PLAN YEAR 2016

MEMBER HANDBOOK

September 1, 2015 - August 31, 2016

ERS
EMPLOYEES RETIREMENT SYSTEM OF TEXAS

SCOTT&WHITE HEALTH PLAN
Now part of Baylor Scott & White Health

SWHP Telephone Directory

24-Hour Customer Service - (800) 321-7947 or (254) 298-3000

Urgent Numbers

Emergency	911
Locate nearest urgent care facility	(800) 321-7947
LiveWell! Nurse Advice Line	(877) 505-7947
Poison Control Center	(800) 222-1222

Georgetown Office

204 S. IH-35, Suite 100, Georgetown, TX 78628	(512) 930-6040

Temple Office (headquarters)

1206 West Campus Drive, Temple, TX 76502	(254) 298-3000

Waco Office

200 W. State Hwy 6, Suite 300, Waco, TX 76712	(254) 756-8000

Other Important Numbers

SWHP Claims	(254) 298-3000
SWHP Claims (Toll-Free)	(800) 321-7947
SWHP Care Coordination Division	(888) 316-7947
TDD	(800) 735-2989
Email	swhpques@sw.org
Texas Department of Insurance	(512) 463-6169
333 Guadalupe	(800) 578-4677
Austin, TX 78701	

Language Line

In an effort to improve communication with non-English speaking members, SWHP uses the interpretive services of AT&T. Please see details on page 13.

Provider and Facility Phone Numbers

For provider and facility contact information, you can call (800) 321-7947.
You may also visit ers.swhp.org and click on the "Find a Provider" tab.

Welcome to a New Plan Year

We are pleased you have selected membership in Scott & White Health Plan (SWHP).

We will make every effort to ensure your membership in SWHP is rewarding and satisfactory to you. This handbook will help you understand and explain how to access the services outlined in your SWHP Evidence of Coverage.

Because your membership may mean some changes in the way you and the members of your family receive health care, we encourage you to take a few moments and read the material contained in this handbook.

Please keep a copy of this handbook and your Evidence of Coverage in a safe and handy location. They outline your complete coverage of benefits and explain to you how to obtain medical advice and care.

You and SWHP are partners, and your satisfaction and good health are the goal.

SWHP is your advocate

Scott & White Health Plan will help you get an appointment when you need to be seen! If you are having difficulty getting an appointment to see one of our participating providers, please call us.

Our personalized service will get you an appointment to see a clinician when you need to be seen. Please call us at (800) 321-7947.

We are your advocate!

Service – 24/7

Scott & White Health Plan Customer Service is available 24/7.

Call (800) 321-7947 any time day or night to speak to an advocate. We also offer other valuable services to our members 24/7 including:

- **Nurse Advice Line (Health Coaches)** (877) 505-7947 - call anytime you need medical advice or need information on a health issue,
- **Dialog Center** - ers.swhp.org (Disease Management section) - includes shared decision- making, email a health coach, interactive tools, and
- **MyBenefits** - ers.swhp.org - check on your claims and benefits.

Pick up the phone or visit the website—when it is convenient for you!

Identification Card

As a SWHP member, you will receive an identification card. You should carry your card with you at all times and present it to the desk personnel when reporting for appointments. The identification card identifies you and each family member covered under your plan as a SWHP member, includes your ID numbers, and your required copayment for different services.

Instructions for out-of-network care are located on the back of the card. Be sure all information on the card is accurate. If there are any errors or omissions, please call or email a Customer Service Advocate at a SWHP office near you.

If you need to order additional cards, you may do so by visiting ers.swhp.org or by contacting Customer Service.

Accessing Medical Benefits

SWHP is an Open Access Health Plan. A member can go to any network provider without a referral. Due to the nature of some specialties, some physician offices may require a referral prior to making your appointment. This is the choice of that physician's office and not a requirement of SWHP.

Please review your Evidence of Coverage (EOC) or Summary of Benefits for your plan's specific benefits. You may find these documents by visiting ers.swhp.org and selecting "Benefits," or requesting paper copies by contacting SWHP.

Primary Care

Although it is not required, we encourage you to select a Primary Care Physician (PCP) who will oversee your care. If you choose to designate a PCP, please refer to our online provider directory at ers.swhp.org to select from the following categories:

- **Family Medicine -** Family medicine physicians are specialists in the common health care problems that affect an entire family. Care is provided for patients of all ages – from newborns to the elderly. A typical family medicine practice includes diagnosis and treatment for acute and chronic illnesses, routine physicals, and preventive care, including routine obstetric care with prenatal visits and uncomplicated deliveries. Family medicine physicians are located in many SWHP network locations and most offer evening and weekend appointment times for urgent care needs.
- **Internal Medicine -** Internal Medicine is staffed by general internists who are physicians that specialize in adult care. They provide primary care for both simple and complex medical problems that arise. Internists do not perform surgery, deliver babies, or take care of children under 16 years of age.
- **Pediatrics -** Pediatricians specifically provide care for newborns, infants, children, and adolescents. Working as a team with nurses, counselors, therapists, and other skilled personnel, these physicians aim to provide quality health care for this age group. If you choose to designate a PCP, consider which clinic location would be most convenient for you. Each person enrolled in your plan may select his or her own PCP.

Physical Examinations

Preventive care is covered 100% for SWHP members; however, you are not required to receive a physical examination as part of your membership in SWHP. Periodic checkups or health assessments are provided to members at intervals appropriate to their age, sex, and medical history.

If you are a new member with a medical problem that requires you to be on medication, you should contact your provider and arrange an appointment. It is very important to make the distinction between an appointment for a medical problem or a routine checkup. There may be a waiting period for routine checkups.

Routine Appointments

To make a routine appointment, contact your provider's office. To help the staff schedule your appointment quickly, please refer to the following:

- If it is your first appointment, indicate this to the appointment clerk.
- Have your identification card ready for any required information.
- Periodic examinations (e.g., annual pap smears or physical) may need to be scheduled 8-12 weeks in advance. Other routine appointments are scheduled according to the urgency of the problem.
- Notify your physician's office as quickly as possible if you cannot keep an appointment.

After Hours Care / Nurse Advice Line

Telephone calls are answered 24 hours a day, seven days a week when calling the main Temple office numbers: (800) 321-7947 or (254) 298-3000.
The Care Coordination Division (CCD) is contacted for authorizations for inpatients, emergency surgeries, and procedures.

If you are ill or injured, you can contact the LiveWell! Nurse Advice Line at (877) 505-7947. The nurse advice line is staffed 24 hours a day, every day of the year.

Our nurses can give you information about how to take care of yourself at home or can help determine if an appointment, an urgent care visit, or an emergency room visit is most appropriate for your symptoms. It is free, completely voluntary, and confidential. However, this service is not meant to replace a doctor's care.

Out-of-Network Care

SWHP out-of-network benefits are limited to accidental injuries and sudden illnesses. SWHP does not pay for out-of-network elective procedures or treatment for minor illness. SWHP will not assume financial responsibility for out-of-network treatment if you are well enough to return to a SWHP provider or facility.

When seeking treatment in an out-of-network emergency room, provide your member identification card. This will speed up the processing and payment of your bill by SWHP. This will also allow the treating physician to discuss your emergency care with your provider if necessary.

Urgent and Emergency Care

SWHP will provide benefits for medically necessary emergency care whether you are within the service area or temporarily out of the service area.

Emergency care is defined as the sudden and unexpected onset of a condition of such a nature that a prudent layperson, possessing an average knowledge of medicine and health, believes his/her health could be jeopardized if he/she does not get immediate treatment.

Examples of emergency conditions include, but are not limited to, the following:

- unusual or excessive bleeding,
- broken bone,
- acute abdominal or chest pain,
- loss of consciousness,
- suspected heart attack,
- sudden persistent pain,
- serious burn,
- poisoning,
- convulsions, or
- difficulty breathing.

In all emergency situations, you are encouraged to seek care with the nearest SWHP approved provider. However, if the time needed to reach a SWHP approved provider might endanger your health, go to the nearest emergency room. Medically necessary emergency care is covered.

If you are hospitalized as a result of the emergency, you should contact the Care Coordination Division (CCD) within 24-48 hours of any admission at (888) 316-7947. Coverage for continued treatment is assured when approval is obtained from the SWHP Medical Director through the CCD. SWHP will approve or deny the requested post-stabilization treatment within one hour if contacted by the provider or facility.

Emergency care in a hospital emergency room requires a copayment**,** which will be waived if hospital admission occurs within 24 hours.

While a medical emergency is considered a life threatening condition, urgent care is considered less severe than an emergency, but requiring care more quickly than elective care.

Examples of urgent care includes, but is not limited to, the following:

- sudden illnesses and injuries,
- lacerations, and
- fever.

SWHP encourages you to access one of its urgent care centers if you find yourself needing urgent care after-hours. Urgent Care Clinic hours vary at each clinic. If you do not know when to access an urgent care clinic, please contact a SWHP LiveWell! nurse through our Nurse Advice Line at (877) 505-7947.

For more information on the SWHP Nurse Advice Line, please refer to LiveWell! on page 2. You may also find a list of Urgent Care Clinics on our website at ers.swhp.org.

Specialty Care

All non-emergent medical care must be provided by SWHP network providers. SWHP does not require a referral from a primary care physician before you can access a specialist. Simply call the specialist's office and make an appointment.

Due to the nature of some specialties, some physician offices may require a referral prior to making your appointment. This is the choice of that physician's office and not a requirement of SWHP.

Behavioral Health Services as well as certain other services may require prior authorization through SWHP Care Coordination Division (CCD). Examples of services, procedures, or tests that may require prior notification and/or authorization by SWHP are listed under "Prior Authorization."

Hospital and Hospice Admissions

Each day you are in the hospital, SWHP nurses and Medical Directors review with your physician the level of care you require and work with him/her to determine the amount of time you need to stay in the hospital. SWHP pays for urgent/emergent medically necessary admissions, but must be contacted within 24-48 hours of your hospitalization.

Notification requested:

- Acute (contracted) hospital admissions (medical, surgical, behavioral health)
- Admissions to inpatient or outpatient (contracted) hospice programs

Prior Authorization

For elective hospital admissions and certain types of procedures listed below, you need a prior authorization from the SWHP Care Coordination Division (CCD) before the day of the procedure if you want to be sure SWHP will pay for the hospital and procedure.

Prior Authorization required:

- Admissions to Long Term Acute Care (LTAC), Rehabilitation, and Skilled Nursing facilities
- Admissions to behavioral health/substance abuse residential, partial hospitalization, and day programs (not office visits to contracted providers)
- Neuropsychological and psychological testing
- Applied behavioral analysis therapy
- Outpatient electroconvulsive therapy (ECT)
- Solid organ and stem cell transplants (Pre-transplant Eval; Transplant; Post-transplant care)
- Orthognathic surgery
- Treatments for sleep apnea (other than CPAP/CPAP-related supplies)
- Home health services, including all requests for hourly or private duty nursing
- Durable medical equipment (DME) (see specific items listed)
- Orthotics and prosthetics (see specific items listed)
- X-Stop Spacer for Spinal Stenosis
- Artificial disc implantation/replacement
- Spinal fusion and vertebroplasty
- Ventricular Assist Devices (VAD)
- Genetic testing (except Chromosome testing)
- Intrathecal Pain Pump implantation/therapy
- Spinal stimulators
- Vagal nerve stimulators
- Fixed Wing or Jet Medical Transports
- IVIG therapy
- Lung Volume Reduction Surgery
- Transaortic or Transapical Valve Insertion or Replacement (TAVI/TAVR)
- Insulin pumps and/or continuous glucose monitors
- Bone-Anchored Hearing Aids (BAHA)
- Cochlear implants
- Dental services and anesthesia for dental services
- Epidural Adhesiolysis
- LINX Procedure

Durable Medical Equipment (purchase or rental):

- Oral appliances
- Electric, semi-electric, air fluidized, and advanced technology beds and related equipment
- Oxygen and related equipment
- Ventilators and related equipment
- High frequency chest wall oscillation air-pulse generator system; including vest, hose, and related equipment
- Bone stimulators
- Spinal cord stimulators
- Functional neuromuscular stimulation, transcutaneous stimulation of sequential muscle groups of ambulation with computer control, entire system
- Functional electrical stimulation, transcutaneous stimulation of nerve and/or muscle groups, complete system
- Power wheelchairs and related equipment
- Power operated vehicles and related equipment
- Custom-made and specially-sized wheelchairs and related equipment
- Dialysis equipment
- Defibrillators and related equipment (includes chest/vest defibrillators)
- Non-specific, miscellaneous, and unlisted DME codes

Orthotics and Prosthetics:

- Breast implants (unless status post medically indicated mastectomy)
- Lower and upper limb prosthetics (including myoelectric and microprocessor controlled) and related equipment/supplies
- Facial, nasal, and auricular prostheses
- Non-specific, miscellaneous, and unlisted orthotic and prosthetic codes

This list is not inclusive and may be subject to change.

If you have any questions on the list or if you require an urgent coverage determination, please contact the CCD at (888) 316-7947. Someone will be happy to answer any questions or concerns you may have. If you do not contact the CCD prior to obtaining any of the above services, SWHP has the right to review and potentially deny coverage for the procedure or service.

Behavioral Health Care

Behavioral health care is defined as care needed for treatment of emotional problems and psychiatric conditions. SWHP pays for medically necessary care in accordance with your benefit plan. SWHP's behavioral health care staff includes psychiatrists, psychologists, counselors, and social workers.

OB/GYN Care

SWHP encourages adult female members to obtain a well-woman exam every year. If you have designated a PCP, he/she or a SWHP network obstetrics/gynecology physician may perform the exam.

Optometry Care

Routine refraction examinations with participating optometrists are limited to one per member per plan year and are subject to your office visit copayment.

Routine eye exam – 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, prescriptions, or fittings of contact lenses or eyeglasses, or the cost of the contact lenses or eyeglasses.

Annual examinations for routine eye refractions are not normally required unless there is a condition leading to rapid change in the refraction characteristics of the eye. In the rare instance where a repeat refraction would be necessary in less than a year, you must obtain approval from a SWHP Medical Director to receive the care.

Skilled Nursing Facility

Coverage is provided for care in a skilled nursing facility only if the member is admitted to a SWHP network skilled nursing facility by a SWHP network provider and the SWHP provider certifies the skilled level of care is medically necessary. The SWHP Medical Director must determine skilled nursing care is medically necessary and approve the admission. SWHP does not cover custodial, convalescent, respite care, or other institutional care which does not meet the definition of skilled nursing care.

If you have any questions about your skilled nursing facility benefits, please contact a Customer Service Advocate at a SWHP office near you.

REMEMBER: All skilled nursing facility care services require both prior approvals from the SWHP Medical Director and a referral by your SWHP provider for SWHP coverage.

Texas Mandated Benefits

The following benefits mandated by the state of Texas are included in your coverage:

- Amino Acid-Based formulas for Diagnosis and Treatment of Certain Diseases or Disorders
- Alzheimer's Disease
- Autism Spectrum Disorder
- Acquired Brain Injury
- Brain Injury
- Cardiovascular Disease Screening
- Chemical Dependency
- Routine Care during Clinical Trials
- Craniofacial Abnormalities
- Diabetes
- Hearing Test for Newborns
- Orally Administered Anti-Cancer Medications
- Osteoporosis
- PKU
- Prosthesis and Orthotics
- TMJ
- Telehealth/Telemedicine

Accessing Pharmacy Benefits

Prescription Drug Benefit

SWHP offers a prescription drug benefit. You simply pay a copayment to receive certain prescription medications. Please refer to the Evidence of Coverage for copayment amounts and limitations. New and refill medications (34-day supply) may be dispensed by any SWHP network pharmacy provider or the Scott & White Pharmacy – Salado (mail order).

A formulary is a list of selected medications that are covered by your drug benefit. These medications are chosen by a committee composed of physicians and pharmacists. The formulary is designed to help your doctor in the selection of safe, appropriate, and cost-effective drug therapies. It is under constant review and may change as new medicines or new information on current medicines becomes available. Some medicines are not covered by your drug benefit. Examples of non-covered medicines are medicines for cosmetic purposes or weight loss, medicines available without a prescription, or medicines used for experimental purposes. If your physician prescribes a medication that is not on the formulary, and is not specifically excluded from coverage, you and your physician may choose one of the following options:

- Your physician may change your prescription to a medicine listed on the formulary. This will generally result in a lower copayment for the medicine.
- You may have the prescription filled and you will be responsible for a portion or total cost of the medication according to your Evidence of Coverage.

Occasionally, there are special situations in which SWHP may review formulary exceptions. The SWHP Medical Director reviews the individual case and may approve an exception. To initiate this review, your provider will need to send a request to SWHP.

Generic Drugs

SWHP covers the generic equivalent drug if available and if the generic drug has received an "A" rating by the Food and Drug Administration. This rating indicates the generic product performs equally to the brand-name. If a generic form of a brand-name drug becomes available, the brand-name medication may be subject to a higher copayment and possibly a penalty. The generic medication may be covered at the lower copayment.

Maintenance Drugs

The Maintenance Drug List is made up of routinely prescribed medications for certain chronic illnesses that affect a large number of SWHP members. Please refer to your formulary for the most up-to-date list of maintenance-eligible medications.

Your drug benefit allows a larger supply of medicine for a specified copayment.

To receive maintenance quantities, the medication:

- must be dispensed by a SWHP-owned pharmacy or Scott & White Pharmacy – Salado (mail order),
- must be included on the Maintenance Drug List, and
- must be approved by your physician for a three month supply (90 days).

Prior Authorization

SWHP may require you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from SWHP before you fill your prescriptions.

One-time prescriptions or refillable prescriptions that exceed the authorization requirement amounts in the Prescription Drug Schedule of Benefits will require prior authorization by the SWHP Medical Director.

Quantity Limits

For certain drugs, SWHP limits the amount of the drug that SWHP will cover. In addition to limiting medications to one month supply, additional quantity limits may be applied. For a list of drugs subject to quantity limits, please refer to the formulary.

Step Therapy

In some cases, SWHP requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, SWHP may not cover drug B unless you try Drug A first. If Drug A does not work for you, SWHP will then cover Drug B. For a list of drugs subject to step therapy requirements, please refer to the formulary.

Drug Formulary

The formulary (drug list) is tiered meaning there are different copayment levels for drugs on different levels:

Tier 1 (T1): generally preferred generic copay
Tier 2 (T2): generally preferred brand-name copay
Tier 3 (T3): generally non-preferred brand-name/generic copay

The SWHP formulary is an open formulary. This means that drugs not listed on the formulary may be covered at a non-formulary copay as long as the drug is medically necessary, other plan rules are followed, and the drug is not considered an excluded drug. Excluded drugs are not covered. For example, a drug used for cosmetic purposes may be considered an excluded drug. Please review your Evidence of Coverage and other plan materials to determine which drugs may be considered excluded from coverage.

You can find our drug list on our website at ers.swhp.org. It is located on the "Quick Links" tab, "Drug Formulary." You can find out if your drug has any additional requirements or limits by looking at our drug list. For more detailed information about your SWHP prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have any questions about your prescription drug benefit, please contact a Customer Service Advocate at a SWHP office near you.

Accessing Value Added Benefits

SWHP Website

For more information enrollees can visit SWHP's website at ers.swhp.org. Below are some of the items available.

- Find a provider
- Prescription refills
- Health resources
- Health Plan news and publications
- LiveWell! programs
- Change your Primary Care Physician (PCP)
- Order an ID card or print a temporary one
- Check claims status
- View Explanations of Benefits (EOBs)
- Estimate medical expenses
- Frequently asked questions
- Find forms and resources to manage your plan

LiveWell! Programs

LiveWell! is designed to make your health and medical decisions less confusing and overwhelming. Helping you understand your options for care and communicate more effectively with your doctors are the primary goals of the program. Listed below are the valuable services available to you through **LiveWell!**.

LiveWell! Nurse Advice (Health Coach) Line

If you or one of your dependents is ill or injured, you can contact the LiveWell! nurse advice line at (877) 505-7947. The Nurse Advice Line is staffed 24 hours a day, every day of the year. Our nurses can offer health coaching to help you take care of yourself at home or can help determine if an appointment, an urgent care visit, or an emergency room visit is most appropriate for your symptoms.

If you feel you have an emergency, please contact 911 or go to the nearest emergency room.

LiveWell! Disease and/or Condition Care Programs

Our disease and condition care management programs provide you with the tools and resources to learn more about your health and to continue to make positive changes in your life. These programs, addressing over 65 different diseases and conditions, are available to Scott & White Health Plan commercial (HMO, PPO, and ASO) members.

The Dialog Center

The Dialog Center is an online health and wellness site that complements personal health coaching. Members may register to use the Dialog Center by going to ers.swhp.org and selecting the Disease Management link. The Dialog Center contains:

The HealthWise® Knowledgebase

- Look up information on medical conditions, tests, and drugs.
- Watch videos made by patients and/or doctors.
- Use interactive tools such as quizzes and calculators.
- Check on symptoms you may be having through the Symptom Checker.
- Look up information on Support Groups.
- Available in English and Spanish.

Shared Decision-Making®

- Shared Decision-Making® Programs contain unbiased information organized around Preference-Sensitive Decisions. For example: Should I have knee surgery or manage my condition non-surgically?
- Includes medical opinions reflecting different points of view
- Shares the experiences of real patients who made different choices when faced with the same decision
- Programs are designed to help members have meaningful dialog with their doctor about their options
- Topics range from breast and prostate conditions to back pain and heart disease

Health Coach Message Center

- Send secure email to a Health Coach
- Receive messages from your Health Coach
- Bookmark information you receive from your Health Coach so you can find it easily

Health News

Dedicated to supporting excellence in medical and news reporting. The site aims to:

- Improve the accuracy of news stories about medical treatments, tests and procedures
- Help consumers evaluate the evidence for and against new ideas in health care
- Support and encourage the ABCs of health journalism - Accuracy, Balance and Completeness

News stories are monitored daily and selected for review from the major U.S. media including:

- The nation's top 50 circulation newspapers
- The evening network newscasts of ABC, CBS and NBC
- The Associated Press wire service; the weekly news magazines TIME, Newsweek and U.S. News & World Report

LiveWell! Health Education Audio Reference (HEAR) Library

For those who want to listen to information about a health topic, Scott & White Health Plan offers the Health Education Audio Reference (HEAR) Library with over 300 English-language and 25 Spanish-language topics.

To listen to information on a heath topic, call (**877) 505-7947** and select option 2. You can hear a list of topics there, or you may go to **ers.swhp.org** and select Wellness/Value Added Services to find a list of topics.

Dinner Tonight - Healthy Cooking School

Scott & White Health Plan and Texas A&M AgriLife Extension offer The Dinner Tonight Healthy Cooking School. It has a unique niche with demonstration recipes that are

- Cost effective
- Easy to prepare
- Very nutritious

The goal of our cooking school is to promote family mealtime, teach families healthy meal planning and food preparation techniques, and promote Texas agriculture!

Dinner Tonight Healthy Cooking School classes are held at the Temple Scott & White Health Plan building.

VitalBridges

SWHP has established VitalBridges, a program designed to improve coordination of care for members after they have been discharged from the hospital. Within two days of discharge, we will call the member.

Members will be asked:

- if they have scheduled a follow-up visit with their regular doctor.
- if they need help getting to their doctor appointment.
- if they need in-home services such as visiting nurses or home health services.

If members have questions about their medications, a SWHP pharmacist:

- will call and assist them with their questions.
- do a medication reconciliation.
- may make a medication recommendation or help the member prepare for that at their doctor visit.

If members have a question about their health or condition, they will be given the SWHP Nurse Advice Line number to call. An outbound call from the Nurse Advice Line can also be arranged if that is needed. Other member needs will be assessed and if found these will be referred back to SWHP for follow-up.

Step Up Scale Down

Step Up Scale Down is a 12-week program featuring nutrition and exercise education.

Each week features a different topic including goal setting, reading nutrition labels, meal planning, and starting or stepping up your exercise program. The classes will be taught by nurses, clinical pharmacists, and wellness professionals with expertise in exercise and nutrition.

Classes will be offered at selected Scott & White Clinics and Pharmacies across our service area as well as at the Scott & White Health Plan offices. Step Up Scale Down is free for Scott & White Health Plan members.

LiveWell! Succeed Health Risk Assessment

LiveWell! Succeed is an online health risk assessment. It is designed to identify basic information about your health. It includes questions concerning your personal health history, substance abuse, stress/coping, physical activity, and nutrition.

After completing the assessment, you will receive a report that includes a response to each of your answers. Each response consists of an explanation and advice that may help you with your health choices.

To begin your online assessment, visit ers.swhp.org and log in to MyBenefits. Select "LiveWell! Health Risk Assessment" then select "Get Started."

For details and registration information please contact the Scott & White Health Plan at (800) 321-7947.

LiveWell! Lifestyle Management Programs

We help support healthy choices by providing individual personalized plans that fit your life.

LiveWell! Relax. Address your unique sources and symptoms of stress with a stress management strategy developed just for you.

LiveWell! Nourish. Receive strategies for making smart food choices and a nutrition plan that fits your lifestyle.

LiveWell! Breathe. Learn to deal with cravings, boost your motivation and decrease your dependency.

LiveWell! Balance. Gain a positive self-image through a personalized weight management and physical activity plan.

LiveWell! Care for Your Back. Get strategies, videos, and exercises designed to help you care for your back.

LiveWell! Overcoming Depression. Live a fuller life by learning ways to help manage your depression.

LiveWell! Care for Your Health. Discover the skills you need to take better care of your health and get back to living.

LiveWell! Overcoming Binge Eating. Explore your relationship between food and your emotions to free yourself from your compulsive overeating.

LiveWell! Overcoming Insomnia. Learn techniques that address your specific problem and discover healthy, restful, stress-free sleep.

To participate in any of the lifestyle management programs, visit ers.swhp.org and log in to MyBenefits. Select "LiveWell! Lifestyle Management Programs," then select "Coaching Sessions."

Poison Control Center

The Central Texas Poison Control Center is located at Scott & White Memorial Hospital and Clinic in Temple. It is supported by an intrastate long-distance telephone tax and designated by the Texas Legislature to provide poison information and prevention services to health care professionals and the public within Public Health Region 7. The Texas Poison Center Network is comprised of six poison centers regionally located throughout the state, the Department of State Health Services, and the Advisory Commission on State Emergency Communications. This area serves the two million people residing in Central Texas, and includes Austin, Waco, and extends east to College Station and west to San Saba.

If you would like some educational material, please call (800) 222-1222. Emergency and consultative services to both the public and health care providers are available through (800) 222-1222 or, if an emergency, call 911. Calling (800) 222-1222 accesses all poison centers by region within the state of Texas, when calling from Texas, and will access Central Texas Poison Control Center when calling within Public Health Region 7. The center operates 24 hours a day, every day of the week. For those who are not within the service area and are interested in speaking with Central Texas Poison Control Center directly, please call (254) 724-7405.

Complex Care Management Program

Scott & White Health Plan Complex Care Management is a program for members who have chronic conditions or complex care needs. A licensed nurse or social worker case manager will work with members, families, and the physician to create a plan to meet the member's ongoing complex care needs.

Case Managers advocate for members. They assist them with setting goals and a personal plan to improve their health. They also can assist with arrangements for necessary services. Case Managers answer questions and provide education to help members have a better understanding of their condition and plan of care.

The purpose of the program is to help members get the best possible results and the greatest value from their health plan. Participation is voluntary. There is no additional cost to members for this program.

For more information, please fill out our referral form to request a screening at ers.swhp.org. Select Disease Management and scroll to the Complex Care Guidance section to see if Complex Care Guidance is the right program for your needs. You may also contact a SWHP office near you.

Maternal Options Maintenance Support (MOMS)

Sometimes new mothers feel a little overwhelmed. MOMS is an optional program that provides valuable family support following your baby's birth. Through personal phone calls, our knowledgeable licensed nurses answer routine questions about mom and baby care, provide tips for healthy lifestyle habits and help mothers and their families get off to a great start. For more information on MOMS, visit ers.swhp.org, select "Wellness/Value Added Services" then "Maternity-related Topics."

Quality Improvement Program

A goal of the Quality Improvement Program is to improve the health of its members. To reach this goal, SWHP has developed programs that are designed to aid in disease prevention and management. Programs include the following: diabetes mellitus, cardiovascular disease, immunizations, and women's health. If you would like information about the complete Quality Improvement Program description, its goals, process and/or outcomes, please contact the SWHP Quality Improvement Division at (888) 316-7947.

Vitality Coordinators

SWHP has placed Vitality Coordinators into several Scott and White clinics and employer groups. Vitality Coordinators are nurses who work in the clinical setting side by side with providers, clinic nurses, and the other members of the clinical team. They also work on-site at some employer locations. Their goal is to close gaps in care for SWHP members receiving care in these specific clinics.

Prior to a member's appointment, they are the first clinical team member to review the health record and identify gaps in the member's health care. Any gaps identified are documented for the provider's review at the time of the office visit. After the provider and clinical team have seen the patient, the Vitality Coordinator updates the member's health record once more to ensure closures in such gaps have been appropriately addressed and documented.

The Vitality Coordinator has a set of orders that he/she can follow to automatically close gaps in care for the member's health benefits.

Some of the ways they help our members:

- Identifies and encourages members who have not been seen in the clinic to come in for care.
- Supports and provides health education for members with knowledge gaps or questions about their health.
- Works under the direction of providers.
- Coordinates services such as immunizations, blood pressure checks, lab orders, appointment assistance, diabetes education, obesity management/prevention etc.
- Conducts chart audits to make sure members, especially those with chronic conditions, are up to date on their routine follow-up appointments, tests and immunizations.
- Makes referrals to other SWHP care programs or coordinates needed care with other clinical staff as indicated by the physician's care plan for the member
- Helps the member to navigate the complex healthcare system and receive quality care.
- Is a patient advocate and identifies clinical gaps in care.
- Supports member engagement and participation in the physician's plan of care.

Requests for Coverage of New Technical Procedures

SWHP has a process whereby a group of physicians and other healthcare professionals evaluate requests for coverage of new technological procedures or treatments. The Technical Assessment Committee (TAC) receives a proposal from a requesting doctor that outlines a new or currently uncovered medical or behavioral procedure, pharmaceutical, device, test or treatments; the perceived advantages over current therapy and criteria for utilization; and supporting papers from peer-reviewed scientific journals. The Technical Assessment Committee then meets to evaluate the physician's request for coverage. The recommendations of the Technical Assessment Committee are presented to the SWHP Quality Improvement Committee for a final approval determination. If you have a request of coverage for a new medical or behavioral procedure, Pharmaceutical, device, test or treatment, please contact your physician or the Care Coordination Division at (888) 316-7947.

Medical Cost Estimator

Now you can estimate the cost of care before seeking treatment. Ask your doctor's office for the Diagnosis Code or CPT/HCPCS Code. If you have your Summary of Benefits handy, you can even estimate out-of-pocket expenses. Visit ers.swhp.org and select the "Medical Cost Estimator" link (in the Quick Links) to find an estimate of charges for various procedures.

Status Changes

Continuation of Coverage

If you or your dependents are no longer eligible under your current coverage, you may be able to continue your SWHP membership through one of the following options:

- Under the COBRA Federal Regulations, you have the right to continue the same coverage through your employer under certain conditions of your loss of coverage and if your employer has 20 or more employees. This coverage is at your own expense. Dependents may also be eligible for COBRA continuation coverage when they become ineligible or upon the death of the contract holder. You should check with your employer for more information on this option.
- Under Texas Continuation of Coverage, you have the right to continue the same coverage through your employer under certain conditions of your loss of coverage and if your employer has less than 20 employees. This coverage is at your own expense. You should check with your employer for more information on this option. This conversion option could extend your SWHP coverage for up to nine months.

Continuity of Treatment

If SWHP terminates your physician, SWHP may continue to reimburse your physician if you are seeing him/her under a special circumstance such as a disability, acute condition, or life-threatening illness. Your physician must submit a request to SWHP Medical Director that explains the reasons for continuing treatment under his/her care. If SWHP grants the request, SWHP will reimburse your physician at the contract rate for up to 90 days from the date of his/her termination.

For patients new to SWHP who are in active treatment for medical conditions with non-SWHP network providers, SWHP may grant up to 90 days to transition care to SWHP providers, based on individual case review.

Customer Service

SWHP is dedicated to serving you and your family. To enhance our service to you, Customer Service Advocates are available through telephone interaction 24 hours a day, seven days a week, email, or through personal meetings by appointment. Customer Service Advocates can assist you in many ways. They help you take full advantage of your SWHP benefits by:

- answering questions about using SWHP,
- explaining your benefits,
- helping you choose or change your Primary Care Physician (Choosing a Primary Care Physician is optional.),
- assisting you in resolving complaints and appeals, and
- sending you printed materials upon your request.

To contact a Customer Service Advocate, call or email a SWHP office near you. Phone numbers and email addresses are available on the inside front cover.

Interpretive and Communication Services

In an effort to improve communication with non-English speaking members, SWHP uses the interpretive services of AT&T. Members do not have to call a special line for this service. When contacting SWHP, members may notify the Care Coordination Division (CCD) staff and/or Customer Advocates of their primary language and the call will be completed with the help of an AT&T interpreter at no charge to the member.

SWHP uses a toll free TTY number, (800) 735-2989, to assist with communication services for members with hearing or speech difficulties. The TTY number is listed on the SWHP webpage at ers.swhp.org and is also included in your member correspondence and member publication materials.

Information About Practitioners

If you would like to know the professional qualifications of a SWHP network provider, contact a Customer Service Advocate at a SWHP office near you or visit us online at ers.swhp.org and click “Find a Provider.”

You can inquire about your physician’s medical school, residency completion, board certification status, and other information you may need in order to choose a practitioner in the network.

Complaints and Appeals

SWHP is dedicated to addressing your concerns and resolving them promptly. If there is ever a time when you are not satisfied with the performance of SWHP or one of its providers, you should contact a Customer Service Advocate immediately. All grievances are documented and thoroughly investigated. SWHP encourages your input and will not discriminate against you, refuse coverage, or engage in any other retaliation if you choose to file a Complaint or request an Appeal of a decision. Additionally, SWHP is prohibited from retaliating against a physician or provider who has filed a Complaint against SWHP on your behalf.

Complaints

SWHP's definition of a Complaint is an oral or written form of dissatisfaction that is not able to be resolved promptly to your satisfaction. When you call a Customer Service Advocate to express dissatisfaction, he/she will immediately document your issues. SWHP will send an acknowledgment letter of the receipt of oral or written Complaint no later than five (5) business days after the date of the receipt of the Complaint. The acknowledgment letter will include a description of SWHP’s Complaint procedures and time frames. If the Complaint is received orally, SWHP will also send you a Complaint form (as required by the Texas Department of Insurance), the return of which, while not required, will aid in the prompt resolution of the Complaint. This form does not go into your medical record; it simply helps SWHP address your Complaint with the appropriate person or department. SWHP responds to oral and written Complaints in the same manner and informs you of a resolution within thirty (30) calendar days of receipt of the Complaint. The response letter will contain a full description of the process for Appeal, including the timeframes for the Appeals process and the timeframes for the final decision on the Appeal.

Appeals of Complaints (Appeal Hearing)

SWHP’s definition of an Appeal is a request for SWHP to review its decision regarding a previously filed Complaint. Appeals of Complaints are presented to a panel, which is held within thirty (30) calendar days after receipt of the request. You have the right to appear before the panel and to present written or oral information in support of your request to revise the previous decision.

SWHP will appoint members to the Complaint Appeal Panel, which shall advise SWHP on the resolution of the Complaint. The Complaint Appeal Panel shall be composed of one SWHP 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 SWHP.

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

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

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

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

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, SWHP 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) business 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.

Notice of the final decision of SWHP 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.

Appeals of Adverse Determinations

An Adverse Determination is a denial of coverage based upon medical necessity or experimental and investigational determination. When you call a Customer Service Advocate to request a first level Appeal, he/she will immediately document your issues and send you an Appeal form (as required by the Texas Department of Insurance) the return of which, while not required, will aid in the prompt resolution of the Appeal. SWHP will review our decision and provide you with a written determination within thirty (30) calendar days of the receipt of the Appeal. If we continue to deny the payment, coverage, or service requested, you may request review by an independent review organization. The SWHP will permit and pay for an Appeal to an independent review organization in the event the decision rendered was an Adverse Determination to the complainant.

If you are seeking review of the denial of an emergency care or an ongoing hospital stay, you are entitled to an expedited review by a provider of the appropriate specialty who has not previously reviewed your case. The time for resolution of your expedited Appeal will be based upon the medical immediacy of your condition, but may not exceed one (1) business day from the date all information necessary to complete the Appeal is received by SWHP.

Independent Review of Adverse Determinations

SWHP 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.

SWHP 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 of the Appeal resolution;
4. any documentation and written information submitted to SWHP 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.

SWHP 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.

To read the full Complaints and Appeals Policy, please see page 13 or your Evidence of Coverage. For more information on your Complaint and Appeal rights, please contact a Customer Service Advocate at a SWHP office near you.

Claims

Claims are usually submitted by the provider of service to SWHP on your behalf, and you are responsible for giving them your insurance information at the time of service. If you receive services out of the SWHP service area, the provider may request payment in full at the time of service. You will need to submit a copy of the medical expenses (itemized bill showing paid in full) to SWHP.

Information needed to process your claim:

- A copy of the bill
- An itemized copy of the services which includes valid procedure and diagnosis codes
- Explanation of why services were received outside the SWHP network
- The date of service
- The name of the patient
- The name of the contract holder
- The enrollee identification number
- Written proof of the payment (copy of the canceled check, receipt, etc.)
- Explanation of Medicare Benefits (if applicable)

Please forward the claim to the following address:

Scott & White Health Plan
MS-A4-126
Attn: Claims Department
1206 West Campus Drive
Temple, TX 76502

If you have any questions about how to submit your claim or other claims questions, please call SWHP at (800) 321-7947 or (254) 298-3000.

Claims Status Notification

After SWHP has received a claim from the provider or from you for reimbursement, additional information may be needed to process the claim. You will be notified with a Claims Status Notification by mail defining what additional information is needed to complete the processing of your claim. Please read the notification carefully to see what action, if any, is needed from you. If you have any questions regarding a Claims Status Notification, please contact SWHP at (800) 321-7947 or (254) 298-3000.

Coordination of Benefits

You may be eligible for Coordination of Benefits if you have more than one health insurance plan. Coordination of Benefits requires insurers to share the responsibility for paying for services they both cover. The primary insurer pays first; the secondary insurer pays the balance (provided the balance is not more than the secondary carrier would have paid under provider's contract and the member's contract benefits). If you have any questions, or if you would like to see if you are eligible for Coordination of Benefits, please call SWHP at (800) 321-7947 or (254) 298-3000.

Workers' Compensation

If you see a SWHP network physician about an injury that occurred while you were on the job, you must report this to the clinic at the time of your visit. This allows your charges to be filed with the appropriate Workers' Compensation insurance carrier.

Frequently Asked Questions

How do I obtain emergency care? When should I call 911 instead?

SWHP will provide benefits for medically necessary emergency care whether you are temporarily out of the service area or within the service area. Emergency care is defined as the sudden and unexpected onset of a condition of such a nature that a prudent layperson, possessing an average knowledge of medicine and health, believes their health could be jeopardized if they do not get immediate treatment. SWHP will approve or deny the requested post-stabilization treatment within one hour if contacted by the provider or facility. Some examples of emergency conditions include the following:

- Unusual or excessive bleeding
- Broken bone
- Acute abdominal or chest pain
- Loss of consciousness
- Suspected heart attack
- Sudden persistent pain
- Serious burn
- Poisoning
- Convulsions
- Difficulty in breathing

In all emergency situations, you are encouraged to seek care with the nearest SWHP approved provider; however, if the time needed to reach a SWHP approved provider might endanger your health, go to the nearest emergency room. Medically necessary emergency care is covered. If you are hospitalized as a result of the emergency, you should contact the SWHP Care Coordination Division within 24 - 48 hours of any admission at (888) 316-7947. Coverage for continued treatment is assured when approval is obtained from the SWHP Medical Director through the Care Coordination Division. Emergency care in a hospital emergency room requires a copay, which will be waived if hospital admission occurs within 24 hours.

While a medical emergency is considered a life-threatening condition, urgent care is considered less severe than an emergency, but requiring care more quickly than elective care. Urgent care includes, but is not limited to, sudden illnesses and injuries, lacerations, and fever. SWHP encourages you to access one of its Urgent Care Clinics if you find yourself needing urgent care after hours. Urgent Care Clinic hours vary at each clinic. If you do not know when to access an Urgent Care Clinic, please contact a SWHP LiveWell! nurse through our nurse advice line at (877) 505-7947.

How do I obtain primary care services?

To make a routine appointment, contact your physician's office. To help the staff schedule your appointment quickly, please refer to the following.

- If it is your first appointment, indicate this to the appointment clerk.
- Have your identification card ready for any required information.
- Periodic examinations (e g., annual pap smears or history and physical) may need to be scheduled 8 -12 weeks in advance. Other routine appointments are scheduled according to the urgency of the problem.
- Notify your physician's office as quickly as possible if you cannot keep an appointment.
- You may access any of our contracted physicians. Your copay is based on whether the physician is a primary care physician or specialist. PCPs include:
    - Family Practice treats all age groups from newborns to the elderly. They provide routine medical care, referrals to specialists, some minor surgical procedures, and obstetrics/gynecology services.
    - Community Internal Medicine physicians treat patients 16 years and older. They provide routine medical care, gynecology services, and referrals to specialists.
    - Pediatrics treats children up to age 18 and provides routine care as well as referrals to specialists.
    - OB/GYN specializes in women's health and family planning.

For a list of physicians visit the 'Find A Provider' page at ers.swhp.org or call Customer Service toll-free at (800) 321-7947 or (254) 298-3000.

How do I obtain specialty care, behavioral health care services, and hospital services?

All non-emergent medical care must be provided by SWHP network providers. You may see a network specialist without a referral. Behavioral health services and elective hospital admissions require prior authorization through SWHP Care Coordination Department.

How do I get care after normal office hours?

After-hours telephone calls or emergency requests are routed to the Scott & White Memorial Hospital operator. The Care Coordination Division is contacted for authorizations for in-patient admissions and emergency surgeries and procedures.

If you are ill or injured, you can contact the LiveWell! Nurse Advice Line at (877) 505-7947. They are staffed 24 hours a day, every day of the year. Our nurses can give you information about how to take care of yourself at home or can help determine if an office visit, an urgent care visit, or an emergency room visit is most appropriate for your symptoms. It is free, completely voluntary, and confidential. However, this service is not meant to replace a doctor's care.

We also have several after-hours and Urgent Care Clinics available. Visit ers.swhp.org for a list of these clinics or call Customer Service at (800) 321-7947 or (254) 298-3000.

What does "Open Access HMO" mean?

Scott & White is now an Open Access HMO. This means that a member can go to any network provider without a referral. Members may choose a network primary care physician (PCP) if they would like to designate one, but PCPs are no longer required by the Scott & White Health Plan.

What benefits and services are included and excluded from my coverage?

You may check your benefits by logging in to **'MyBenefits'** on the ers.swhp.org website. Select **'My Information'**, **'Member Detail'**, then the **'Policy Benefit Name'** link. You will be able to view a PDF of your benefits and exclusions. You may also call our Customer Service department at (800) 321-7947 or (254) 298-3000.

How can I find my copays and other charges for which I am responsible?

You may check your copays and other charges by logging in to '**MyBenefits**' from the top right corner of the website. Select '**My Information**', '**Member Detail**', then the '**Policy Benefit Name**' link. You will be able to view a PDF of your copays, benefits, and exclusions. You may also call our Customer Service department at (800) 321-7947 or (254) 298-3000.

What benefit restrictions apply to services obtained outside SWHP's system or service area?

You may view benefit restrictions by logging in to **'MyBenefits'** from the top right corner of the website. Select **'My Information'**, **'Member Detail'**, then the **'Policy Benefit Name'** link. You will be able to view your Evidence of Coverage (EOC), which lists restrictions in your plan. You may also call our Customer Service department at (800) 321-7947 or (254) 298-3000.

What does "not mutually exclusive" mean?

Out-of-pocket maximums are not mutually exclusive from other out-of-pocket limits. This 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 $6,450 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 $4,450 in copayments, totaling $6,450 in overall out-of-pocket expense.)

How do I submit a claim for covered services?

You must access services through a Scott & White network provider unless you have received prior authorization through SWHP Care Coordination Division. For covered services provided by SWHP network providers, members do not have to file a claim. The participating provider will file the claims on your behalf. Just make sure you present your ID card at the time of service which identifies you as a member.

For services provided by non-participating providers, you will need to file a claim for reimbursement directly to SWHP at the following address:

Scott & White Health Plan
Attn: Claims Dept.
1206 West Campus Drive
Temple, TX 76502

Once SWHP receives your claim, you will receive an acknowledgement letter within 15 days. The acknowledgment letter will indicate if any additional information is needed.

What should I do if I get a bill that should have been paid by SWHP?

As soon as you receive the bill, please contact a SWHP Claims Representative at a SWHP office near you for assistance.

How can I obtain language assistance?

In an effort to improve communication with non-English speaking members, SWHP uses the interpretive services of AT&T. When calling a SWHP representative, you can request to be linked to a highly trained interpreter. Let the Customer Service Advocate know your primary language and the call will be completed with the help of an AT&T interpreter. You do not have to call a special line for this service.

SWHP also has several interpreters available through Customer Service at (800)-321-7947.

How do I voice a complaint?

If there is ever a time when you are not satisfied with the performance of SWHP or one of its providers, you should contact a Customer Service Advocate immediately. All grievances are documented and thoroughly investigated. SWHP encourages your input and will not discriminate against you, refuse coverage, or engage in any other retaliation if you choose to file a Complaint or request an Appeal of a decision. Additionally, SWHP is prohibited from retaliating against a physician or provider who has filed a Complaint against SWHP on your behalf.

SWHP's definition of a Complaint is an oral or written form of dissatisfaction that is not able to be resolved promptly to your satisfaction. When you call a Customer Service Advocate to express dissatisfaction, he/she will immediately document your issues. SWHP will send an acknowledgment letter of the receipt of oral or written Complaint no later than five (5) business days after the date of the receipt of the Complaint. The acknowledgment letter will include a description of SWHP's Complaint procedures and time frames. If the Complaint is received orally, SWHP will also send you a Complaint form (as required by the Texas Department of Insurance), the return of which, while not required, will aid in the prompt resolution of the Complaint. This form does not go into your medical record; it simply helps SWHP address your Complaint with the appropriate person or department. SWHP responds to oral and written Complaints in the

same manner and informs you of a resolution within thirty (30) calendar days of receipt of the Complaint. Refer to the Complaint and Appeal section on page 13.

How do I appeal a decision that adversely affects coverage, benefits, or my relationship with the organization?

SWHP's definition of an appeal is a request for SWHP to reverse a previous adverse decision. All appeals are presented to a panel, which is held within 30 calendar days after receipt of the request. You have the right to appear before the panel and to present written or oral information in support of your request to reverse the previous decision. The SWHP will permit and pay for an immediate appeal to an independent review organization in the event the decision rendered was an Adverse Determination (denial of coverage based on medical necessity determination) to the complainant and the request was presented to the SWHP within 180 days of the previous decision. For more information on your appeal rights, please contact a Customer Service Advocate at (800) 321-7947. Refer to the Complaint and Appeal section on page 13.

How can I add or delete someone from coverage under my plan?

If you are an active employee, contact your Benefits Coordinator. If you are a retiree, please contact the Employees Retirement System toll-free at (877) 275-4377.

What if I need additional identification cards, a copy of my policy, or any other materials?

You may request an identification card online at ers.swhp.org. To receive a copy of your policy, identification cards, summaries of benefits, or any other material, you may also contact a Customer Service Advocate at (800) 321-7947.

How does SWHP evaluate new technology for inclusion as a covered benefit?

SWHP has a process whereby a group of physicians and other health care professionals evaluate requests for coverage of new technological procedures or treatments. The Technical Assessment Committee receives from a requesting doctor, a proposal to SWHP that outlines a new or currently uncovered medical or behavioral procedure, devices or treatments, the perceived advantages over current therapy, criteria for utilization, and supporting papers from peer-reviewed scientific journals.

The Technical Assessment Committee then meets to evaluate the physician's request for coverage. The recommendations of the Technical Assessment Committee are presented to the SWHP Quality Improvement Committee for a final approval determination. If you have a request for coverage of a new medical or behavioral procedure, device, or treatment, please contact your physician or the Care Coordination Division at (888) 316-7947.

How do I obtain care and coverage when I am out of SWHP's service area?

As a member of SWHP, you are covered worldwide for any true emergency that occurs. Incidents such as heart attacks, deep lacerations, loss of consciousness, breathing difficulties, broken bones, and other critical conditions that require immediate treatment are covered with your emergency room copay/coinsurance. If you have a medical problem that is urgent but is not an emergency, you are encouraged to contact our Nurse Advice Line at (877) 505-7947. This is a 24-hour line that you can access from anywhere in the world for medical advice and assistance in managing your illness.

When seeking treatment in an out-of-network emergency room, provide your member identification card. This will speed up the processing and payment of your bill by SWHP. This will also allow the treating physician to discuss your emergency care with your network physician, if necessary.

What kind of coverage will my college-age child have while he or she is away at school?

SWHP will cover any emergency that occurs while away at school. It will be important to plan for routine medical needs while the student is away. If your child is attending school within the State and will be located near one of our provider clinics, your child can receive care at the facility. If the student is attending school out of the SWHP service area, it may be necessary to consider supplementary coverage for routine medical care. The student may want to use the college dispensary for his/her routine medical care. The student can also access our Nurse Advice Line at (877) 505-7947 at any time for medical advice and assistance.

I am currently seeing a doctor outside of SWHP; can I continue to see that doctor?

SWHP is a Health Maintenance Organization (HMO), and your care has been prepaid and prearranged for within the SWHP network. If you would like SWHP to pay for the doctor visit, you must see a SWHP physician. You may continue to see the physician outside the SWHP network, but SWHP will not pay for the visit. You may want to get copies of your medical care records from the outside doctor so that your SWHP physician can continue care.

How do I get a referral outside the SWHP network when you cannot provide the services that I need?

SWHP network is a large, multi-specialty network and, in most cases, can meet the majority of your medical needs. If you develop a medical condition that your Scott & White physicians cannot care for, you will need a recommendation from your SWHP network physician and the approval of the SWHP Medical Director before any out-of-plan services can be covered. A formal review of your case will be provided and you will receive a letter outlining clearly what SWHP will or will not cover with the outside physician.

What happens if I am hospitalized outside the service area?

Please have someone call SWHP within 24-48 hours of your admission so that we can begin coordinating your care as soon as possible. The instructions for reporting an out-of-plan admission are printed on the back of your member identification card. Simply use the toll-free line.

If you are hospitalized while traveling with others, we suggest that you always have someone else within your group know what to do in case you are unable to speak for yourself.

What are your pharmaceutical management procedures?

Our procedures describe the method for managing the drug formulary (drug listing) in order to provide the most cost-effective therapy options.

Prior Authorization: Scott and White Health Plan may require you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from Scott and White Health Plan before you fill your prescriptions.

Quantity Limits: For certain drugs, Scott and White Health Plan limits the amount of the drug that Scott and White Health Plan will cover. This may be in addition to a standard one-month or three-month supply.

Step Therapy: In some cases, Scott and White Health Plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, Scott and White Health Plan may not cover drug B unless you try Drug A first. If Drug A does not work for you, Scott and White Health Plan will then cover Drug B.

Prescriptions have copays (after the $50 per person deductible):

A = Generally Tier 1 Generic copay (preferred generic)
B = Generally Tier 2 Preferred brand-name copay
C = Generally Tier 3 Non-preferred brand-name copay

Excluded drugs are not covered. For example, a drug used for cosmetic purposes may be considered an excluded drug. Please review your Evidence of Coverage and other plan materials to determine which drugs may be considered excluded from coverage.

You can find our drug list on the ERS formulary page at ers.swhp.org. You can find out if your drug has any additional requirements or limits by looking at our drug list. For more detailed information about your Scott & White Health Plan prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have any questions about Scott and White Health Plan, please call our Customer Service at (800) 321-7947 or (254) 298-3000.

How do I obtain information about participating practitioners and providers?

If you would like to know the professional qualifications of a SWHP network physician, contact a Customer Service Advocate at a SWHP office near you or click 'Find A Provider.' You can inquire about your physician's medical school, residency, board certification status, and any other information you may need to choose a practitioner in the network.

If I decide I want to designate a primary care physician (PCP), how do I select a primary care physician (PCP)?

Scott & White is an Open Access HMO. A member can go to any network provider without a referral. Members may choose a network primary care physician (PCP) if they would like to designate one, but PCPs are no longer required by the Scott & White Health Plan.

If you would like to select a PCP, please refer to our online directory at ers.swhp.org. Each person listed on your plan may select a PCP from the following physicians:

- Family Practice treats all age groups from newborns to the elderly. They provide routine medical care, referrals to specialists, some minor surgical procedures, and obstetrics/gynecology services.
- Community Internal Medicine physicians treat patients 16 years and older. They provide routine medical care, gynecology services, and referrals to specialists.
- Pediatrics treats children up to age 18 and provides routine care as well as referrals to specialists.
- OB/GYN for women's health and family planning.

When selecting a PCP, consider which clinic would be most convenient to meet your own needs. Each person listed on your plan can select his or her own doctor.

If you would like specific information about any of the PCPs, just contact your Customer Service Advocate at a SWHP office near you. Once you designate a PCP, you can make an appointment with that physician. If your PCP is unavailable, you can see any other physicians of the same specialty that work with the clinic.

You may also select or change your PCP online at ers.swhp.org.

What if I do not like my PCP after I have designated him or her?

You can change your PCP anytime, online at ers.swhp.org or by contacting your Customer Service Advocate at a SWHP office near you.

Do all family members need to use a PCP/or the same PCP?

No covered person is required to designate a PCP. If they wish to do so, each person listed on your plan can select his or her own doctor.

Glossary

Anniversary Date – The beginning of the benefit year.

Annual Enrollment – A period during which subscribers have an opportunity to select the health plan being offered to them. Most open enrollment periods are held for one month every year. Members are allowed to add or delete changes in the plan during open enrollment.

Behavioral Health Care – The assessment and treatment of mental and/or psychoactive substance abuse disorders.

Benefit Package – The services a plan offers to a group or an individual.

Coordination of Benefits – A provision in a contract that applies when a person is covered under more than one group medical program. It requires the payment of benefits to be coordinated by all programs to eliminate over-insurance or duplication of benefits.

Copayment – A cost sharing arrangement in which the health plan member pays a specified flat amount for a specific service. Typical copayments are fixed amounts for physician office visits, prescriptions, or hospital services.

Drug Formulary – A listing of prescription medications, which are preferred for use by SWHP and are dispensed through participating pharmacies. The list is subject to periodic review and modification by SWHP.

Effective Date – The date on which a policy's coverage goes into effect.

Member – Any person eligible for service as either a subscriber or a dependent in accordance with a contract.

PCP (Primary Care Physician) – A physician who may be selected within the panel of contracted or salaried providers who will provide and coordinate your healthcare. A PCP is not required by SWHP.

Premium – A fixed periodic payment that entitles the member to all covered services regardless of the number and type of services used.

Service Area – The geographical area within certain boundaries where SWHP provides services to members. A member should not have to drive more than 30 miles to obtain emergency care.

TDI (Texas Department of Insurance) – In Texas, the agency that administers insurance laws and regulations.

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Utilization – The extent to which a given group uses services during a specified period of time.

Additional Member Information

Member Rights and Responsibilities

Rights

1. You have the right to be provided with information regarding member's rights and responsibilities.
2. You have the right to be provided with information about SWHP, its services and practitioners providing member's care.
3. You have the right to be treated with respect; member's provider and others caring for member will recognize his/her dignity and respect the need for privacy as much as possible.
4. You have the right to participate in decision-making regarding member's health care.
5. You have the right to have candid discussion of appropriate or medically necessary treatment options for member's conditions, regardless of cost or benefit coverage.
6. You have the right to voice complaints, appeals, or grievances about the member's coverage through SWHP or care provided by SWHP providers in accordance with member's Health Care Agreement.
7. You have the right to make recommendations regarding Scott & White Health Plan's member's rights and responsibilities policies.
8. You have the right to have an advance directive, such as Living Will or Durable Power of Attorney for Health Care Directive, which expresses member's choice about future care of names someone to decide if member cannot speak for himself/herself.
9. You have the right to expect that medical information is kept confidential in accordance with member's Health Care Agreement.
10. You have the right to select a Primary Care Physician (PCP) to coordinate your health care. It is not a requirement to select a PCP.

Responsibilities

1. It is your responsibility to notify SWHP regarding any out-of-plan care.
2. It is your responsibility to follow SWHP instructions and rules and abide by the terms of your health care agreement.
3. It is your responsibility to provide information (to the extent possible) the organization and its practitioners and providers need in order to provide care.
4. It is your responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
5. It is your responsibility to follow plans and instructions, to the best of your ability, for care you have agreed on with your practitioner(s) and provider(s).
6. It is your responsibility to give SWHP providers a copy of an advance directive, if one exists.
7. It is your responsibility to advise SWHP or SWHP providers of any dissatisfaction you may have in regard to your care while a patient, and to allow the opportunity for intervention to alter the outcome whenever possible.

Your Privacy is Very Important to Us

As a trusted name in health care, Scott & White Health Plan knows the importance of keeping your protected health information (PHI) private and confidential. PHI includes medical and any individually identifiable information; for example, your name, social security number, or address. Scott & White Health Plan protects your PHI by:

- limiting who can see your PHI;
- limiting how your PHI is used and disclosed; and
- setting and strictly adhering to Scott & White Health Plan privacy policies.

Scott & White Health Plan uses and discloses your PHI without your written consent to conduct the following functions:

- Treatment – includes sharing information with providers involved in your care in order for you to receive medical treatment
- Payment – to pay claims for covered services to providers
- Other health care operations – for quality improvement purposes, including medical research, developing clinical guidelines, case management, medical review, legal services/litigation, detection of fraud and abuse, as well as audit functions (in accordance with applicable law).

For the complete Notice of Privacy Practices or for additional information on our privacy practices, please contact your local Scott & White Health Plan office or visit our website, ers.swhp.org.

Notice of Mandatory Benefits

This notice is to advise you of certain coverage and/or benefits that are provided by your contract with SWHP.

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

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

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

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

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy
Coverage and/or benefits are provided to each covered person for reconstructive surgery after mastectomy, including:

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

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

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

Examinations for Detection of Prostate Cancer
Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include:

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

Inpatient Stay following Birth of a Child
For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a healthcare facility for a minimum of:

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

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to (a) give birth in

a hospital or other healthcare facility; or (b) remain in a hospital or other healthcare facility for the minimum number of hours following birth of the child.

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

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

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

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

Coverage of Tests for Detection of Human Papillomavirus and Cervical Cancer
Coverage is provided, for each woman enrolled in the plan who is 18 years of age or older, for expenses incurred for an annual medically recognized diagnostic examination for the early detection of cervical cancer. Coverage required under this section includes at a minimum 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.

If any person covered by this plan has questions concerning the above, please call SWHP at (800) 321-7947, or write us at:

Scott & White Health Plan
MS-A4-126
1206 West Campus Drive
Temple, TX 76502

Exclusions

Please review your Evidence of Coverage for information on covered benefits and exclusions.

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

Altered Sexual Characteristics
Any procedures or treatments designed to alter physical characteristics of You or Your Covered Dependent from Your or Your Covered Dependent's biologically determined sex to those of another sex, regardless of any diagnosis of gender role disorientation or psychosexual orientation, including treatment for hermaphroditism and any studies or treatment related to sex transformation or hermaphroditism, are excluded.

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

Chiropractic Services
Chiropractic Services are excluded.

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

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.

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.

Dental Care
All dental care is excluded, except for coverage stated under the Dental Benefits and Certain Oral Surgery section of this Agreement.

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.

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

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

Experimental or Investigational Treatment
Any Treatments that are considered to be Experimental or Investigational are excluded, but may be appealed under the Appeal of Adverse Determination provision of this Agreement. This exclusion does not apply to routine patient care costs for enrollees in clinical trials pursuant to Section [13.6.26] of your Evidence of Coverage (EOC).

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.

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

Genetic Testing
Genetic tests are excluded unless approved by the FDA, ordered by a Participating Physician, and approved by the Medical Director.

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

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

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.

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.

Miscellaneous
Artificial aids, corrective appliances, and medical supplies, such as batteries (except for batteries for hearing aids), dressings, syringes (except for insulin syringes), dentures, eyeglasses and corrective lenses, unless covered by Rider, are excluded.

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

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.

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.

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.

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.

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.

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

Refractive Keratotomy
Radial Keratotomy and other refractive eye surgery is excluded.

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.

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.

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.

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.

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.

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.

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

Vision Corrective Surgery, including Laser Application
Traditional or laser surgery for the purposes of correcting visual acuity is excluded.

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.

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.

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