Scott&White CARE PLANS

LARGE EMPLOYER HEALTH CARE EVIDENCE OF COVERAGE

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

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

Corporate Office
[1206 West Campus Drive
Temple, Texas 76502
(254) 298-3000
(800) 321-7947]

ERS
Employees Retirement System of Texas

ERS CS 9/2020

CERTIFICATE OF COVERAGE

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

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

Important Notices:

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

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

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

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

_____

[Jeffrey C. Ingrum]
President and CEO
Scott & White Care Plans
[1206 West Campus Drive
Temple, Texas 76502]

Summary of HMO Benefits for Plan Year 2021[1, 10]

Benefit Description	Member's Cost Share PY 2020
Plan year out-of-pocket coinsurance maximum per person (Not mutually exclusive from other out of pocket limits[11])	$2,000
Overall plan year out-of-pocket maximum per person, including coinsurance and copayments (Not mutually exclusive from other out pocket limts[11])	$6,750
Overall plan year out-of-pocket maximum per family, including coinsurance and copayments (Not mutually exclusive from other out of pocket limits[11])	$13,500
Lifetime Maximum	None
Physicians and Lab Services	
*Physician office visit, Primary Care Physician (if applicable)	$25
*Specialist office visit	$40
*Routine preventive care- One per calendar year or as directed by the primary care physician (if applicable) • Children and Well Baby periodic exams • Well Woman exam (to include Cervical Cancer Screening) • Men's Health Exam	No charge
Baylor Scott & White E-Visits	No charge
*Diagnostic x-rays, and lab tests	20%
Diagnostic mammography	No charge
High Tech Radiology (CT Scans, MRI, and Nuclear Medicine) Outpatient testing only	$100 copayment plus 20%
*Immunizations- For children and adults	No charge
*Vision, speech, and hearing screenings- For all enrolled Participants	20% without office visits, $40 plus 20% with office visit
*Colorectal Cancer Screening- (zero cost sharing for certain preventive services under the Affordable Care Act)	No charge
*Exam for Detection and Prevention of Osteoporosis- (zero cost sharing for certain preventive services under the Affordable Care Act)	No charge
*Cervical Cancer Screening- (zero cost sharing for certain preventive services under the Affordable Care Act)	No charge
*Tubal Ligation- (zero cost sharing for certain preventive services under the Affordable Care Act)	No charge
Speech and hearing testing- For all enrolled Participants	20% without office visit $40 plus 20% with office visit
Speech therapy and rehabilitative therapy, including physical and occupational therapy- Covered as any other illness and not subject to any maximum	20% without office visit $40 plus 20% with office visit
Manipulative Therapy/Chiropractic Services	20% without office visit. $40 plus 20% with office visit. Maximum number of Manipulative Therapy 35 per plan year
Allergy testing	20%
Allergy serum	20%
Allergy serum administration- When allergy shot is administered **without** an office visit	20%
Routine eye exam- One per year[2]	$40
Office surgery and procedures (all office surgeries, excluding vasectomies and tubal ligations)	20%

*Under the Affordable Care Act, preventive health services are paid at 100% (i.e. at no cost to the member) dependent upon physician billing and diagnosis. In some cases, you will be responsible for payment of some services.

Benefit Description	Member's Cost Share PY 2020
*Maternity care (physician services only)- Pre- and post-natal care, and network obstetrician delivery charges (including delivery by C-section)- see "**Hospital Services- for inpatient charges**" (Does not include complications of pregnancy, which are treated the same as any other illness)	Pre-natal office visit and obstetrician delivery: No charge Post-natal office visit: $25 copayment primary care physician, $40 copayment specialist
Family Planning	$40
Vasectomy	20%
Infertility benefits[3]	50%
Hospital Services [9]	
Inpatient hospital- Semi-private room and board or intensive care units; other inpatient charges, including medically necessary surgical procedures. Includes orthognathic surgery. Personal items not covered are as follows: guest trays, cots, telephone, maternity kits, and paternity kits	$150 per day copayment per admission up to $750 copayment max per admission, $2250 copayment per person per year plus 20%
Outpatient day surgery	$100 copayment plus 20%
Blood and blood products- Inpatient and outpatient	20%
Outpatient facilities, including pre-admission testing and/or treatment room	20%
Emergency care- In area and out-of-area covered at listed copayment. If hospitalized, copayment is applied to hospital confinement	$150 copayment plus 20%
Urgent care- Includes physician's after-hours care or at an Urgent Care Facility	$50 copayment plus 20%
Extended Care Services (Based on medical necessity)	
Skilled nursing facility (based on medical necessity)-	20%
Hospice care- Inpatient and outpatient (based on medical necessity)	20%
Home health	20%
Private duty nursing	20%
Other Medical Services	
Hearing Aids (repairs not covered)- for Covered Members over age 18	Plan pays $1,000 per ear every 3 years
Hearing Aid batteries- Not subject to any maximum amounts	20%
Hearing Aids and Cochlear Implants – for Covered Members age 18 and under	20%. Benefit limited to one per ear every 3 years
Accidental Dental[4]- Restoration or replacement of dental work that was in place at the time of the injury, including but not limited to crowns, veneers, bridges, and implants, occurring while covered under the plan for services provided within 24 months of the date of the accident. Certain oral surgeries are covered.	20%
Durable Medical Equipment[5,6]- Includes medically necessary purchase and/or rental. Benefits for rental are limited to, and will not exceed the purchase price of the equipment. (Repairs are covered if not due to neglect or abuse). This benefit also includes diabetic supplies other than insulin, diabetic oral agent(s), and syringes as specified in Section 1358.051(2), Tex. Ins. Code	20%

*Under the Affordable Care Act, preventive health services are paid at 100% (i.e. at no cost to the member) dependent upon physician billing and diagnosis. In some cases, you will be responsible for payment of some services.

Benefit Description	Member's Cost Share PY 2020
Prostheses- Artificial devices, surgical or non-surgical which replace body parts, including arms, legs, eyes and cochlear implants are covered. Replacements and repairs are covered as required by medical necessity. Prosthetic devices, orthotic devises, and professional services related to the fitting and use of these devices are included, if services are pre-authorized and provided by a contracted provider.	20%
Organ Transplants- Covered as any other illness for kidney, cornea, liver, heart, heart-lung, lung, pancreatic-kidney, bone marrow, and other organ transplants that the HMO determines to be not experimental and/or not investigational according to the current medical plan guidelines. Donor expenses are covered. Artificial organs (e.g. heart) not covered.	$150 per day copayment per admission, up to $750 copayment max. per admission, $2250 copayment max. per person per year plus 20%
Ambulance- Professional local ground or air ambulance transportation services to the nearest hospital, appropriately equipped and staffed for the treatment of the participant's condition	20%
Behavioral Health Care Benefits	
Inpatient mental health	$150 per day copayment per admission, up to $750 copayment max. per admission, $2250 copayment max. per person per year plus 20%
Inpatient serious mental illness- Covered as any other illness[7]	$150 per day copayment per admission, up to $750 copayment max. per admission, $2250 copayment max. per person per year plus 20%
Inpatient chemical dependency- Covered as any other illness (based on medical necessity)	$150 per day copayment per admission, up to $750 copayment max. per admission, $2250 copayment max. per person per year plus 20%
Outpatient mental health therapy	$25
Outpatient serious mental illness therapy- Covered as any other illness[7]	$25
Outpatient chemical dependency therapy- Same as any other illness and not subject to any maximums	$25

*Under the Affordable Care Act, preventive health services are paid at 100% (i.e. at no cost to the member) dependent upon physician billing and diagnosis. In some cases, you will be responsible for payment of some services.

Benefit Description	Member's Cost Share PY 2020
Prescription Drugs[8]	
Individual Plan Year Deductible	$50
Participating Retail Pharmacy- Tier 1, Tier 2 & Tier 3	
Up to 30-day supply per prescription or refill of **Non-Maintenance** medication	$10/$35/$60
Up to 30-day supply per prescription or refill for **Maintenance** medication	$10/$45/$75
Infertility drugs	50%
Up to a 30-day supply of insulin for one copayment	$10/$35/$60
Up to a 30-day supply of each diabetic oral agent for one copayment	$10/$35/$60
The supply of necessary disposable syringes for the insulin supply for one copayment	$35
Diabetic supplies other than insulin, diabetic oral agent(s), and syringes as specified in Section 1358.051(2), Tex. Ins. Code up to a 30 day supply	20%
Specialty Tier 1, Tier 2, and Tier 3: up to a 30 day supply	$10/$35/$60
Participating Maintenance or Mail Order Pharmacy- Tier 1, Tier 2 & Tier 3	
Up to a 90-day supply per prescription or refill for one maintenance copayment	$30/$105/$180
Up to a 90-day supply of insulin for one mail order copayment	$30/$105/$180
Up to a 90-day supply of each diabetic oral agent for one maintenance copayment	$30/$105/$180
The supply of necessary disposable syringes for the insulin supply for one maintenance copayment	$105
Diabetic supplies other than insulin, diabetic oral agent(s), and syringes as specified in Section 1358.051(2), Tex. Ins. Code up to a 90 day supply	20%

*Under the Affordable Care Act, preventive health services are paid at 100% (i.e. at no cost to the member) dependent upon physician billing and diagnosis. In some cases, you will be responsible for payment of some services.

Pre-existing conditions are covered as of 12:01 a.m. September 1, 2012 and lifetime benefits maximums are unlimited.

Footnotes:

1. This Summary of HMO Benefits reflects the current benefit plan structure and is subject to change as required by state and federal laws, rules and regulations or if ERS deems it to be in the best interest of ERS, the Texas Employees Group Benefits Program (GBP), its Participants, and the state of Texas. All state mandated services shall be provided for in the HMO's Evidence of Coverage whether included in or omitted from this Summary of Benefits. The Summary of HMO Benefits itemizes the services required by Chapter 1551, TIC, generally, by the TIC and the rules of TDI. The Summary of HMO Benefits is not intended to identify all services required by the TIC, TDI; however, the followed benefits should be listed.
    a. Well-child care from birth per TIC section 1271.154;
    b. Screening test for hearing loss for newborns per TIC section 1367.103;
    c. Tests for detection of prostate cancer per TIC section 1362.003;
    d. Tests for detection of colorectal cancer per TIC section 1363.003;
    e. Coverage for hospital stays following performance of a mastectomy and certain related procedures per TIC section 1357.054;
    f. Coverage for reconstructive surgery after mastectomy per TIC section 1357.004;
    g. Benefits for detection and prevention of osteoporosis per TIC section 1361.003;
    h. Coverage for abnormalities per TIC section 1367.151-153;
    i. Telemedicine per TIC section 1451.004;
    j. Anesthesia for dental procedures in a hospital setting per TIC Chapter 1360;
    k. Coverage for certain benefits related to brain injury per TIC Chapter 1352;
    l. Coverage for prescription contraceptive drugs and devices and related services per TIC section 1369.104;
    m. Coverage for inpatient stay following childbirth per TIC section 1366.055;
    n. Coverage for special dietary formulas for individuals with Phenylketonuria (PKU) or other heritable disease per TIC section 1359.003;
    o. Coverage for certain amino acid-based elemental formulas per TIC section 1377.051;
    p. Coverage for off-label drug use per TIC Chapter 1369;
    q. Coverage for fibrocystic breast conditions per TIC section 544.201-204;
    r. Eligibility for benefits for Alzheimer's disease per TIC Chapter 1354;
    s. Coverage for cervical cancer per TIC Chapter 1370;

t. Coverage for certain tests for early detection of cardiovascular disease per TIC section 1376.003;
u. Coverage for routing patient care costs for enrollees participating in certain clinical trials per TIC section 1379.051; and
v. Coverage for autism spectrum disorder from date from date of diagnosis, only if the diagnosis was in place prior to the child's 10th birthday per TIC section 1355.015. Applied Behavior Analysis is limited to $36,000 annually after the child's 10th birthday.
w. Coverage for hearing aids and cochlear implants for dependents age 18 and under per TIC section 1367.253.
x. Coverage for diagnostic mammography per TIC Chapter 1356

2. Routine eye exam means an eye exam by a Doctor of Ophthalmology or a Doctor of Optometry which, when within the scope of their license, includes such services as:
   - External examination of the eye and its structure;
   - Determination of refractive status; and
   - Glaucoma screening test.

It does not include a contact lens exam, prescription or fittings of contact lenses or eyeglasses, and the cost of the contact lenses or eyeglasses.

3. Infertility benefits do not include sterilization reversal, transsexual surgery, gender reassignment, intra-fallopian transfer and related services, artificial insemination, or in-vitro fertilization. Also excluded from coverage are any services or supplies used in any procedures performed in preparation for or immediately after any of the above referenced excluded procedures. Pharmaceuticals are covered at 50% copayment.

4. Certain oral surgeries mean maxillofacial surgical procedures limited to:
   - Excision of neoplasm, including benign, malignant and premalignant lesions, tumors, and nonodontogenic cysts;
   - Incision and drainage of cellulitis;
   - Surgical procedures involving accessory sinuses, salivary glands and ducts;
   - Coverage for temporomandibular joint (TMJ) shall be in compliance with Chapter 1360, TIC. Excludes oral appliances and devices used to treat TMJ pain disorders or dysfunction of the joint and related structures, such as the jaw, jaw muscles, and nerves.

5. The diabetes benefit is as listed in Section 1358.051 of the TIC and includes benefits for diabetes equipment, diabetes supplies, and diabetes self-management training programs as follows:
   Diabetic Equipment (20% Copayment)
   a. Blood glucose monitors, including monitors designed to be used by blind individual
   b. Insulin pumps and associated appurtenances
   c. Insulin infusion devices
   d. Podiatric appliances for the prevention of complications associated with diabetes

   Diabetic supplies:
   a. Insulin and insulin analogs (covered under pharmacy benefit)
   b. Syringes (covered under pharmacy benefit at the Tier 2 copayment)
   c. Prescriptive and nonprescriptive oral agents for controlling blood sugar levels (covered under pharmacy benefit)
   d. Glucagon emergency kits (covered under pharmacy benefit)
   e. Test strips for blood glucose monitors (20% payment)
   f. Visual reading and urine test strips (20% copayment)
   g. Lancets and lancet devices (20% copayment)
   h. Injection aids (20% copayment)
   i. Alcohol wipes (20% copayment)

   Diabetic self-management training programs (same as office visit copayment):
   a. Training provided after the initial diagnosis of diabetes in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies
   b. Additional training is provided after a diagnosed significant change in the member's symptoms or condition that requires changes in self-management regime.

c. The Food and Drug Administration approves periodic or episodic continuing education training as warranted by the development of new techniques and treatments for the treatment of diabetes.

6. ERS defines orthotics as pertaining to the feet; therefore, services or supplies for routine foot care, insoles, or shoe inserts of any type are not covered, except when prescribed for a diagnosis of or related to the treatment of diabetes or circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency. Orthotic devices, and the professional services relating to the fitting and use of those devices, are covered if the services are pre-authorized and provided by a contracted provider.

7. Restrictions on mental health benefits are not applicable to expenses incurred for the treatment of "serious mental illness" as defined in Section 1355.001, TIC. At a minimum, covered for autism spectrum disorder must be provided from the date of diagnosis, only if the diagnosis was in place prior to the child's 10th birthday as described in Section 1355.015, TIC. Applied Behavior Analysis is limited to $36,000 annually after the child's 10th birthday.

8. Pharmacy Benefits: ERS allows the use of a formulary provided it offers a broad spectrum of high quality drug therapies. Vitamins are not covered except those that require a prescription by law, have no non-prescription equivalent, and must be listed on the formulary.

9. Weight reduction programs, services, supplies, surgeries, or gym memberships are not covered, even if the Participant has medical conditions that might be helped by weight loss, or even if prescribed by a Physician.

10. **All Applicable Copayment and Deductible Resets**

10.a. Break in Coverage. The prescription drug deductible and the inpatient out-of-pocket maximum per person per plan year should be reset for a Participant designated as a new hire. This would include an employee who left state or higher education employment and experienced a break in health insurance coverage. This participant would be considered a new employee and the prescription deductible and the inpatient out-of-pocket maximum should be calculated the same as for a new employee.

10.b. COBRA/Dependent Coverage. Participants under COBRA and dependents who were previously covered but are not directly insured under the GBP shall not be requested to satisfy a new prescription deductible and inpatient out-of-pocket maximums as soon as their coverage becomes effective as a directly insured GBP Participant.

11. Not mutually exclusive for out-of-pocket maximums means that a Participant's total out-of-pocket maximum could contain a combination of coinsurance and/or copayments. (For example, a Participant could pay up to $6,750 in copayments alone if there was no coinsurance paid throughout the year. If a Participant met the $2,000 coinsurance out-of-pocket maximum, he/she would pay $4,750 in copayments, totaling $6,750 in overall out-of-pocket expenses.)

12. A copayment will not exceed 50 percent of the total cost of services provided. Copayments made by You in a calendar year will not total more than 200 percent of the total annual premium paid during the year, if You can demonstrate the amount that has been paid.

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 Dr. 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 Dr. 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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Health Care Evidence of Coverage

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.

1. DEFINITIONS

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

"**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 Health Plan that the Health Care Services furnished or proposed to be furnished to a member are not medically necessary as defined in this Evidence of Coverage or are experimental or investigational. The term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review.

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

"**Agreement**" means this Scott & White Care Plans evidence of coverage and all attachments and riders herein.

"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.

"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 regulator and organized basis.

"**Amino Acid-Based Elemental Formulas**" means complete nutrition formulas designed for individuals who have an immune response to allergens found in whole foods or formulas composed of whole proteins, fats, and/or carbohydrates. Amino Acid-Based Elemental Formulas are made from individual (single) nonallergenic amino acids (building block 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 Health Plan to reverse a previous decision.

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

"**Autism spectrum disorder**" means a neuro-biological disorder that includes that is characterized by social and communication difficulties and included the previously used diagnoses such as Autism, Asperger's syndrome, or Pervasive Development Disorder—Not Otherwise Specified.

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

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

1) affiliated with a hospital under a contractual agreement with an established system for patient referral; or
2) accredited as a chemical dependency treatment center by the Joint Commission on Accreditation of Health Care Organizations; or
3) licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or
4) licensed, certified, or approved as a chemical dependency treatment program or center by any other agency of the State of Texas having legal authority to so license, certify, or approve.

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

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

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

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

"**Complaint**" is any oral or written expression of dissatisfaction with any aspect of Health Plan's operation, including but not limited to dissatisfaction with plan administration; procedures related to review or appeal of an adverse determination; the denial, reduction, or termination of a service for reasons not related to medical necessity; the way a service is provided; or disenrollment decisions expressed by a Complainant. The term does not include a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information. The term does not include dissatisfaction or disagreement with an adverse determination.

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

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

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

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

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

"**Covered Dependent**" means a member of Your family who meets the eligibility provisions as specified in Section 2 of this Agreement.

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

"**Crisis Stabilization Unit**" means an appropriately-licensed and accredited 24-hour residential program that is usually short-term in nature that provides intensive supervision and highly structured activities to Members who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

"**Custodial Care**" means care designed principally to assist an individual in engaging in the activities of daily living, or services which constitute personal care, such as help in walking and getting in and out of bed; assistance in bathing, dressing, feeding and using the toilet; preparation of special diets; and supervision of medication, which can usually be self-administered and which does not entail or require the continuing attention of trained medical or other paramedical personnel. This included 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 home, or rest home or similar institution.

"Dependent" means the spouse of an employee or retiree or any unmarried child who is either under 26 years of age or disabled; provided that in the case of a disabled child 26 years of age or older, such child is dependent upon the employee or retiree for care or support.

- "Child" means the presence of a child as defined in the Act and whose eligibility requirements are stated in the Rules of the Board of Trustees of ERS.
- "Disabled" means any medically determinable physical or mental condition which prevents the child from engaging in self-sustaining employment; provided that satisfactory proof of such disability and dependency is submitted by the employee or retiree at such intervals as may be required by ERS, but not more frequently than annually.

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

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

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

"**Durable Medical Equipment**" means equipment that:

1) can withstand repeated use,
2) is primarily and customarily used to treat a medical condition,
3) generally is not useful to a person in the absence of a covered illness or injury, and
4) is appropriate for use in the home.

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

"**Effective Date**" means the date the coverage for You or Your Covered Dependent actually begins as specified in Section 2 of this Agreement.

"**Eligible Employee**" means an employee as specified in Section 2 of this Agreement.

"**Eligibility Date**" means the date the Member satisfies the definition, of either Eligible Employee or Dependent and is in a class eligible for coverage under the Health Plan as specified in Section 2 of this Agreement.

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

1) placing his or her health in serious jeopardy;
2) serious impairment to bodily functions;
3) serious dysfunction of any bodily organ or part;
4) serious disfigurement; or
5) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

"**Employer**" means Group.

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

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

1) 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;
2) Communications about the Treatment that have been provided to patients as part of an informed consent;
3) Communications about the procedure or Treatment that have been provided from the physician undertaking a study of the Treatment to the institution or government sponsoring the study;
4) Documents or records from the institutional review board of the hospital or institution undertaking a study of the Treatment;
5) Regulations and other communications and publications issued by the Food and Drug Administration and the Department of Health and Human Services; and
6) the Covered Person'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 their considered opinions or recommendations regarding publication of the manuscript. In addition, in order to qualify as peer reviewed medical literature, the manuscript must actually 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 use of terms of similar meaning shall be considered to be Experimental or Investigational.

"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].

"**Group**" means the Employees Retirement System of Texas (ERS).

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

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

"**Health Plan**" means Scott & White Care Plans.

"**Health Professionals**" means those health care professionals, licensed in the State of Texas (or, in the case of Health Care Services rendered on referral, licensed in the State in which that care is provided) who are associated with, or engaged by, directly or indirectly, Health Plan to provide Health Care Services in the Service Area. "Health Professionals" includes, but is not limited to, a Doctor of Dentistry, a Doctor of Podiatry, a Doctor of Optometry, a Doctor of Chiropractic, a Doctor in Psychology, Acupuncturists, a Licensed Audiologist, a Licensed Speech-Language Pathologist, a Licensed Hearing Aid Fitter and Dispenser, a Licensed Dietitian, a Licensed Master Social Worker-Advanced Clinical Practitioner, a Licensed Professional Counselor or a Licensed Marriage and Family Therapist, and other practitioners of the healing arts as specified in the Texas Insurance Code.

"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 drug infusion services provided when You or Your Covered Dependent is medically homebound, or when Your home is determined by the Medical Director to be the most appropriate setting for the drug infusion

"Homebound" means You are confined to Your place of residence due to an illness or injury that makes leaving the home medically contraindicated, or because the act of transport would be a serious risk to your life or health.

"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, and is either accredited by the Joint Commission on Accreditation of Health Care Organizations or is certified as a hospital provider under Medicare;
- Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians for compensation from its patients;

- Has organized departments of medicine and major surgery and maintains clinical records on all patients;
- Provides 24-hour nursing services by or under the supervision of registered nurses;
- Has in effect a Hospital Utilization Review Plan; 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 alcohol abuse or drug abuse, hospice, place for the provision of rehabilitative care, or a place for the treatment of pulmonary tuberculosis.

"**Independent Review Organization**" means an organization selected as provided under Section 4202.001 et seq. of the Texas Insurance Code.

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

"**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.

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

"**Medically Necessary**" means those Health Care Services which, in the opinion of the Medical Director are:

1. In accordance with the generally accepted standard of medical practices;

2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease, and;
3. Not primarily for the convenience of the patient or health care 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 the diagnosis or treatment of the patient's illness, injury, or disease.

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

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

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

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

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

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

"**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.

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

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

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

"**Out-of-Pocket Maximum**" means the total dollar amount of Out-of-Pocket Expenses which a Member will be required to pay for Covered Services during a Contract Year. Out-of-Pocket Maximum is determined for Covered Services and not for any medical services or treatments which are not Medically Necessary or not covered.

"**Out-of-Pocket Expenses**" means the portion of Covered Services for which a Member is required to pay at the time services and treatments are received. Out-of-Pocket Expenses apply to Covered Services only. Medical services and

treatments, which are not covered by this Plan or are not Medically Necessary, are not included in determining Out-of-Pocket Expenses.

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

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

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

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

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

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

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

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

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

"Post-Stabilizaton" means covered services that are:

- Related to an emergency medical condition;
- Provided after You are stabilized;
- Provided to maintain the stabilized condition, or certain circumstances, to improve or resolve the member's condition.

"**Premium**" means those periodic amounts required to be paid to Health Plan for or on behalf of a Subscriber and Covered Dependents, if any, as a condition of coverage under this Agreement.

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

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

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

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

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

"**Psychiatric Day Treatment Facility**" means a mental health facility, licensed by the State of Texas, which provides treatment for individuals suffering from acute, mental and nervous disorders in a structured psychiatric program utilizing individualized treatment plans with specific attainable goals and objectives appropriate both to the patient and the treatment modality of the program and that is clinically supervised by a doctor of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology. The facility at which the treatment is performed must have a contract with Health Plan to provide its services to Members, must treat its patients not more than eight hours in any twenty-four hour period, and must be accredited by the Program for Psychiatric Facilities, or its successor, of the Joint Commission on Accreditation of Health Care Organizations.

"**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.

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

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

"Research Institution" 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 that provides residential care and treatment for emotionally disturbed children and adolescents and that is accredited as a residential treatment center by the Council on Accreditation, the Joint Commission on Accreditation of Healthcare Organizations, or the American Association of Psychiatric Services for Children.

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

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

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

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

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

"**Skilled Nursing Facility**" means an institution (or a distinct part of an institution) appropriately licensed under state law which is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled or sick persons, and is not primarily for the treatment and care of mental diseases. Skilled nursing facility care is a level of care that requires the daily involvement of skilled nursing or rehabilitation staff and that, as a practical matter, can't be provided on an outpatient basis.

Examples of skilled nursing facility care include intravenous injections and physical therapy. The need for custodial care (for example, assistance with activities of daily living, like bathing and dressing) cannot, in itself, qualify you for coverage in a skilled nursing facility.

"Specialty Pharmacy Drug" means any prescription drug regardless of dosage form, identified as a Specialty Pharmacy Drug on the drug formulary, including orally administered anticancer medications, or a drug which requires at least one of the following in order to provide optimal patient outcomes:
1. Specialized procurement, handling, distribution, or is administered in a specialized fashion;
2. Complex benefit review to determine eligibility;
3. Complex medical management requiring close monitoring by a physician or clinically trained individual;
4. FDA mandated or evidence-based medical-guidelines determined comprehensive patient and/or physician education; or
5. Has any dosage from with a total cost greater than $1,000 per retail maximum day's supply.

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

"Subrogation" means recovery from a third party of medical costs that were originally paid by health plan.

"**Telehealth Services**" 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.

"**Telemedicine**" means a health care service delivered by 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.

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

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

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

"**Urgent Care**" means services provided for the immediate treatment of a medical condition that requires prompt medical attention but where a brief time lapse before receiving services will not endanger life or permanent health. Urgent conditions include, but are not limited to, minor sprains, fractures, pain, heat exhaustion, and breathing difficulties other than those of sudden onset and persistent severity. An individual patient's urgent condition may be determined emergent upon evaluation by a Participating Provider.

"**Usual, Customary and Reasonable Charges**" means the amount based on a percentage of available rates published by Centers for Medicare and Medicaid Services (CMS) or a benchmark developed by CMS for the same or similar services within a geographical area; and that have been negotiated with one or more Participating Providers in a geographical area for the same of similar services. The amount payable may be increased by a fixed percentage for certain services or facilities as agreed to by the Plan.

"**Waiting Period**" means the period of time specified by Group that must pass before a person becomes eligible for coverage under this Agreement.

"**You**" means the Subscriber.

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

2. ELIGIBILITY PROVISIONS

2.1 General Eligibility Provisions

2.1.1 All determinations and interpretations of membership eligibility and effective dates shall be made solely by the Employees Retirement System of Texas (ERS) in accordance with the Rules and Regulations of the Board of Trustees of the Employees Retirement System (Rules).

2.1.2 Employees and retirees of the state of Texas may enroll in an HMO, provided the HMO is approved by the Board of Trustees of the ERS.

2.2 Additional Provisions

2.2.1 It is the responsibility of ERS to inform Health Plan of all changes that affect Member eligibility, including but not limited to marriage of a Covered Dependent, death, address changes, etc.

3. PROVIDERS OTHER THAN HEALTH PLAN PROVIDERS

3.1 Health Plan Not Liable for Expenses of Providers Other Than Health Plan Providers

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

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

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

3.2 Contract Status of Providers

You should be aware of the contract status of the providers from whom you receive treatment, especially participating hospitals, as some facility-based physicians or other health care practitioners such as emergency room physicians, neo-natologists, anesthesiologists, pathologists, radiologists, and assistant surgeons may not be included in Health Plan's network and may balance bill for amounts above the Usual and Customary rate paid by Health Plan. In certain circumstances the Health Plan may authorize you to receive treatment from a non-network provider. If you receive a bill for an amount other than any applicable cost share requirements, from a facility based provider or a non-network provider who has been authorized, contact the Health Plan for assistance. In order to determine the contract status of providers you may consult the provider manual on the Health Plan website at ers.swhp.org, or contact a Health Plan Customer Service Representative at [1-800-321-7947].

Health Plan shall fully reimburse the non-contracting facility based providers, non-network emergency care providers, and non-network providers who were authorized for treatment according to the terms of the Health Care Agreement at the usual and customary or agreed upon rate, except for Copayments, and charges for non-covered services. In no event should You be balanced billed for Covered Services covered under this provision. If you are balanced billed please contact one our customer service representatives and we will remedy this issue with the Physician or Provider.

4. TERMINATION OF COVERAGE

4.1 Termination of Coverage for Members

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

1) except for continuation privileges, on the date on which You and/or Your Covered Dependents cease to be eligible for coverage in accordance with this Agreement; or
2) in the event of fraud or intentional misrepresentation by You or Your Covered Dependent, except as described under Incontestability, or fraud in the use of services or facilities, coverage may be terminated retroactively due to fraud or intentional misrepresentation upon thirty (30) days written notice from Health Plan; or
3) the date Group coverage terminates.

4.2 Termination or Non-Renewal of Coverage for Group

This Agreement shall continue in effect for one (1) year from the Effective Date. After that, this Agreement may be renewed annually. This Agreement may be terminated or non-renewed if Group fails to comply with the terms and conditions of the GBP Contractual Agreement.

4.3 Liability

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

5. CONTINUATION OF COVERAGE OPTION

5.1 Loss of Eligibility

Members who lose eligibility under this Agreement may be eligible to continue coverage under this Agreement according to state or federal law. Contact the Group for more information if eligibility for membership ends due to the occurrence of one of the following qualifying events:

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

5.2 COBRA Continuation of Coverage

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

5.3 Additional Continuation Provisions

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

1) Continuation of group coverage must be requested in writing to Your Employer or Contract Holder not later than the 60th day following the later of:
    a. the date the group coverage will terminate; or

b. the date the Member is given notice of the right of continuation by either the employer or the Contract Holder.

2) A Member electing continuation coverage must pay to the employer or Contract Holder on a monthly basis, in advance, the Premiums, plus 2% of the total health premium when due. The continuation premium must be made not later than the 45th day after the date 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 for continuation coverage, premium payment is considered timely if made on or before the 30th day after the date on which the payment is due.

3) Continuation coverage will continue until the earliest of:
   a. if Member is not eligible for continuation coverage under COBRA, 9 months after the date the election for continuation coverage is made;
   b. if Member is eligible for continuation coverage under COBRA, 6 additional months following any period of continuation under COBRA;
   c. the date on which failure to make payments would terminate coverage;
   d. the date on which the Member is covered for similar services and benefits by another health plan; or
   e. the date on which this Agreement terminates as to all Members.

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

6. REQUIRED PAYMENTS

6.1 Copayments

You are responsible for paying any applicable Copayment and/or for Health Care Services. Copayments are due at the time the service is rendered. Copayments are required payments from You.

A copayment will not exceed 50 percent of the total cost of services provided. Copayments made by You in a calendar year will not total more than 200 percent of the total annual premium paid during the year, if You can demonstrate the amount that has been paid.

6.2 Subrogation and Coordination of Benefits Payments

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

7. HEALTH CARE SERVICES

7.1 Health Care Services Within the Service Area

You and Your Covered Dependents shall be entitled to the Health Care Services specified in the Schedule of Benefits subject to the conditions and limitations stated in the Schedule of Benefits and this Agreement that are considered to be Medically Necessary by the Medical Director. Except for Emergency Care, approved referrals to non-Participating Providers, or covered medical services rendered to a Covered Dependent child under a Qualified Medical Support Order who is outside the Service Area, Health Care Services are available only through Participating Providers. Health Plan shall have no liability or obligation whatsoever for any service or benefit sought or received by You or Your Covered Dependents from any non-participating physician, hospital, extended care facility, or other person, institution or organization, unless prior approval for referral has been obtained from a Medical Director.

You are always responsible for initiating preauthorization, for services that require authorization. To initiate preauthorization, instruct Your Physician to call Us at the telephone number shown in the Contact Information section of this Policy prior to any admission or scheduled date of a proposed service requiring preauthorization.

If We determine that the admission or surgery is not Medically Necessary or Experimental or Investigational, You and Your Physician will be notified by telephone within one calendar day after You file Your request for preauthorization.

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

Your Physician may submit a request to renew an existing authorization at least 60 days before the authorization expires. We shall, if practicable, review the request for medical necessity and issue a determination before the existing authorization expires.

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

A retrospective review may be conducted after You are discharged from a hospital stay or after a covered service is performed. 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.

7.2 Health Care Services Outside of the Service Area

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

7.3 Limitations and Exclusions

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

7.4 Health Care Services that are not Medically Necessary

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

An Adverse Determination will include the reason for the Adverse Determination, the clinical basis for the Adverse Determination, a description of the criteria used in making the Adverse Determination, a description of the complaint and appeals process, and a description of the enrollee's right to an immediate review by an independent review organization for an enrollee with a life-threatening condition. You and the Physician or Provider requesting the Health Care Service will be notified as follows:

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

The initial notice of Adverse Determination may be by telephone or electronic transmission to Your Provider, and will be followed by written notice to You and Your Provider within three working days of receipt of the request.

7.5 Nature of Coverage Provided and Health Plan's Right to Contract

7.5.1 Health Care Services and Your Beliefs

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

to any procedure or Treatment. However, this provision defines the coverage provided under this Agreement. Your decision to follow medical advice or to seek any particular Treatment is solely yours and you agree to bear all legal and ethical consequences of the decision without regard to the coverages provided hereunder.

7.5.2 Provision of Health Services

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

7.6 Refusal to Accept Treatment

Should You or Your Covered Dependent refuse to cooperate with or accept the recommendations of Participating Providers with regard to health care for You or Your Covered Dependent, Participating Providers may regard such refusal as a failure of the patient relationship and as obstructing the delivery of proper medical care. In such cases, Participating Providers shall make reasonable efforts to accommodate You or Your Covered Dependent. However, if the Participating Provider determines that no alternative acceptable to the Participating Provider exists, You shall be so advised. If You or Your Covered Dependent continues to refuse to follow the recommendations, then neither Health Plan nor its Participating Providers shall have any further responsibility under this Agreement to provide care for the condition under Treatment.

7.7 Coordination of Health Care Services

7.7.1 Designation of Primary Care Physician

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

You or Your Covered Dependent may request to use a non-primary care physician specialist as a primary care physician, if You or Your Covered Dependent have a chronic, disabling, or life threatening condition.

7.7.2 Selection of Primary Care Physician

Primary Care Physicians may be selected from the list of Primary Care Physicians published by the Health Plan. The ability to select a particular Participating Physician as a Primary Care Physician is subject to that physician's availability. A current, updated list of Primary Care Physicians may be found at ers.swhp.org. In addition, a female member may select an obstetrician or gynecologist as their primary care physician to provide health care services that are within the scope of the provider’s license.

7.7.3 Changing Your Primary Care Physician

You or Your Covered Dependents may change Your Primary Care Physician any time.

7.8 Continuity of Treatment

7.8.1 Notice of Termination of Treating Physician or Provider

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

7.8.2 Continued Treatment by Terminated Physician or Provider

Except for medical incompetence or unprofessional behavior, the termination does not release the Health Plan from reimbursing the Participating Provider for providing Treatment to You or Your Covered Dependent in certain special circumstances. Special circumstance means a condition which Your physician or provider, or Your Covered Dependent’s physician or provider reasonably believes could cause harm to You or Your Covered Dependent if the physician or provider discontinues Treatment of the Member, and includes a disability, acute condition, life-

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

7.9 Health Care Services Not Available From Contracting Providers

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

8. CLAIM PROCEDURE

8.1 Necessity of Filing Claims

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

8.2 Effect of Failure to File Claim Within 60 Days

Failure to submit written proof of and claim for payment within the 60 day period shall not invalidate or reduce Your entitlement to reimbursement provided it was not reasonably possible for You to submit such proof and claim within the time allowed and written proof of and claim for payment were filed as soon as reasonably possible. Written proof and claim for payment submission should consist of itemized receipts containing: name and address where services were received, date service was provided, amount paid for service, and diagnosis for visit. Claims for reimbursement should be sent to Scott & White Health Plan, Attn: Claims Dept., 1206 West Campus Dr., Temple,

TX 76502. In no event will Health Plan have any obligation under this paragraph if such proof of and claim for payment is not received by Health Plan within one (1) year of the date the services were provided to You or Your Covered Dependent.

8.3 Acknowledgement of Claim

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

8.4 Acceptance or Rejection of Claim

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

8.5 Payment of Claims

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

8.6 Payment to Physician or Provider

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

The Member's right and Benefits under this Plan are personal to the Member and may not be assigned in whole or in part by the Member. We will recognize assignments of Benefits to the degree this Plan is subject to Texas Insurance Code §1204.053. If this Benefit Plan is not subject to §1204.053, We will not recognize assignment or attempted assignments of Benefits. Nothing contained in the written description of health coverage shall be construed to make the Health Plan liable to any third party to whom the Member may be liable for cost of medical care, treatment, or services.

8.7 Limitations on Actions

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

9. EFFECT OF MEDICARE, SUBROGATION AND COORDINATION OF BENEFITS

9.1 Effect of Medicare

9.1.1 For employees who retired and were Medicare eligible before September 1, 1992, HMO will provide benefits secondary to Medicare Part B, if the retiree is enrolled in Medicare Part B. If the retiree is not enrolled in Medicare Part B, HMO will pay primary benefits. The HMO may not require Part B coverage as a condition of enrollment for those retirees.

For employees who retired and became Medicare eligible on or after September 1, 1992, HMO will provide benefits secondary to Medicare Part B as if the retiree were enrolled in Medicare Part B, whether or not the retiree is enrolled in Medicare Part B. The HMO may provide only secondary benefits for any GBP participant eligible for Medicare coverage as a result of end-stage renal disease if the participant declines to elect Medicare Part B coverage.

9.2 Subrogation/Lien/Assignment/Reimbursement

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

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

9.2.1 Right of Recovery

The Plan has the right to recover benefits it has paid on the plan participant:

- 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; and
- reduce a future benefit payment for You or Your dependent by the amount of the payment.

If the Plan incorrectly pays benefits to you or your dependent during the time period of meeting the Out-of-Pocket Maximum, 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.

9.2.2 Assignment

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

No plan participant may assign, waive, compromise or settle any rights or causes of action that he/she or any

dependent may have against any person or entity who causes an injury or illness, or those listed herein, without the express prior written consent of the Plan and/or the Plan administrator.

9.2.3 Reimbursement

The Plan, by providing benefits, acquires the right to be reimbursed for the benefits provided or the reasonable value of services or benefits provided to plan participant up to the maximum amount allowed by Texas law, and this right is independent and separate and apart from the subrogation, lien and/or assignment rights acquired by the Plan and set forth herein.

The Plan is also entitled to recover from plan participant the benefits provided or value of benefits and services provided, arranged, or paid for, by anyone including those listed herein.

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

9.2.4 Plan's Actions

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

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

9.2.5 Obligations of the Plan Participant to the Plan

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

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

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

- The plan participant authorizes the Plan and [The Bratton Firm], to pursue, sue, compromise and/or settle any claims described herein, including but not limited to, subrogation, lien, assignment and reimbursement claims in the name of the plan participant and/or Plan. The plan participant agrees to fully cooperate with the Plan in the prosecution of such a claim. The plan participant agrees and fully authorizes the Plan and [the Bratton Firm] to obtain and share medical information on the plan participant necessary to investigate, pursue, sue, compromise and/or settle the above-described claims. The Plan and [The Bratton Firm] specifically are granted by the plan participant the authorization to share this information with those individuals or entities responsible for reimbursing the Plan through claims of subrogation, lien, assignment or reimbursement in an effort to recoup those funds owed to the Plan. This authorization includes, but is

not be limited to, granting to the Plan and [The Bratton Firm] the right to discuss the plan participant's medical care and treatment and the cost of same with third and first-party insurance carriers involved in the claim. Should a written medical authorization be required for the Plan to investigate, pursue, sue, compromise, prosecute and/or settle the above-described claims, the plan participant agrees to sign such medical authorization or any other necessary documents needed to protect the Plan's interests.

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

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

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

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

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

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

9.2.6 Wrongful Death/Survivorship Claims

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

9.2.7 Death of Plan Participant

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

9.2.8 Control of Settlement Proceeds

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

9.2.9 Payment

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

from any source.

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

9.2.10 Severability

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

9.2.11 Incurred Benefits

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

9.3 Coordination of this Plan's Benefits with other Benefits

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

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

Definitions

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

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

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

of any private insurance plan; or other nongovernmental plan; or an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

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

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

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

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

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

(5) The amount of any benefit reduction by the primary plan because a 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 as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan must be responsible for the plan's compliance with this subchapter.

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

(h) Each plan determines its order of benefits using the first of the following rules that apply.

(1) Nondependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber, or retiree, is the primary plan, and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent, then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other plan is the primary plan. An example includes a retired

employee.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court order stating otherwise, plans covering a dependent child must determine the order of benefits using the following rules that apply.

(A) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(i) The plan of the parent whose birthday falls earlier in the Year is the primary plan; or
(ii) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

(B) For a dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:

(i) if a court order states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.

(ii) if a court order states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of (h)(2)(A) must determine the order of benefits.

(iii) if a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of (h)(2)(A) must determine the order of benefits.

(iv) if there is no court order allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(I) the plan covering the custodial parent;

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

(III) the plan covering the noncustodial parent; then

(IV) the plan covering the spouse of the noncustodial parent.

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

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

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

(3) Active, Retired, or Laid-off Employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan that covers that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the plan

that covers the same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree is the primary plan, and the COBRA, state, or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The plan that has covered the person as an employee, member, policyholder, subscriber, or retiree longer is the primary plan, and the plan that has covered the person the shorter period is the secondary plan.

(6) If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

Effect on the Benefits of this Plan

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

(b) If a Member is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a nonpanel provider, benefits are not payable by one closed panel plan, COB must not apply between that plan and other closed panel plans.

Compliance with Federal and State Laws Concerning Confidential Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. [Organization responsible for COB administration] will comply with federal and state law concerning confidential information for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Each person claiming benefits under this plan must give [Organization responsible for COB administration] any facts it needs to apply those rules and determine benefits.

9.4 Facility of Payment

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

9.5 Right of Recovery

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

9.6 Right to Release and Receive Needed Confidential Information

Health Plan will maintain You and Your Covered Dependents' private health information in a confidential manner, as required by law. Health Plan may use and disclose You and Your Covered Dependents' private health information as necessary for treatment, payment and healthcare operations, including coordination of benefits, utilization review, quality assurance, processing of any claim, financial audit, or for any other purpose reasonably related to the provision of benefits under this Agreement, subject to any limitations stated on the Enrollment Application and Health Plan's notice of privacy practices. Except as described above, use and disclosure of You and Your Covered Dependents' private health information for other purposes will occur only with appropriate written authorization.

Health Plan may release to or obtain from any insurance company or other organization or person any information, with respect to any person, which This Plan deems to be necessary, if permitted by law, as may be necessary to implement this provision.

10. RECORDS

10.1 Records Maintained by Health Plan

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

10.2 Necessity of Requested Information

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

10.2.1 Authorization for Health Care Information from Physicians and Providers

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

10.3 Notification of Changes in Status

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

- eligibility for Medicare;
- coverage under another plan which may be subject to coordination of benefits; and
- eligibility for recovery from a third party of benefits which may be subject to subrogation.

11. COMPLAINT AND APPEAL PROCEDURE

11.1 Purpose

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

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

11.2 Complaints

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

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

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

11.3 Appeals

11.3.1 If the Complainant is not satisfied with Health Plan's resolution of the Complaint, the Complainant will be given the opportunity to appear before an appeal panel or address a written Appeal to an appeal panel.

11.3.2 Health Plan will send an acknowledgment letter of the receipt of oral or written appeal from Complainants no later than five (5) business days after the date of the receipt of the Appeal. The acknowledgment letter will

include a description of Health Plan's Appeal procedures and time frames. If the Appeal is received orally, Health Plan will also enclose a one-page Appeal form, which must be returned for prompt resolution of the Appeal.

11.3.3 Health Plan will appoint members to the complaint appeal panel, which shall advise the Health Plan on the resolution of the Complaint. The complaint appeal panel shall be composed of one Health Plan staff member, one Participating Provider, and one member. No member of the complaint appeal panel may have been previously involved in the disputed decision. The Participating Providers must have experience in the same or similar specialty that typically treats the medical condition, performs the procedure or provides the treatment in the area of care that is in dispute and must be independent of any physician or provider who made any prior determination. If specialty care is in dispute, the Participating Provider serving on the appeal panel must be a specialist in the field of care to which the appeal relates. The members may not be an employee of Health Plan.

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

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

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

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

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

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

11.3.8 Investigation and resolution of Appeals relating to ongoing emergencies or denials of continued stays for hospitalization shall be concluded in accordance with the medical or dental immediacy of the case but in no event to exceed one (1) business day after the Complainant's request for Appeal. Due to the ongoing emergency or continued hospital stay, and at the request of the Complainant, Health Plan shall provide, in lieu of a complaint appeal panel, a review by a Participating Provider who has not previously reviewed the case and is of the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment under discussion for review of the Appeal. The physician or provider reviewing the Appeal may interview the patient or the patient's designated representative and shall render a decision on the Appeal. Initial notice of the decision may be delivered orally if followed by written notice of the determination within three (3) days. Investigation and resolution of Appeals after emergency care has been provided shall be conducted in accordance with the standard Appeal process described above, including the right to a review by an appeal panel.

11.4 Appeal of Adverse Determinations

11.4.1 A member, a person acting on behalf of the member, or the member's physician or health care provider may appeal an Adverse Determination orally or in writing to a Member Relations Coordinator. Health Plan will send an acknowledgment letter of the receipt of oral or written Appeal of Adverse Determination 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 the Health Plan's Appeal procedures and time frames, as well as a reasonable list of documents needed to be submitted by the Complainant for the Appeal. If the Appeal is received orally, the Health Plan will also enclose a one-page Appeal form, the return of which, while not required, will aid in the prompt resolution of the Appeal.

The timeframe for filing the written or oral response is at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination. In addition, if the timeframes for the "Appeal of Adverse Determination" are not met by Health Plan, the enrollee is entitled to an immediate Appeal to an Independent Review Organization. The Health Plan will not require an exhaustion of its internal appeals prior to external review if Health Plan fails to meet its internal appeals process timelines or the claimant with an urgent care situation files an external review before exhausting the internal appeals process

Health Plan will send an acknowledgment letter of the receipt of oral or written Appeal of Adverse Determination 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 the Health Plan's Appeal procedures and time frames, as well as a reasonable list of documents needed to be submitted by the Complainant for the Appeal. If the Appeal is received orally, the Health Plan will also enclose a one-page Appeal form, the return of which, while not required, will aid in the prompt resolution of the Appeal.

Health Plan will issue a response letter to the patient or a person acting on behalf of the patient, and the patient's physician or health care provider, explaining the resolution of the Appeal; and provide written notification to the appealing party of the determination of the Appeal, as soon as practical, but in no case later than thirty (30) calendar days after the date the Health Plan receives the oral or written Appeal or one-page Appeal form from the Complainant. If the Appeal is denied, the written notification shall include a clear and concise statement of:

1) the specific medical or contractual reasons for the resolution;
2) the specific clinical basis for the Appeal denial;
3) a description of the source of the screening criteria that were utilized in making the determination;
4) the specialty of the physician or other health care provider making the denial;
5) notice of the appealing party's right to seek review of the denial by an independent review organization as provided in this Certificate of Coverage;
6) notice of the independent review process;
7) a copy of the form to request a review of the denial by an independent review organization; and
8) procedures for filing a complaint.

If the "Appeal of Adverse Determinations" is denied and within ten (10) business days the provider requests to have a particular type of specialty provider review the case, the Appeal denial shall be reviewed by a Network Provider in the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the Treatment under discussion for review in the Adverse Determination, and such specialty review will be completed within fifteen (15) business days of receipt of the request from the provider.

Health Plan will provide an expedited Appeal procedure for Emergency Care denials, denials of care for Life-Threatening Conditions and denials of continued stays for hospitalized patients. The procedure will include a review by a Network Provider who has not previously reviewed the case and who is of the same or a similar specialty who typically treats the medical condition, performs the procedure, or provides the Treatment under discussion for review. The time in which such expedited Appeal will be completed will be based on the medical immediacy of the condition, procedure or Treatment, but may in no event exceed 72 hours from the date all information necessary to complete the Appeal is received.

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

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

11.5 Independent Review of Adverse Determinations

11.5.1 Health Plan will permit any party whose Appeal of an Adverse Determination is denied to seek review of that determination by an Independent Review Organization assigned to the appeal in accordance with Section 4202.001 et seq. of the Texas Insurance Code.

11.5.2 Health Plan will provide to the Independent Review Organization no later than the three (3) business days after the date of request by the Party a copy of:

1) any medical records of the enrollee that are relevant to the review;
2) any documents used by the plan in making the determination;
3) the written notification described in Section 11.4.2 of this document;
4) any documentation and written information submitted to the Health Plan in support of the Appeal; and
5) a list of each physician or health care provider who has provided care to the enrollee and who may have medical records relevant to the Appeal.

11.5.3 Health Plan will comply with the Independent Review Organization's determination with respect to the medical necessity or appropriateness of health care items and services for an enrollee and the experimental or investigational nature of health care items and services for an enrollee.

12. MISCELLANEOUS PROVISIONS

12.1 Confidentiality

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

12.2 Independent Agents

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

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

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

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

12.3 Entire Agreement

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

12.4 Severability

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

12.5 Modification of Terms

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

12.6 Not a Waiver

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

12.7 Recovery

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

12.8 Notice

With the exception of electronic notices sent pursuant to subparagraph 7.4 of this Agreement, any notice under this Agreement shall be given by United States Mail, postage prepaid, addressed as follows:

If to Health Plan:
Scott and White Health Plan
[1206 West Campus Drive
Temple, Texas 76502]

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

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

12.9 Incontestability

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

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

This Agreement may only be contested because of fraud or intentional misrepresentation of material fact on the Enrollment Application. If Health Plan determines that You made a material misrepresentation of health status on the application, Health Plan will notify Group to determine enrollment status.

12.10 Proof of Coverage

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

12.11 Identification Card

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

12.12 Conformity with State Law

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

12.13 Office of Foreign Assets Control (OFAC) Notice

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

DESCRIPTION OF BENEFITS

13. WHAT'S COVERED?

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

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

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

Medically Necessary Emergency Care received from a Non-Participating Provider, care received from a non-participating facility based provider while at a participating facility, and services from a non-participating imaging and laboratory provider that are performed in connection with a service performed by an 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 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.

13.1 COPAYMENTS AND DEDUCTIBLES

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

13.2 OUT-OF-POCKET MAXIMUMS

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

13.3 BENEFIT LIMITATIONS

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

13.4 BENEFITS

13.4.1 MEDICAL SERVICES

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

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

- physical exams for medical or diagnostic purposes (other than preventive exams);
- newborn hearing screenings;
- necessary diagnostic follow-up care;
- office visits;
- consultations by specialists;
- annual routine eye examination (limit of one per Enrollee per contract year);
- treatment for diseases of the eye;
- outpatient surgery;
- dialysis;
- chemotherapy and radiation therapy for cancer;
- therapeutic radiology;
- allergy tests; and
- home health care.

13.4.2 PREVENTIVE CARE SERVICES

Preventive care services will be provided for the following covered services, and In-Network preventive care will not be subject to Copayment, Coinsurance 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 response 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 in comprehensive guidelines supported by HRSA.

For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention will be considered the most current. The preventive services described in items (a) through (d) may change as USPSTF, CDC, and HRSA guidelines are modified.
Examples of covered services include: routine annual physicals, immunizations, well-child care, cancer screening, mammography, bone density test, screening for prostate cancer and colorectal cancer, smoking cessation counseling services, and health diet counseling and obesity screening/counseling.

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

Covered services not included in items (a) through (d) above will be subject to Copayment, Coinsurance, and Deductibles.

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

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

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

- Well-baby care (after newborn's initial examination and discharge from the hospital;
- Routing annual physical examinations;
- 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 examinations of a newborn child.

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

COLORECTAL CANCER SCREENING
You and Your Covered Dependents are eligible for an annual fecal occult blood test. In addition, if You are 50 years of age or older You may receive a flexible sigmoidoscopy every five (5) year or a colonoscopy every ten (10) years.

EXAMINATION OF DECTECTION AND PREVENTION OF OSTEOPOROSIS
If You or Your Covered Dependent 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 Your Schedule of Benefits.

A Qualified Individual means:

1. A postmenopausal women not receiving estrogen replacement therapy;
2. An individual with:
    a. Vertebral abnormalities;
    b. Primary hyperparathyroidism; or
    c. A history of bone fractures; or
3. An individual who is
    a. Receiving long-term glucocorticoid therapy; and
    b. Being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

DIAGNOSTIC AND SCREENING MAMMOGRAPHY

Benefits are available for both diagnostic and annual screening by low-dose mammography for the presence of breast cancer. Annual screening mammograms are provided to female Members who are 35 years of age or older. Low does mammography 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 two views for each breast; digital mammography; or breast tomosynthesis. Mammograms may be obtained by referral from your PCP, plan obstetrician/gynecologist, or other Specialist, whether or not a well-woman examination is performed at the same time.

OVARIAN AND CERVICAL CANCER SCREENING TEST

You and Your Covered Dependents are eligible for benefits for an annual medically recognized diagnostic test for the early detection of ovarian and cervical cancer, including a CA-125 blood test, a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus. A screening test must be performed in accordance with the guidelines adopted by:

- the American College of Obstetricians and Gynecologists; or
- another similar national organization of medical professionals recognized by the commissioner.

This benefit is available to covered members who are female and over the age of 18.

PHENYLKETONURIA (PKU) OR HERITABLE METABOLIC DISEASE

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

SCREENING FOR HEARING LOSS

Your covered Dependents are eligible for screening test for hearing loss for a child from birth through the date the child is 30 days old; and Medically Necessary diagnostic follow-up care to the screening test for a child from birth through the date the child is 24 months old.

13.4.3 HOSPITAL SERVICES

You and Your Covered Dependents are entitled to the Medically Necessary services of any Participating Hospital to which You or Your Covered Dependent may be admitted by a Participating Physician or Participating Provider. In the event You or a Covered Dependent are admitted to a non-Participating Hospital by a Participating Physician or Participating Provider to whom You or Your Covered Dependent were referred in accordance with Health Plan procedures, the services of the non-Participating Hospital will be covered on the same basis as admission to a Health Plan Hospital, provided admission to the non-Participating Hospital was approved in accordance with this Agreement. Health Plan will cover the cost of a semi-private room, or the equivalent thereof, for covered hospital

admissions for routine acute care. For more intense levels of care, that level of care which is Medically Necessary will be covered. Medically necessary services for an inpatient stay following a mastectomy shall be covered under this provision.

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

- semi-private room;
- inpatient meals and special diets, when medically necessary;
- inpatient medications and biologicals;
- intensive care units;
- nursing care, including private duty nursing, when medically necessary;
- short term rehabilitation therapy services in the acute hospital setting;
- inpatient lab, x-ray and other diagnostic tests;
- skilled nursing facility care;
- inpatient medical supplies and dressings;
- anesthesia;
- inpatient oxygen;
- operating room and recovery room;
- inpatient physical therapy;
- inpatient radiation therapy;
- inpatient inhalation therapy;
- administration and cost of whole blood, , blood plasma, and blood plasma expanders, that are not replaced by You or Your Covered Dependent;
- inpatient physician services, including services performed, prescribed, or supervised by physicians or other health professional including diagnostic, therapeutic, medical, surgical, preventive, referral, and consultative health care services.

13.4.4 EMERGENCY CARE SERVICES

13.4.4.1 QUALIFICATION OF EMERGENCY SERVICES

Medically Necessary Emergency Care is covered by this Agreement, including the treatment and stabilization of an emergency medical condition. However, only those conditions meeting the terms of the definition of Emergency Care will qualify. Health Plan will provide for any medical screening examination or other evaluation required by Texas or federal law that takes place in a hospital emergency facility or comparable facility, and that is necessary to determine whether an emergency medical condition exists. Medically Necessary Emergency Care received from a non-participating Physician or non-Participating Provider will be fully reimbursed according to the terms of the Health Care Agreement at the usual and customary or agreed upon rate, except for Copayments, and charges for non-covered services. In no event should You be balance billed for Medically Necessary Emergency Care received from a non-participating Physician or non-Participating Provider. If You are balance billed please contact our customer service representative and we will remedy this issue with the Physician or Provider.

13.4.4.2 URGENT CARE SERVICES

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

13.4.4.3 EMERGENCY TRANSPORTATION SERVICES

Emergency transportation, when and to the extent it is Medically Necessary, is covered when transportation in any other vehicle would endanger the patient's health. Health Plan will not cover air transportation if ground

transportation is medically appropriate and more economical. If these conditions are met, Health Plan will cover ambulance transportation to the closest appropriate hospital or skilled nursing facility.

13.4.4.4 EMERGENCY MEDICAL SERVICES

Emergency medical services provided by ambulance personnel for which transport is unnecessary or is declined by Member will not be covered.

13.4.4.5 TRANSPORTATION TO PARTICIPATING FACILITY AFTER STABILIZATION

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

The health plan, upon authorization of a Medical Director, may facilitate transportation to an In-Network facility when medically appropriate.

13.4.4.6 EMERGENCY CARE COVERAGE EXCEPTIONS/LIMITATIONS

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

13.4.4.7 HOSPITALIZATION AT OTHER THAN PARTICIPATING HOSPITAL

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

13.4.5 MENTAL HEALTH CARE

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

13.4.5.1 OUTPATIENT MENTAL HEALTH CARE

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

13.4.5.2 INPATIENT MENTAL HEALTH CARE

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

13.4.5.3 COPAYMENTS ON MENTAL HEALTH CARE

For outpatient mental health care you are required to pay the Copayment for each outpatient mental health care visit to or by a Health Professional during normal working hours on a Participating Provider's premises and on weekends, after normal working hours, or away from Participating Provider's premises as stated in the Schedule of Benefits. The copayment will be the same as for any other physical illness.

You are required to pay the Copayment for each day of inpatient mental health care with a Participating Provider as stated in the Schedule of Benefits. The copayment will be the same as for any other physical illness.

13.4.5.4 PSYCHIATRIC DAY TREATMENT FACILITY

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

13.4.5.5 RESIDENTIAL AND STABILIZATION MENTAL HEALTH TREATMENT

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

Such benefits may be covered by Health Plan under the following conditions:

1. as determined by a Participating Physician specializing in psychiatry, You or Your Covered Dependents have a serious mental illness which substantially impairs thought, perception of reality, emotional process, or judgment or grossly impairs behavior as manifested by recent disturbed behavior and which would otherwise necessitate confinement in a hospital if such care and Treatment were not available through a Crisis Stabilization Unit or Residential Treatment Center for Children and Adolescents;

and

2. providers of services for which benefits are to be paid must be licensed or operated by the appropriate state agency or board to provide those services, be located within the Service Area, and be designated by Health Plan as an approved provider with which Health Plan has entered into an agreement for the provision of such services.

13.4.5.6 SERIOUS MENTAL ILLNESS

Treatment for Serious Mental Illness, which includes Medically Necessary Medical Services and Hospital Services, shall be provided under this Agreement as indicated in the Schedule of Benefits. Treatment for Serious Mental Illness is not covered under Outpatient Mental Health Care or Inpatient Mental Health Care coverage provided in sections [13.4.5.1] and [13.4.5.2] of this Agreement.

"Serious Mental Illness" means the following psychiatric illnesses: schizophrenia, paranoid and other psychotic disorders; bipolar disorders (hypomanic, manic, depressive, and mixed), major depressive disorders (single episode or recurrent), schizo-affective disorders (bipolar or depressive), obsessive-compulsive disorders, and depression in childhood and adolescence.

13.4.5.7 COPAYMENTS FOR SERIOUS MENTAL ILLNESS

You will pay the same Copayments for the Treatment of Serious Mental Illness as for any other physical illness.

13.4.6 TREATMENT FOR CHEMICAL DEPENDENCY

13.4.6.1 TREATMENT FOR CHEMICAL DEPENDENCY

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

13.4.6.2 COPAYMENT FOR CHEMICAL DEPENDENCY

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

13.4.7 REHABILITATIVE AND HABILITATIVE THERAPY

13.4.7.1 REHABILITATIVE AND HABILITATIVE THERAPY

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

13.4.7.2 EARLY CHILDHOOD INTERVENTION SERVICES

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

13.4.7.3 COPAYMENT FOR THERAPY

You are required to pay a Copayment for each outpatient therapy visit to or by a Health Professional during normal working hours on the provider's premises, on weekends, after normal working hours or away from the provider's premises as indicated in the Schedule of Benefits.

13.4.7.4 MANIPULATIVE THERAPY/CHIROPRACTIC SERVICES

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

- Examinations
- Manipulations
- Conjunctive Physiotherapy

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13.4.8 HOME HEALTH SERVICES

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

13.4.9 HOSPICE SERVICES

Hospice services consist of Medically Necessary Hospice care that is recommended by a designated Participating Physician, approved in advance by the Medical Director, and provided by a licensed Hospice agency with which Health Plan has arranged for You or Your Covered Dependent's care and Treatment. You are required to pay a Copayment for each day of Hospice Services as stated in the schedule of benefits.

13.4.10 MATERNITY SERVICES

13.4.10.1 MATERNITY SERVICES

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

13.4.10.2 INPATIENT MATERNITY SERVICES

Coverage includes a minimum of forty-eight (48) hours of inpatient care to a mother and her newborn child following an uncomplicated vaginal delivery and ninety-six (96) hours of inpatient care to a mother and her newborn following an uncomplicated delivery by caesarean section. The plan provides coverage for the administration of a newborn screening test, including the cost of the test kit.

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

13.4.10.3 DELIVERY AS EMERGENCY CARE

In the event You or Your Covered Dependent delivers at a non-Participating Hospital, a routine delivery shall not be considered Emergency Care, and will not be covered.

13.4.10.4 COPAYMENTS FOR MATERNITY SERVICES

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

13.4.11 FAMILY PLANNING AND INFERTILITY SERVICES

13.4.11.1 FAMILY PLANNING AND INFERTILITY SERVICES

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

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

Note: see the benefit for Covered Preventive Services for coverage Care contraceptive devices, services and procedures.

13.4.12 DURABLE MEDICAL EQUIPMENT/ CONSUMABLE SUPPLIES/ ORTHOTICS/PROSTHETIC DEVICES

Medically Necessary Durable Medical Equipment, Prosthetic Devices or Orthotic Devices are covered under this Agreement. Except as otherwise noted, the Medical Director shall determine the conditions under which such equipment shall be covered. The conditions include, but are not limited to the following: the length of time covered, the equipment covered, the supplier, and the basis of coverage; i.e., rental, purchase, or loan. Health Plan shall provide coverage for these benefits as specified in the Schedule of Benefits.

13.4.12.1 CONSUMABLE SUPPLIES

Consumable supplies are non-durable medical supplies that: are usually disposable in nature; cannot withstand repeated use by more than one individual; are primarily and customarily used to serve a medical purpose; generally are not useful to a person in the absence of illness or injury; and may be ordered and/or prescribed by a physician. Consumable supplies are covered only if the supply if required in order to use Durable Medical Equipment, Orthotic Device, or Prosthetic Device. Repair, maintenance, and cleaning due to abnormal wear and tear or abuse are Your responsibility.

13.4.12.2 DURABLE MEDICAL EQUIPMENT

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

13.4.12.3 PROSTHETIC DEVICES

Prosthetic Devices may be covered under the conditions determined by Provider and as are Medically Necessary to replace defective parts of the body following injury or illness. Health Plan shall cover the initial device; professional services for fitting and use; and replacements due solely to growth, other Medically Necessary replacements for medical reasons and normal repairs. For Limb Prosthetics, Health Plan shall provide coverage subject to the applicable copayments specified in the Schedule of Benefits. For all other Prosthetics, Health Plan shall provide coverage subject to the applicable Copayments, specified in the Schedule of Benefits.

13.4.12.4 ORTHOTIC DEVICES

Orthotic Devices may be covered under the conditions determined by the Provider and as are Medically Necessary. Health Plan shall cover the initial device; professional services for fitting and use; and Medically Necessary replacements for medical reasons and normal repairs. Health Plan shall provide coverage for Orthotic Devices subject to the applicable Copayments specified in the Schedule of Benefits.

13.4.12.5 HEARING AIDS AND COCHLEAR IMPLANTS

We provide coverage for the cost of one hearing aid per hearing impaired ear every three years for Covered Persons age 18 and under. This coverage also includes services related to a covered hearing aid device prescribed by a licensed audiologist, hearing instrument specialist, or an ear, nose, and throat (ENT) doctor, including:

- 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 gains; and
- for a cochlear implant, an external speech processor and controller with necessary components replacement every three years.

Coverage is limited to one hearing aid in each ear every three years; or one cochlear implant in each ear with internal replacement as medically or audio logically necessary. Coverage is subject to all of the requirements of the health plan and doesn't include replacement hearing aid batteries. Prior authorization by the health plan is required

13.4.13 BREAST RECONSTRUCTION BENEFITS

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

13.4.14 MINIMUM INPATIENT STAY FOLLOWING MASTECTOMY

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

13.4.15 BENEFITS FOR TREATMENT AND DIAGNOSIS OF CONDITIONS AFFECTING TEMPORO-MANDIBULAR JOINT

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

13.4.16 TREATMENT FOR CRANIOFACIAL ABNORMALITIES OF A CHILD

Coverage for Covered Dependents, includes reconstructive surgery for craniofacial abnormalities to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infection or disease. Cosmetic surgery is an excluded service to the extent it is not necessary to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infection or disease for a Covered Dependent. Dental services are excluded from coverage under this Agreement, except as defined in the Dental Benefits and Certain Oral Surgeries section of this Agreement.

13.4.17 DIABETIC SUPPLIES, EQUIPMENT AND SELF-MANAGEMENT TRAINING

If You or a Covered Dependent has been diagnosed with insulin dependent diabetes, non-insulin dependent diabetes, or abnormal elevated blood glucose levels induced by pregnancy or another medical condition, as Medically Necessary and prescribed by a Participating Physician, You or Your Eligible Dependent are eligible for coverage for Diabetic Supplies, Diabetic Equipment, and Diabetic Self-Management Training under this Agreement. Coverage for Diabetic Supplies and Diabetic Equipment shall be provided under the prescription drug or durable medical equipment supplies section of the contract with applicable Copayments as noted in the Schedule of Benefits. Diabetic Self-Management Training shall be provided on the same basis as other analogous chronic medical conditions are covered, including, but not limited to the applicable Copayments. Coverage shall also be provided for new or improved Diabetic Supplies or Diabetic Equipment, upon approval of the United States Food and Drug Administration, as Medically Necessary and prescribed by a Participating Physician.

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

Test strips for blood glucose monitors shall be provided according to the copayment levels described in the Schedule of Benefits. Insulin, syringes, oral agents available with or without a prescription, and Glucagon Emergency Kits shall be provided according to the terms of the Prescription Drug Benefit.

13.4.17.2 COPAYMENTS/MAXIMUMS FOR DIABETIC EQUIPMENT AND SUPPLIES

All other Diabetic Equipment and Diabetic Supplies shall be provided according to the terms of this Agreement. You are required to pay Copayments for Diabetic Equipment, Diabetic Supplies, and Diabetic Self-Management Trainings as stated in the Schedule of Benefits.

13.4.18 TRANSPLANT SERVICES

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

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

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

Transplant services require prior authorization.

13.4.19 ACQUIRED BRAIN INJURY

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

- Cognitive rehabilitation therapy;
- Cognitive communication therapy;
- Neurocognitive therapy;
- Neurocognitive rehabilitation;
- Neurobehavioral testing;
- Neurobehavioral treatment;
- Neurophysiological testing;
- Neurophysiological treatment;
- Neuropsychological testing;
- Neuropsychological treatment;
- Psychophysiological testing;
- Psychophysiological treatment;
- Neurofeedback therapy;
- Remediation required for and related to the treatment of an acquired brain injury;
- Post-acute transition services; and

- Community reintegration services, including outpatient day treatment services or other post-acute care treatment services.

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

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

13.4.19.1 COPAYMENTS FOR ACQUIRED BRAIN INJURY

Copayments for Covered Services for treatment of Acquired Brain Injury shall be the same as the Copayment for other Covered Service provided by the under the health benefit plan.

13.4.20 TELEMEDICINE

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

13.4.21 DENTAL BENEFITS AND CERTAIN ORAL SURGERY

Coverage for dental benefits is limited to dental care necessary to restore and correct Member's "Healthy Natural Teeth" and/or dental work that was in place at the time of the injury, including, but not limited to, crowns, veneers, bridges, and implants, occurring as a direct result of an "Accidental Injury" while covered under the plan. Such dental care must be provided within 24 months from the time the "Accidental Injury" and shall not include normal dental Treatment. As used in this paragraph, "Accidental Injury" means an injury caused by an external force or element such as a blow or fall which results in the need for emergency dental care. "Accidental Injury" shall not include biting or chewing accidents. "Healthy Natural Teeth" means natural teeth which are whole or properly restored, without impairing periodontal or other conditions, and which are not in need of Treatment other than Treatment resulting directly from an "Accidental Injury."

Medically Necessary orthognathic surgery, diagnostic, and surgical procedures for the Treatment of conditions affecting the temporomandibular joint (TMJ), including the jaw and craniomandibular joint, and Certain Oral Surgery shall not be considered dental care and shall be covered under the terms of this agreement as any other physical illness. Certain Oral Surgery means excision of neoplasms, including benign, malignant, and premalignant lesions, tumors, and nonodontogenic cysts; incision and drainage of cellulitis; and surgical procedures involving accessory sinuses, salivary glands, and ducts. Treatment of the TMJ shall be provided on the same basis as diagnostic and surgical Treatment to any other skeletal joint. Oral appliances and devices used to treat TMJ pain disorders or dysfunction of the joint and related structures, such as the jaw, jaw muscles, and nerves, are excluded.

You are required to pay the Copayment for dental benefits for each visit to or by a Health Professional as listed in the Schedule of Benefits. You are required to pay the same copayment for orthognathic and Certain Oral Surgery as required for any other physical illness. You are required to pay the same copayment for surgical Treatment of the TMJ as for other benefits.

13.4.22 AUTISM SPECTRUM DISORDER SERVICES

Coverage is provided for screening for autism spectrum disorder at ages 18 and 24 months.

Coverage for generally recognized services prescribed to enrollees diagnosed with Autism Spectrum Disorder, is provided from the date of diagnosis, in accordance to a treatment plan recommended by the enrollee's Participating Physician.
As used in this provision, "generally recognized services" may include services such as:

1. evaluation and assessment services;
2. Applied Behavior Analysis;
3. behavior training and behavior management;
4. speech, occupational or physical therapy; or
5. medications or nutritional supplements used to address symptoms of autism spectrum disorder.

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

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

13.4.22.1 COPAYMENTS FOR AUTISM SPECTRUM DISORDER SERVICES

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

13.4.23 AMINO ACID-BASED ELEMENTAL FORMULAS

As approved by the Medical Director and ordered by a Participating Physician, Medically Necessary Amino Acid-Based Elemental Formulas may be covered under this Agreement. The Medical Director shall determine the conditions under which such formulas may be covered. Health Plan shall provide coverage for these benefits up to the maximum benefit per Contract Year.

13.4.23.1 COVERAGE FOR AMINO ACID-BASED ELEMENTAL FORMULAS

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

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

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

13.4.23.2 COPAYMENTS ON AMINO ACID-BASED ELEMENTAL FORMULAS

You or Your Covered Dependents are required to pay the Copayments as stated in the Schedule of Benefits for Routine Patient Care Costs and/or Prescription Drugs, as applicable.

13.4.24 CARDIOVASCULAR DISEASE SCREENING FOR HIGH RISK INDIVIDUALS

As approved by the Medical Director, certain cardiovascular disease screening tests for high-risk individuals may be covered under this Agreement. The Medical Director shall determine the conditions under which such screening tests may be covered. Health Plan shall provide coverage for these benefits up to the maximum benefit per contract year.

13.4.24.1 COVERAGE FOR CARDIOVASCULAR DISEASE SCREENING

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

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

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

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

Such screening test must be approved by the Medical Director and performed by a Participating Provider.

13.4.24.2 COPAYMENTS ON CARDIOVASCULAR DISEASE SCREENING

You or Your Covered Dependents are required to pay the following Copayments for cardiovascular screening tests: $100 Copayment plus 20% for CT scans, and 20% for ultrasounds. Benefits for cardiovascular screening tests shall be limited to a $200 Benefit Maximum every 5 years.

13.4.25 ROUTINE PATIENT CARE COSTS FOR CLINICAL TRIALS

Subject to the terms of this Agreement and the Exclusions and Limitations Provisions herein, You or Your Covered Dependent may be covered for Routine Patient Care Costs in connection with You or Your Covered Dependent's, participation in a phase I, phase II, phase III, or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of a Life-Threatening Disease or Condition and is approved by:

1. the Centers of Disease Control and Prevention of the United State Department of Health and Human Services;
2. the National Institutes of Health;
3. the United States Food and Drug Administration;
4. the United State Department of Defense;
5. the United States Department of Veterans Affairs; or
6. 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.

We are not required to reimburse the Research Institution conducting the clinical trial for the Routine Patient Care Cost provided through the Research Institution unless the Research Institution, and each Provider providing routine patient care through the Research Institution, agrees to accept reimbursement at the rates that are established under the plan, as payment in full for the routine patient care provided in connection with the clinical trial.

This provision does not provide benefits for services that are a part of the subject matter of the clinical trial and that are customarily paid for by the Research Institution conducting the clinical trial.

13.4.25.1 COPAYMENTS AND LIMITATIONS ON COVERAGE FOR ROUTINE PATIENT CARE COSTS

We do not provide benefits for routine patient care services provided by Non-Network Providers.

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

13.4.25.2 CANCELLATION OR NONRENEWAL PROHIBITED

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

13.4.26 CONTRACEPTIVE METHODS

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.

13.4.27 ORAL ANTICANCER MEDICATIONS

Oral anticancer medications are covered under Oral Chemoparity Drug benefit, and are subject to the lowest cost-sharing amounts applied to Oral Chemoparity Drug in the attached Schedule of Benefits. The Oral Chemoparity Drug benefits provided oral anticancer medications on the same basis as intravenously administered or injected cancer medications provided by the health plan.

13.4.27.1 ORAL ONCOLOGY PROGRAM

Prescriptions for drugs included in the Oral Oncology Program benefit, as described on the SWHP drug list, will only be dispensed for a maximum 15-day supply for the first two months of therapy, at 50% of the applicable retail copayment. This is an exception to the SWHP 30 days at a retail pharmacy and mandatory mail order pharmacy rules. After the first four fills, members continuing on therapy may fill their prescription for up to a 30-day supply.

13.5 OUT-OF-NETWORK REFERRALS

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

13.5.1 OUT-OF-POCKET EXPENSES FOR REFERRALS

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

14. EXCLUSIONS AND LIMITATIONS

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

14.1 Abortions
Elective abortions,
non-therapeutic termination of pregnancy (abortion), including any abortion-inducing medications 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.

14.2 Ambulance services are not covered::

- When another mode of transportation is clinically appropriate;
- For stable, non-emergency conditions, unless pre-authorized;
- When provided for the convenience of the Member, family, companion, ambulance provider, Hospital, or attending Physician;
- Where no transportation of a Member occurs;

Additionally, air or sea ambulance services are not covered:

- When ground ambulance is clinically appropriate;
- To locations other an acute care Hospital.

14.3 Assistant Surgeons, unless determined to be Medically Necessary

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

14.5 Circumcision in any male other than a newborn (age 30 days or less), unless Medically Necessary.

14.6 Cosmetic or Reconstructive Procedures or Treatments
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), uncles specifically covered in Section 13 Covered Benefits. Among the procedures We do not cover are:

- Excision or reformation of any skin on any part of the body, hair transplantation, removal of port wine stains, chemical peels or abrasions of the skin, 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 Your body (such as enlargement, reduction, or implantation, except for breast construction following a mastectomy)';
- Hari 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 correct deviated septum.

14.7 Complications of non-covered procedures
Treatment related to complication of non-covered procedures are not a covered benefit.

14.8 Court-Ordered Care

Health Care Services provided solely because of the order of a court or administrative body, which Health Care Services would otherwise not be covered under this Agreement, are excluded. This exclusion does not prohibit coverage of a dependent pursuant to a qualified medical support order.

14.9 Custodial Care

Custodial Care as follows is excluded:

- Any service, supply, care or Treatment that the Medical Director determines to be incurred for rest, domiciliary, convalescent or Custodial Care;
- Any assistance with activities of daily living which include activities such as walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking drugs; or
- Any Care that can be performed safely and effectively by a person who does not require a license or certification or the presence of a supervisory nurse.

Such services will not be Covered Services no matter who provides, prescribes, recommends or performs those services. The fact that certain Covered Services are provided while You or Your Covered Dependent are receiving Custodial Care does not require the Health Plan to cover Custodial Care.

14.10 Dental Care

All dental care or oral surgery (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 (for example, periodontium), 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 Member over age 19, correction of malocclusion, and nay non-surgical dental care involved in the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome, such as oral appliance and devices;
- Treatment of dental abscess or granuloma;
- 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 Section 13.4.21 Dental Services.

14.11 Disaster or Epidemic

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

14.12 Electron Beam Therapy (ENT)

14.13 Exceeding Benefit Limits

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

14.14 Experimental or Investigational Treatment

This includes any drug, devices, treatment, or procedure that would not be used in the absence of the

Experimental or Investigation drug, device, treatment, or procedure. We consider a 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 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 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 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 drug, device, treatment or procedure.

14.15 Family Member (Services Provided by)

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

14.16 Family Planning Treatment

The reversal of an elective sterilization procedure is excluded.

14.17 Foot Care (Routine)

Including treatment of weak, strained or flat fee, corns, calluses, or medications such as Lamisil or Sporanox for the treatment of uncomplicated nail fungus. We also do not cover corrective orthopedic shoes, arch supports, splints, or other foot care items, except as noted under Section 13. Covered Benefits. This will not apply to the removal of nail roots.

14.18 Genetic Testing

With the exception of those required under applicable state or federal law and Medically Necessary perinatal genetic counseling. Genetic testing relating to pre-implantation of embryos for in-vitro fertilization is not covered. 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.

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14.19 Household Equipment

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

- Corrective shoes, shoe inserts, arch supports, and Orthotic inserts, except as provided for under Section 3*, What is Covered* 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.

14.20 Illegal Acts

Charges for services received as a result of Injury or Sickness caused by or contributed to by the covered person engaging in an illegal act or occupation or by committing or attempting to commit a crime, criminal act, assault or other felonious behavior. 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 include situations in which the covered person 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.

14.21 Infertility Diagnosis and Treatment

The following infertility services are not covered:

- in vitro fertilization;
- artificial insemination;
- gamete intrafallopian transfer;
- zygote intrafallopian transfer, and similar procedures;
- reversal of voluntarily induced sterility;
- surrogate parent services and fertilization;
- donor egg or sperm;
- abortions unless determined to be Medically Necessary or required to preserve the life of the mother
- any costs related to surrogate parenting, sperm banking for future use, or any assisted reproductive technology or related treatment that is not specified in Section 13 Covered Benefits.

14.22 Mental Health

Services for mental illness or disorders are limited to those services described in Mental Health Care and Treatment for Chemical Dependency provisions of this Agreement including counseling and related services For or in connection with marriage, child, career, social adjustment, finances, or medical social services and: Psychiatric therapy on Court Order or as a condition of parole or probation.

14.23 Miscellaneous

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

14.24 Non-Covered Benefits/Services
Treatments, which are excluded from coverage under this Agreement and complications of such Treatments, are excluded.

14.25 Non-Emergent Treatment for Non-Participating Providers
In cases involving non-emergent Treatments performed or prescribed by non-Participating Providers, either inside or outside of the Service Area, and for which Health Plan has not authorized an out-of-network referral, Health Plan will not cover any expenses associated with such Treatments. Complications of those Treatments will not be covered prior to the date Health Plan arranges for Member's transfer to Participating Providers. In no event shall Health Plan cover any Treatments which are excluded from coverage under this Agreement or complications of those Treatments.

14.26 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, Customary, and Reasonable charges for such service or supply prevailing in the area in which the service or supply was received.

14.27 Orthotrispy and related procedures.

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

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

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

14.30 Physical Therapy services, unless provided by a physical therapist.

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

14.32 Prescription Drugs
Over-the-counter drugs are not covered.

14.33 Surgery for Refractive Correction

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

14.35 Routine Foot Care
Services for routine foot care, including, but not limited to, trimming of corns, calluses and nails, except those services related to diabetes, are excluded.

14.36 Speech and Hearing Loss
Unless covered by a rider, services for the loss or impairment of speech or hearing are limited to those rehabilitative services described in the Rehabilitative Therapy provision.

14.37 Sports rehabilitation, refers to continued treatment for sports related injuries in an effort to improve above and beyond normal ability to perform activities of daily living (ADLs).

Sports-related rehabilitation or other similar avocational activities is not covered 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.

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

14.39 Therapies and Treatments
The following therapies and treatments are not covered: Equine therapy; cranial sacral therapy; recreational therapy; exercise programs; hypnotherapy, music therapy; reading therapy; sensory integration therapy; vision therapy; vision training; orthoptic therapy; orthoptic training; behavioral vision therapy; visual 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.

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

14.41 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 Participating Physician or Participating Provider and Medical Director.

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

14.43 War, Insurrection, or Riot
Treatment for Injuries or sickness as a result of war, participation in a riot, civil insurrection, or act of terrorism is excluded.

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