 Empire Central Drive Dallas, TX 75247	TEXAS SCOTTISH RITE HOSPITAL FOR CHILDREN 2222 Welborn Street Dallas, TX 75219	BAYLOR SCOTT & WHITE THE HEART HOSPITAL-DENTON 2801 South Mayhill Road Denton, TX 76208
EASTLAND MEMORIAL HOSPITAL DISTRICT 304 South Daugherty Street Eastland, TX 76448	CONCHO COUNTY HOSPITAL 614 Eaker Street Eden, TX 76837	SIERRA MEDICAL CENTER 1625 Medical Center Dr. El Paso, TX 79902
THE HOSPITALS OF PROVIDENCE- EAST CAMPUS 3280 Joe Battle Blvd. El Paso, TX 79938	THE HOSPITALS OF PROVIDENCE EMERGENCY ROOM MONTWOOD 1890 George Dieter Drive El Paso, TX 79936	THE HOSPITALS OF PROVIDENCE TRANSMOUNTAIN CAMPUS 2600 Transmountain Road El Paso, TX 79911
SCHLEICHER COUNTY MEDICAL CENTER 102 N US Hwy 277 Eldorado, TX 76936	FREESTONE MEDICAL CENTER 125 Newman Street Fairfield, TX 75840	BAYLOR SCOTT & WHITE ALL SAINTS MEDICAL CENTER FORT WORTH 1400 8th Avenue Fort Worth, TX 76104
BAYLOR SCOTT & WHITE HEART AND VASCULAR HOSPITAL-FORT WORTH 1400 Eighth Avenue Fort Worth, TX 76104	BAYLOR SURGICAL HOSPITAL AT FORT WORTH 1800 Park Place Avenue Fort Worth, TX 76110	COOK CHILDREN'S MEDICAL CENTER 801 7th Avenue Fort Worth, TX 76104
BAYLOR SCOTT & WHITE MEDICAL CENTER - CENTENNIAL 12505 Lebanon Road Frisco, TX 75035	BAYLOR SCOTT & WHITE MEDICAL CENTER AT FRISCO 5601 Warren Parkway Frisco, TX 75034	TEXAS SCOTTISH RITE HOSPITAL FOR CHILDREN 5700 Dallas Parkway Frisco, TX 75034
TEXAS SCOTTISH RITE HOSPITAL FOR CHILDREN 3800 Gaylord Parkway, Suite 850 Frisco, TX 75034	CORYELL MEMORIAL HOSPITAL 1507 West Main Street Gatesville, TX 76528	GLEN ROSE MEDICAL CENTER 1021 Holden Street Glen Rose, TX 76043
BAYLOR SCOTT & WHITE EMERGENCY HOSPITAL GRAND PRAIRIE 3095 Kingswood Blvd., Suite 100 Grand Prairie, TX 75052	BAYLOR SCOTT & WHITE MEDICAL CENTER - GRAPEVINE 1650 West College Grapevine, TX 76051	LIMESTONE MEDICAL CENTER 701 McClintic Drive Groesbeck, TX 76642
HAMILTON GENERAL HOSPITAL 400 North Brown Hamilton, TX 76531	SETON MEDICAL CENTER HARKER HEIGHTS 850 W Central TX Expressway Harker Heights, TX 76548	VALLEY BAPTIST MEDICAL CENTER-HARLINGEN 2101 Pease Street Harlingen, TX 78550
VALLEY BAPTIST MEDICAL CENTER-HARLINGEN 1717 Treasure Hills Blvd Harlingen, TX 78550	HILL REGIONAL HOSPITAL 101 Circle Drive Hillsboro, TX 76645	THE HOSPITALS OF PROVIDENCE HORIZON CITY CAMPUS 13600 Horizon Blvd, Suite 100 Horizon City, TX 79928
TEXAS CHILDREN'S HOSPITAL I-10 and Barker Cypress, 18200 Katy Fwy. Houston, TX 77094	TEXAS CHILDREN'S HOSPITAL 6621 Fannin Street Houston, TX 77030	HUNTSVILLE MEMORIAL HOSPITAL 110 Memorial Hospital Drive Huntsville, TX 77340
BAYLOR SCOTT & WHITE MEDICAL CENTER-IRVING 1901 North MacArthur Blvd Irving, TX 75061	BAYLOR SURGICAL HOSPITAL AT LAS COLINAS 400 West I-635, Suite 101 Irving, TX 75063	KIMBLE HOSPITAL 349 Reid Road Junction, TX 76849

BAYLOR SCOTT & WHITE EMERGENCY HOSPITAL KELLER 620 South Main Street, Suite 100 Keller, TX 76248	ADVENTHEALTH CENTRAL TEXAS 2201 South Clear Creek Road Killeen, TX 76549	ST. MARK'S MEDICAL CENTER One St. Mark's Place La Grange, TX 78945
BAYLOR SCOTT & WHITE MEDICAL CENTER –LAKEWAY 100 Medical Parkway Lakeway, TX 78738	ADVENTHEALTH ROLLINS BROOK 608 North Key Avenue Lampasas, TX 76550	CRESCENT MEDICAL CENTER LANCASTER 2600 W Pleasant Run Lancaster, TX 75146
COVENANT HOSPITAL LEVELLAND 1900 South College Avenue Levelland, TX 79336	BAYLOR SCOTT & WHITE MEDICAL CENTER –LLANO 200 West Ollie Street Llano, TX 78643	COVENANT CHILDREN'S HOSPITAL 4015 22ND Pl Lubbock, TX 79410
COVENANT MEDICAL CENTER 3615 19TH Street Lubbock, TX 79410	GRACE MEDICAL CENTER 2412 50th Street Lubbock, TX 79412	BAYLOR SCOTT & WHITE EMERGENCY HOSPITAL MANSFIELD 1776 North US 287, Suite 100 Mansfield, TX 76063
METHODIST MANSFIELD MEDICAL CENTER 2700 East Broad St. Mansfield, TX 76063	BAYLOR SCOTT & WHITE MEDICAL CENTER –MARBLE FALLS 810 West Hwy 71 Marble Falls, TX 78654	FALLS COMMUNITY HOSPITAL 322 Coleman Street Marlin, TX 76661
BAYLOR SCOTT & WHITE HEART AND VASCULAR HOSPITAL-MCKINNEY 5268 West University Drive McKinney, TX 75071	BAYLOR SCOTT & WHITE MEDICAL CENTER-MCKINNEY 5252 West University Drive McKinney, TX 75071	METHODIST MCKINNEY HOSPITAL 8000 W Eldorado Pkwy McKinney, TX 75070
RESOLUTE HEALTH HOSPITAL 555 Creekside Crossing New Braunfels, TX 78130	BAYLOR SCOTT & WHITE MEDICAL CENTER -PFLUGERVILLE 2600 E. Pflugerville Parkway, Suite 100 Pflugerville, TX 78660	COVENANT HOSPITAL PLAINVIEW 2601 Dimmitt Road Plainview, TX 79072
COVENANT HOSPITAL PLAINVIEW-SWING BED UNIT 2601 Dimmitt Road Plainview, TX 79072	BAYLOR SCOTT & WHITE MEDICAL CENTER-PLANO 4700 Alliance Blvd Plano, TX 75093	BAYLOR SCOTT & WHITE THE HEART HOSPITAL-PLANO 1100 Allied Drive Plano, TX 75093
BAYLOR SCOTT AND WHITE EMERGENCY HOSPITAL MURPHY 511 FM 544, Suite 100 Plano, TX 75094	CHILDREN'S MEDICAL CENTER-DALLAS 7000 N. Preston Road, Suite 100 Plano, TX 75024	CHILDREN'S MEDICAL CENTER-PLANO 7601 Preston Road Plano, TX 75024
TEXAS SCOTTISH RITE HOSPITAL FOR CHILDREN 7000 West Plano Parkway, Suite 110 Plano, TX 75093	METHODIST RICHARDSON MEDICAL CENTER 2831 E President George Bush Hwy. Richardson, TX 75082	BAYLOR SCOTT & WHITE EMERGENCY HOSPITAL ROCKWALL 1975 Alpha, Suite 100 Rockwall, TX 75087
CHILDREN'S MEDICAL CENTER-DALLAS 1005 West Ralph Hall Parkway, Suite 233 Rockwall, TX 75032	BAYLOR SCOTT & WHITE MEDICAL CENTER –ROUND ROCK 300 University Blvd Round Rock, TX 78665	BAYLOR SCOTT & WHITE MEDICAL CENTER –LAKE POINTE 6800 Scenic Drive Rowlett, TX 75088
SHANNON MEDICAL CENTER 120 East Harris San Angelo, TX 76903	BAPTIST MEDICAL CENTER 111 Dallas St. San Antonio, TX 78205	FOUNDATION SURGICAL HOSPITAL OF SAN ANTONIO 9522 Huebner Road San Antonio, TX 78240

MISSION TRAIL BAPTIST HOSPITAL 3333 Research Plaza San Antonio, TX 78235	NORTH CENTRAL BAPTIST HOSPITAL 520 Madison Oak San Antonio, TX 78258	NORTH EAST BAPTIST HOSPITAL 8811 Village San Antonio, TX 78217
SOUTH TEXAS SPINE & SURGICAL HOSPITAL 18600 North Hardy Oak Blvd. San Antonio, Texas 78258	ST LUKE'S BAPTIST HOSPITAL 7930 Floyd Curl San Antonio, TX 78229	UNIVERSITY HEALTH SYSTEM 4502 Medical Drive, 5th Floor San Antonio, TX 78229
CENTRAL TEXAS MEDICAL CENTER 1340 Wonder World Dr, Bldg 2, Suite 2100 San Marcos, TX 78666	CENTRAL TEXAS MEDICAL CENTER 1301 Wonder World Drive San Marcos, TX 78666	BAYLOR SCOTT & WHITE SURGICAL HOSPITAL AT SHERMAN 3601 N. Calais St. Sherman, TX 75090
WILSON N JONES REGIONAL MEDICAL CENTER 500 N. Highland Avenue Sherman, TX 75092	LILLIAN M HUDSPETH MEMORIAL HOSPITAL 308 Hudspeth Street Sonora, TX 76950	METHODIST SOUTHLAKE HOSPITAL 421 E State Hwy. 114 Southlake, TX 76092
BAYLOR SCOTT & WHITE MEDICAL CENTER-SUNNYVALE 231 South Collins Road Sunnyvale, TX 75182	BAYLOR SCOTT & WHITE MEDICAL CENTER-TAYLOR 305 Mallard Lane Taylor, TX 76574	BAYLOR SCOTT & WHITE McLANE CHILDREN'S MEDICAL CENTER 1901 SW HK Dodgen Loop Temple, TX 76502
BAYLOR SCOTT & WHITE MEDICAL CENTER-TEMPLE 2401 South 31st Street Temple, TX 76508	BAYLOR SCOTT & WHITE MEDICAL CENTER AT TROPHY CLUB 2850 East State Highway 114 Trophy Club, TX 76262	BAYLOR SCOTT & WHITE TEXAS SPINE & JOINT HOSPITAL 1814 Roseland Blvd Tyler, TX 75701
BAYLOR SCOTT & WHITE MEDICAL CENTER-HILLCREST 100 Hillcrest Medical Blvd Waco, TX 76712	PROVIDENCE HEALTH CENTER 6901 Medical Parkway Waco, TX 76712	BAYLOR SCOTT & WHITE MEDICAL CENTER AT WAXAHACHIE 2400 North I-35E Waxahachie, TX 75165
NORTH RUNNELS HOSPITAL 7821 State Highway 153 Winters, TX 79567		

Medical Schedule of Benefits

Point of Service
BSW Plus HMO Network
PS21_1500_04
LC1SA5E2

This Consumer Choice of Benefits 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 insurance agent to discover which state-mandated health benefits are excluded in the Evidence of Coverage. The following is a summary of the copayment amounts members must pay when receiving the covered benefits listed below. Refer to the Evidence of Coverage for a detailed explanation of covered and non-covered benefits. If you have any questions or would like more information about the Issuer's medical benefits go to swhp.org or contact Customer Service, Monday through Friday, 7:00 a.m. – 7:00 p.m. CT, at 800-321-7947, TTY Line 711.

The Issuer does not discriminate based on race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

Plan Year	Calendar Year	
	HMO Participating Provider	**POS Non-Participating Provider**
Medical Deductible	$1,500 per Member $3,000 per Family	$3,000 per Member $6,000 per Family
Maximum Out of Pocket *Includes Medical Deductible, Pharmacy Deductible, Copayments and Coinsurance.*	$5,000 per Member $10,000 per Family	$15,000 per Member $30,000 per Family
Annual Maximum	Unlimited	
Preauthorization Penalty for Benefits Requiring Preauthorization *For preauthorization requirements and penalties see swhp.org/ind-fam/tools-resources*		Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of $500 or 50% reduction in benefits.
Member may be balance billed and will be responsible for POS Non-Participating Provider balance billing charges over the allowed amount. The balance billing charge will not be applied toward the maximum out of pocket.		

Medical Benefits	*HMO Participating Provider Member Copayment*	*POS Non-Participating Provider Member Copayment*
Adult PCP Office Visit Includes medical services that are not preventive care services. *Office visit charge applies when seen by a physician and/or a licensed clinician under the supervision of the physician.*	No charge for the first non-preventive sick visit in the plan year. $25 copayment per visit for subsequent visits in that plan year	50% after deductible
Pediatric PCP Office Visit For a covered dependent through the age of 18. *Office visit charge applies when seen by a physician and/or a licensed clinician under the supervision of the physician.*	No charge	50% after deductible

Medical Benefits	*HMO Participating Provider Member Copayment*	*POS Non-Participating Provider Member Copayment*
Specialist Physician Office Visit Includes medical services that are not preventive care services. *Office visit charge applies when seen by a physician and/or a licensed clinician under the supervision of the physician.*	$50 copayment per visit	50% after deductible
Annual Routine Eye Exam* For a covered dependent through the age of 18	Not Covered	Not Covered
Preventive Care Routine Annual Physical Exam, Immunizations, Well-Baby Care, Well-Child Care, Cancer Screening Mammography, Bone Mass Measurement for Osteoporosis, Prostate Cancer Screening Exam, Colorectal Cancer Screening Exam, Ovarian and Cervical Cancer Screening Exam, Prenatal Visits, Tubal Ligation, Cardiovascular Disease Screening*, any evidence−based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.	No charge	50% after deductible (No charge for child immunizations through the 6th birthday)
Allergy Testing, Serum and Injections	20% after deductible	50% after deductible
Diagnostic Test Routine lab, EKG, and X-rays.	No charge; deductible does not apply	50% after deductible
Imaging and Radiology (Including Facility and Physician charges) Angiography, CT Scans, MRIs, Myelography, PET Scans, Stress Tests.	20% of charges; deductible does not apply	50% after deductible
Outpatient Surgery Facility charges, Medical Injectables, Medical Supplies, Observation Unit, Surgical Procedures, Pain Management.	20% after deductible	50% after deductible
Outpatient Physician Services	20% after deductible	50% after deductible
Emergency Care Copayment waived if episode results in hospitalization for the same condition within 24 hours.	$500 copayment per visit, plus 20% of charges; deductible does not apply	$500 copayment per visit, plus 20% of charges; deductible does not apply
Ambulance Transportation Ground or Air.	$500 copayment per service, plus 20% of charges; deductible does not apply	$500 copayment per service, plus 20% of charges; deductible does not apply
Urgent Care	$50 copayment per visit	$50 copayment per visit
Inpatient Care Facility charges, Physician charges, Pre-admission Testing, Prescription Drugs, Specialty Pharmacy Drugs, Medical Injectables, Medical Supplies, Blood and Blood Products, Laboratory Tests and X-rays, Pain Management, Maternity Labor and Delivery, Surgical Procedures, Operating and Recovery Room, Neonatal Intensive Care Unit (NICU), Intensive Care Unit (ICU), Coronary Care Unit, Rehabilitation Facility, Mental Health Care, Serious Mental Illness, Chemical Dependency.	20% after deductible	50% after deductible
Skilled Nursing Facility*	20% after deductible	50% after deductible
Outpatient Mental Health Care, Serious Mental Illness and Chemical Dependency	$25 copayment per visit	50% after deductible
Maternity Care and Family Planning Postnatal Care, Family Planning (as medically necessary).	$25 copayment per visit	50% after deductible

Medical Benefits	*HMO Participating Provider Member Copayment*	*POS Non-Participating Provider Member Copayment*
Infertility (Diagnosis Only)	$50 copayment per visit	50% after deductible
Rehabilitation* Physical Therapy, Occupational Therapy, Speech Therapy.	$25 copayment per visit	50% after deductible
Habilitation* Physical Therapy, Occupational Therapy, Speech Therapy.	$25 copayment per visit	50% after deductible
Chiropractic Care*	$25 copayment per visit	50% after deductible
Home Health Care*	20% after deductible	50% after deductible
Hospice Care	No charge; deductible does not apply	50% after deductible
Durable Medical Equipment (DME) Orthotics, Prosthetics.	20% after deductible	50% after deductible
Diabetes Management Diabetes Self-Management Training, Diabetes Education, Diabetes Care Management.	$25 copayment per visit	50% after deductible
Diabetes Equipment and Supplies	Same as DME or pharmacy, as appropriate	50% after deductible
Nutritional Counseling	$25 copayment per visit	50% after deductible
Hearing Aids* and Cochlear Implants	20% after deductible	50% after deductible
Telehealth Service and Virtual Visits	No charge	50% after deductible
Other Telehealth Service and Telemedicine Medical Service	The amount of the deductible or copayment may not exceed the amount of the deductible or copayment required for a comparable medical service provided through a face-to-face consultation.	50% after deductible
Amino Acid Based Elemental Formulas	Same as DME or pharmacy as appropriate	50% after deductible
Other Medical Benefits Including, but not limited to Acquired Brain Injury, Autism Spectrum Disorder, Chemotherapy, Craniofacial Abnormalities, Limited Accidental Dental, Organ and Tissue Transplants, Phenylketonuria (PKU) or Heritable Metabolic Disease, Temporomandibular Joint Pain Dysfunction Syndrome (TMJ).	Depending upon location of service, benefits will be the same as those stated under each covered benefit category in this Schedule of Benefits	50% after deductible
All Other Covered Medical Benefits (not specified herein)	20% after deductible	50% after deductible

Covered Benefit Limitations*

Cardiovascular Disease Screening
Limited to once every 5 years

Chiropractic Care
Limited to 35 visits per plan year

Rehabilitation
Limited to 35 visits for rehabilitation services per plan year. Limit is combined for physical therapy, occupational therapy, and speech therapy

Habilitation
Limited to 35 visits for habilitation services per plan year. Limit is combined for physical therapy, occupational therapy, and speech therapy

Hearing Aids
Limited to one device per ear every 3 years. Limited to members through the age of 18.

Home Health Care
Limited to 60 visits per plan year

Skilled Nursing Facility
Limited to 25 days per plan year

Pharmacy Schedule of Benefits

Point of Service

LRX30008

LRXSGA21

This pharmacy rider is issued to you in connection with and amends your Evidence of Coverage. This rider is effective as of the date of your Evidence of Coverage. If you have any questions or would like more information about the Issuer's pharmacy benefits go to swhp.org or contact Customer Service, Monday through Friday, 7:00 a.m. – 7:00 p.m. CT, at 800-321-7947, TTY Line 711.

The Issuer does not discriminate based on race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

Plan Year	Calendar Year	
	HMO Participating Provider	***POS Non-Participating Provider***
Pharmacy Deductible	$0 per Member $0 per Family	$0 per Member $0 per Family
Maximum Out of Pocket *Includes Medical Deductible, Pharmacy Deductible, Copayments and Coinsurance.*	Integrated with Medical	Integrated with Medical
Annual Maximum	Unlimited	
Member may be balance billed and will be responsible for POS Non-Participating Provider balance billing charges over the allowed amount. The balance billing charge will not be applied toward the maximum out of pocket.		

Pharmacy Benefits	*Member Copayment*		
	HMO Participating Provider		**POS Non-Participating Provider**
	30-day Standard	***90-day Maintenance****	
ACA preventive drugs	$0 copayment per prescription	$0 copayment per prescription	50% after deductible
Tier 1 Preferred generic drugs	$8 copayment per prescription	$20 copayment per prescription	50% after deductible
Tier 2 Preferred brand name drugs	$35 copayment per prescription	$87.50 copayment per prescription	50% after deductible
Tier 3 Non-preferred generic drugs and non-preferred brand name drugs	$70 copayment per prescription	$175 copayment per prescription	50% after deductible
Specialty Tier 1 Specialty preferred generic drugs	$200 copayment per prescription	Not Covered	50% after deductible
Specialty Tier 2 Specialty preferred brand name drugs	$300 copayment per prescription	Not Covered	50% after deductible
Specialty Tier 3 Specialty non-preferred brand name drugs	$400 copayment per prescription	Not Covered	50% after deductible
Preferred diabetic test strips for blood glucose monitors	$8 copayment per prescription	$20 copayment per prescription	50% after deductible
Non-preferred diabetic test strips for blood glucose monitors	$35 copayment per prescription	$87.50 copayment per prescription	50% after deductible
*Maintenance drugs are allowed up to a 90-day supply if obtained through a Baylor Scott & White Pharmacy or participating pharmacy. Mail Order: Available for a 1- to 90-day supply. Non-maintenance drugs obtained through mail order are limited to a 30-day supply maximum. Some specialty drugs may require preauthorization. 30-day supply only.			