Insurance Company of SCOTT&WHITE

# EDUCATIONAL INSTITUTION MEDICAL STUDENT PLAN

# SCOTT AND WHITE BLANKET ACCIDENT AND SICKNESS INSURANCE POLICY

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

THIS POLICY IS NOT A POLICY OF WORKER'S COMPENSATION INSURANCE

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

## BLANKET POLICY

Insurance Company of Scott and White agrees to provide the benefits specified in this Agreement, in accordance with and subject to the terms states herein and all applicable local, state, and federal laws. This Agreement, enrollment forms, and any attachments to them form the entire contract.

In consideration of the Insurance Company of Scott and White Agreement to provide benefits for the Health Care Services specified in this Agreement and subject to the terms stated herein, Subscriber promised to pay all Required Payments when due, abide by all of the terms of this Agreement and comply with all applicable local, state, and federal laws.

Note: Capitalized words are defined terms. Whenever these terms are used, the meaning is consistent with the definition given. Use of the pronoun “his”, “he”, or “him” will be considered to include the feminine unless the context clearly indicates otherwise.

**Important Notices:**

1. This Master Policy becomes effective at 12:01 am June 1, 2014. Coverage becomes effective on that date or the date application and full premium for the term of coverage selected by the Eligible Student is received by Health Plan, whichever is later. The Master Policy terminates at 11:59 pm. May 31, 2015. Coverage terminates on that date, or if paying other that by a single premium payment, at the end of the period through which premium is paid, whichever is earlier.
2. The coverage provided under this Agreement is indemnity accident and sickness insurance. The Schedule of Benefits enclosed with this Agreement indicates benefits, percentages, deductibles, copayment amounts, maximums, and other benefit and payment issues which apply to the Plan. The Schedule of Benefits includes:
    - Preventive Care Services
    - Inpatient Hospital Services
    - Emergency Care Services
    - Medical Services
    - Behavioral Health Services/Mental Health
    - Chemical Dependency
3. This Blanket Policy is issued in and subject to the laws of the State of Texas.

This Agreement is not a policy of Worker’s Compensation Insurance.

In witness whereof Insurance Company of Scott and White has cause this insurance Policy to be executed as of the Effective Date.

Marinan R. Williams
Interim President and Chief Executive Officer Insurance Company of Scott and White 1206 West Campus Dr.
Temple, Texas 76508

**IMPORTANT NOTICE**

**To obtain information or make a complaint:**

**You may call Insurance Company of Scott and White's toll-free telephone numbers for information or to make a complaint at**

**LOCAL/LONG DISTANCE NUMBERS**

| Temple | Georgetown |
|---|---|
| (254) 298-3000 | (512) 930-6040 |
| (800) 321-7947 | (800) 758-3012 |

**Waco**
**(254) 756-8000**
**(800) 684-7947**

**You may also write to Insurance Company of Scott and White at:**

**1206 West Campus Drive**
**Temple, TX 76502**

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

**1-800-252-3439**

**You may write the Texas Department of Insurance**

**P.O. Box 149104**
**Austin, TX 78714-9104**
**FAX # (512) 475-1771**
**E-Mail: Consumer Protection @tdi.texas.gov**
**Web: http://www.tdi.texas.gov**

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

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

**AVISO IMPORTANTE**

**Para obtener informacion o para someter una queja:**

**Usted puede llamar al numeros de telefono gratis de Insurance Company of Scott and White's para informacion o para someter una queja al**

**NUMEROS LOCALES/DE LARGA DISTANCIA**

| Temple | Georgetown |
|---|---|
| (254) 298-3000 | (512) 930-6040 |
| (800) 321-7947 | (800) 758-3012 |

**Waco**
**(254) 756-8000**
**(800) 684-7947**

**Usted tambien puede escribir a Insurance Company of Scott and White**

**1206 West Campus Drive**
**Temple, TX 76502**

**Puede communicarse con el Departmento de seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al**

**1-800-252-3439**

**Puede escribir al Departamento de Seguros de Texas**

**P.O. Box 149104**
**Austin, TX 78714-9104**
**FAX # (512) 475-1771**
**E-Mail: Consumer Protection @tdi.texas.gov**
**Web: http://www.tdi.texas.gov**

**DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el Insurance Company of Scott and White primero. Si no se resuelve la disputa, puede entonces communicarse con el departamento (TDI).**

**UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.**

## SCHEDULE OF BENEFITS

| Paragraph Reference | Benefit | Coinsurance |
|---|---|---|
| | **Contract Period Deductible** | **Individual/Family** |
| | Does not apply to Out-of-Pocket Maximum<br>Family deductible is cumulative | $250/$750 |
| | **Coinsurance** | 30% after Contract Period deductible |
| | | |
| | **Out of Pocket Maximum (Contract Period Contract Period)** | **Individual/Family** |
| | No carryover will be allowed | $5,000/$10,000<br>Once the Out of Pocket Maximum above is reached, then Covered Services will be covered at 100% up to the Allowed Amount |
| **11.1.1** | **Medical Services** | $25 copay |
| | Non-Preventive Services performed in Physician Office (non-surgical, including lab and x-ray) | |
| | Physician surgical services in any setting<br>Lab and x-ray in other outpatient setting | 30% after Contract Period deductible |
| | Infusion Therapy | 30% after Contract Period deductible |
| | All other outpatient services and supplies | 30% after Contract Period deductible |
| | Office & Outpatient Surgery | 30% after Contract Period deductible |
| | Independent Lab/Freestanding Imaging Center | 30% after Contract Period deductible |
| | Outpatient Facility Lab & X-Ray Services | 30% after Contract Period deductible |
| | Renal Dialysis, Chemotherapy & Radiation Therapy | 30% after Contract Period deductible |
| **11.1.2** | **Hospital Services** | |
| | Semiprivate room and board, services and supplies, intensive care unit | 30% after Contract Period deductible |
| **11.1.3** | **Emergency Care** | |
| | Physician and Facility Charges | 30% after Contract Period deductible |
| **11.1.4** | **Preventive Care Services** | None |
| **11.1.5** | **Mental Health Care and Treatment for Chemical Dependency** | |
| | Hospital Services:<br>Inpatient (Facility) | 30% after Contract Period deductible |
| | Inpatient (Professional Provider)<br>(Includes Psychological Testing) | 30% after Contract Period deductible |

| Paragraph Reference | Benefit | Coinsurance |
|---|---|---|
| | Office/Outpatient Visits<br>• Office<br>• Psychological Testing (Outpatient)<br>• All other outpatient expenses (professional provider) | 30% after Contract Period deductible; $25 copay for Serious Mental Illness treatment |
| **11.1.5.4** | **Treatment for Chemical Dependency** | Same as any other sickness |
| | (in a substance abuse facility)<br>(inpatient or outpatient facility) | Treatment in a physician's or other provider's office after completion of a treatment program is considered mental health care |
| **11.1.6** | **Rehabilitative Therapy** | |
| | (Physical, Occupational, Speech, Respiratory, and Manipulative) | 30% after Contract Period deductible |
| **11.1.7** | **Home Health Services (Extended Care)** | |
| | Home Health Care | 30% after Contract Period deductible |
| | Home Health Care Maximum Days Per Contract Period | 60 days |
| | Skilled Nursing Facility | 30% after Contract Period deductible |
| | Skilled Nursing Facility Maximum Days Per Contract Period | 60 days |
| **11.1.8** | **Home Infusion Therapy Benefit** | |
| | Copayment for each day of home infusion therapy (NOTE: Specialty Pharmacy Drugs administered through home infusion will be subject to the applicable Specialty Pharmacy Drug copayment) | 30% after Contract Period deductible |
| | Maximum number of days of Home Infusion Therapy services for which Copayment is due. | 60 days |
| **11.1.9** | **Hospice Services** | |
| | Copayment for each day of Hospice services | 30% after Contract Period deductible |
| **11.1.10** | **Maternity and Family Planning Services** | $25 copay per Physician office visit; 30% after Contract Period deductible for inpatient services |
| | Maternity Care | |
| **11.1.11** | **Durable Medical Equipment/Orthotics/Prosthetic Devices** | |
| | Copayment for Durable Medical Equipment, Orthotics and Prosthetic Devices and all other related covered services | 30% after Contract Period Deductible |
| | Copayment for Durable Medical Equipment | 30% after Contract Period deductible |
| | Copayment for Orthotic Devices and Prosthetic Devices | 30% after Contract Period deductible |
| | Copayment for each outpatient visit to or by a Provider other than a Primary Care Physician | 30% after Contract Period deductible |
| | Maximum benefit per Member per Contract Year for Durable Medical Equipment | $1,000 |
| | Maximum benefit per Member per Contract Year for Limb | |

| Paragraph Reference | Benefit | Coinsurance |
|---|---|---|
| | Prosthetic Devices | $1,000 |
| | Maximum Lifetime benefit per Member per Contract Year for Limb Prosthetic Devices | $1,000 |
| | Maximum benefit per Member per Contract Year for all other Prosthetic Devices | $1,000 |
| | Maximum benefit per Member per Contract Year for Orthotic Devices | $1,000 |
| 11.1.12 | **Coverage for Prescription Drugs** | |
| 11.1.12.1 | **Inpatient Prescription Drugs** | Same as other inpatient services |
| | Includes Specialty Pharmacy Drugs administered in an inpatient setting | |
| 11.1.12.2 | **Outpatient Specialty Pharmacy Drugs** | Same as other outpatient services |
| | Deductible- You are required to pay a deductible prior to receiving coverage for covered outpatient Specialty Pharmacy Drugs | |
| | **Copayments** | 10% after Contract Period deductible |
| | Specialty Pharmacy Drugs on the formulary at Level 1 | |
| | Specialty Pharmacy Drugs on the formulary at Level 2 (Preferred Specialty Pharmacy Drugs) | 20% after Contract Period deductible |
| | Specialty Pharmacy Drugs on the formulary at Level 3 (Premium Preferred Specialty Pharmacy Drugs) | 30% after Contract Period deductible |
| | Specialty Pharmacy Drugs on the formulary at Level 4 (Non-Preferred Specialty Drugs). **NOTE:** Copayments for Non-Preferred Specialty Pharmacy drugs will not be considered Out-of-Pocket Expenses for purposes of meeting Out-of-Pocket Maximums | 50% after Contract Period deductible |
| 11.1.12.3 | **Outpatient Non Specialty Pharmacy Drugs Administered in Outpatient Setting** | Same as other outpatient services |
| | Non-Specialty Pharmacy Drugs Administered in Provider's Office or other Outpatient setting | |
| 11.1.12.4 | **Outpatient Prescription Drugs** | Not covered unless Prescription Drug Rider is attached |
| | Non-Specialty Pharmacy Drugs and Outpatient Prescription Drugs non administered in Provider's office | |
| 11.1.13 | **Outpatient Radiological or Diagnostic Examinations** | |
| | Member is required to pay a Copayment for Outpatient radiological/Diagnostic examinations described below | |
| | Angiograms, CT scans, MRIs, Myelography, PET scans, stress tests with radioisotope imaging | 30% after Contract Period deductible |
| | Radiology Daily Copayment Maximum | Not Applicable |
| | **Benefits for Screening Exams that are Preventive Care Services** | No Charge |

| Paragraph Reference | Benefit | Coinsurance |
|---|---|---|
| | Copayment for each office visit | |
| | **Benefits for Screening Exams that are not Preventive Care Services** | Not Applicable |
| | Copayment for each outpatient visit | |
| | Note: Coverage for formulas necessary to treat Phenylketonuria or a heritable disease are available only on the orders of a physician. | |
| 11.1.15 | **Breast Reconstruction Benefits** | Same as for other benefits |
| | Copayment for Breast Reconstruction benefits | |
| 11.1.16 | **Minimum Inpatient Stay Following Mastectomy or Related Procedure** | Same as for other inpatient health care services |
| 11.1.17 | **Benefits for the Treatment and Diagnosis of Conditions affecting Temporomandibular Join** | Same as for other benefits |
| 11.1.18 | **Treatment for Craniofacial Abnormalities of a Child** | Same as for other benefits |
| 11.1.19 | **Diabetes Supplies, Equipment and Self-Management Training** | Covered under Prescription Drug Plan or DME benefit as applicable. |
| | Copayment for Preferred Level test strips for blood glucose monitors | |
| | Copayment for Non-Preferred Level test strips for blood glucose monitors | Covered under Prescription Drug Plan or DME benefit as applicable. |
| | Copayment for Diabetes Equipment and Diabetes Supplies | Same as prescription drugs or durable medical equipment and supplies, as appropriate |
| | Diabetes Self-Management Training | Same as other patient instruction |
| 11.1.20 | **Transplant Services** | Same as other similar services |
| 11.1.22 | **Benefits for Acquired Brain Injury** | Same as other similar benefits |
| 11.1.24 | **Amino Acid-Based Elemental Formulas** | |
| | Copayment for Amino Acid-Based Elemental Formulas | 30% after Contract Period deductible |
| | Note: Coverage for Amino Acid-Based Elemental Formulas are available only on the order of a physician | |
| 11.1.25 | **Cardiovascular Disease Screening for High Risk Individuals** | Same as for other CT scans after Contract Year Deductible |
| | Copayment for CT scan measuring coronary artery calcification | |
| | Copayment for Ultrasonography measuring carotid intimamedia thickness and plaque | Same as for other CT scans after Contract Year Deductible |
| | Maximum benefit per Member every 5 years for cardiovascular disease screening test | $200 |
| 11.1.26 | **Routine Patient Care Costs for Clinical Trials** | Same as other benefits |
| | Copayments for Routine Patient Care Costs by Enrollee in Clinical Trial | |
| | **Prescription Drug Rider** (all copays are per 30-day supply) | |
| | and will not apply to Deductible or Out-of-Pocket Maximum)<br>*Members electing to purchase brand name drugs when* | |

| Paragraph Reference | Benefit | Coinsurance |
|---|---|---|
| | *"Dispense as Written" (DAW) is not indicated and a generic equivalent is available, will be required to pay the non-formulary copay, but in no case will member be required to pay more than the actual cost of the drug.* | |
| | **Authorization Requirements**<br>A one-time prescription which costs the amount specified or more and refillable prescription whose total cost is the amount specified to the right will require preauthorization by the ICSW Medical Director | A one–time prescription of $175<br>Total cost of $1,200 |
| | **Quantity Limitations**<br>Covered drugs are provided in quantities per prescription or refill up to the limits listed to the right | Initial or refill prescription up to a 34-day supply or 100 units, whichever is less. Maintenance up to a 90-day supply or 360 units, whichever is less |
| | **Maximum Benefit**<br>The prescription drug benefit is subject to a maximum benefit payment per Member per Contract Year | $500, then 50% of coverage after deductibles |
| | **Non-Generic Deductible**<br>You are required to pay a Deductible for out-of-pocket expenses for drugs that do not appear on List A Formulary Generic Drugs prior to receiving coverage for covered prescription drugs. | $75 |
| | Copayments<br>Drugs appearing on List A (Formulary generic drugs) | $10 |
| | Drugs appearing on List B (Formulary preferred brand drugs) | $30 |
| | Drugs appearing on List C (Formulary non-preferred and alternate choice drugs) | $50 |
| | Drugs not appearing on Health Plan Formularies | Greater of $50 or 50% of charges |
| | **Maintenance Drug Copayments**<br>Drugs appearing on List A (Formulary preferred generic drugs) | $20 |
| | Drugs appearing on List B (Formulary preferred brand drugs) | $60 |
| | Drugs appearing on List C (Formulary non-preferred and alternate choice drugs | $100 |
| | Drugs not appearing on Health Plan Formularies | Not Covered |
| | Copayments-Secondary Benefit Level<br>Drugs on any level except those appearing on List A (Formulary preferred generic drugs) will have the Secondary Benefit Copayment applied once the Primary Benefit Limit is reached | |

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## 1. DEFINITIONS

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

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

1.2 "Agreement" means this ICSW Blanket Accident and Sickness Policy and all attachments and riders herein.

1.3 "Allowed Amount" means the amount established by Insurance Company of Scott and White as the maximum payment for services provided by a Hospital, Physician, or Provider.

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

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

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

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

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

1.8 "Cognitive communication therapy" means services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.

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

1.10 "Community reintegration services" means services that facilitate the continuum of care as an affected Member transition into the community.

1.11 "Coinsurance" means the percentage, if any, shown in the Schedule of Benefits, of the cost of Health Care Services for which the Member is responsible.

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

1.13 "Complaint" is any oral or written expression of dissatisfaction with any aspect of Health Plan's operation including but not limited to dissatisfaction with plan administration, the denial, reduction, or termination of a service, the way a service is provided, or disenrollment decision expressed by a Complainant. The term does not include a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information.

1.14 "Contract Date" means 12:01 am June 1, 2015, the date on which coverage for this Agreement commences.

1.15 "Contract Holder" means Educational Institution.

1.16 "Contract Period" means that period of time which begins at 12:01 am, June 1, 2015 and ends at 11:59 pm, May 31, 2016.

1.17 "Copayment" means the dollar amount, if any, shown in the Schedule of Benefits payable by the Member to a Hospital. Physician, Provider, or emergency room when Health Care Services are obtained from the Hospital, Physician, Provider, or emergency room.

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

1.19 "Creditable Coverage" means any group health coverage or individual health coverage that qualified under regulations implementing the Federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191).

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

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

1.22 "Deductible" means the dollar amount, if any, shown in the Schedule of Benefits payable by the Member for Health Care Services before benefits under the Health Benefit Plan will be payable.

1.23 "Deductible Family Maximum" means the dollar amount payable by the Subscriber and the Subscriber's Covered Dependents for Covered Services each Plan Year before benefits are paid. Once the Family Maximum amount has been satisfied, no further Deductibles will be required for the remainder of the Plan Year. The Deductible Family Maximum is satisfied when (1) one family member satisfies the deductible, and (2) the cumulative total of all deductible amounts paid by or on behalf of Subscriber and Your Covered Dependents equals the Deductible Family Maximum stated in the Schedule of Benefits.

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

1.25 "Diabetic Self-Management Training" means any of the following training or instruction provided by a Physician or Provider following initial diagnosis of diabetes: instruction in the care and management of the

condition, nutritional counseling, counseling in the proper use of diabetic equipment and supplies; subsequent training or instruction necessitated by a significant change in the Member's symptoms or condition which impacts the self-management regime, and appropriate periodic or continuing education as warranted by the development of new techniques and treatment for diabetes.

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

1.27 "Durable Medical Equipment" or "DME" means equipment that:

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

1.28 "Effective Date" means the date the covered for Subscriber or Your Covered Dependent actually begins. It may be different from the Eligibility Date or the Contract Date.

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

1. Subscriber's legal spouse
2. Subscriber's Son or Daughter who is
    a. Unmarried; and
    b. Under the Age of Ineligibility; or
        i. If the Age of Ineligibility or older
            1. at the time of reaching the Age of Ineligibility, incapable of self-sustaining employment reason of physical disability or mental incapacity; and
            2. chiefly dependent upon Subscriber for support and maintenance
3. Subscriber's grandson or granddaughter who is:
    a. Unmarried;
    b. Under the Age of Ineligibility; or
        i. If the Age of Ineligibility or older
            1. at the time of reaching the Age of Ineligibility, incapable of self-sustaining employment by reason of physical disability or mental incapacity; and
            2. chiefly dependent upon Subscriber for support and maintenance; and
    c. dependent upon Subscriber for federal income tax purposes for whom Subscriber for federal income tax purposes at the time of application.
4. Any child for whom Subscriber is obligated to provide health coverage by a Qualified Medical Support Order pursuant to the terms of that order.
5. Subscriber's Son or Daughter of any age who is:
    a. Unmarried
    b. Medically certified as disabled; and
    c. Chiefly dependent upon Subscriber for support and maintenance

1.30 "Eligible Student" means a Student at Educational Institution during the Contract Period.

1.31 "Eligibility Date" means the date the Member satisfies the definition of either Eligible Student or Dependent.

1.32 "Emergency Care" shall mean Health Care Services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and

health to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

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

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

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

1. well-designed and well conducted investigations published in recognized peer reviewed medical literature, such as the New England Journal of Medicine or the Journal of Clinical Oncology, when such papers report conclusive findings of controlled or randomized trials. The Medical Director shall consider the quality of the body of studies and the consistency of the results in evaluating the evidence;
2. communications about the Treatment that have been provided to patients as part of an informed consent;
3. communications about the procedure or Treatment that have been provided from the physician undertaking a study of the Treatment to the institution or government sponsoring the study;
4. documents or records from the institutional review board of the hospital or institution undertaking a study of the Treatment;
5. regulations and other communications and publications issued by the Food and Drug Administration and the Department of Health and Human Services; and
6. the Member's medical records.

As used above, "peer review medical literature" means one or more U.S. scientific publications which require that manuscripts be submitted to acknowledged experts inside or outside the editorial office for their considered opinions or recommendations regarding publications of the manuscript. In addition, in order to qualify as peer reviewed medical literature, the manuscript must actually been reviewed by acknowledged experts before publication.

Treatments referred to as "experimental", "experimental trial", "investigational", "investigational trial", "trial", "study", "controlled study", "controlled trial", and any other term of similar meaning shall be considered to be Experimental or Investigational.

1.35 "Group" means Educational Institution.

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

1.37 "Health Care Services" means those Medically Necessary services which are included in the Description of Benefits and any amendments or riders thereto.

1.38 "Health Plan" means Insurance Company of Scott and White.

1.39 “Health Professionals” means those health care professionals, licensed in the State where care is provided who provide Health Care Services.

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

1.41 “Individual Treatment Plan” means a Treatment plan prepared or approved by the Medical Director with specific attainable goals and objectives appropriate to both the Members and the Treatment modality of the program.

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

1.43 “Medical Necessary” means those Health Care Services, which in the opinion of the Member’s Physician, whose opinions are subject to the review, approval or disapproval, and actions of the Medical Director or the Quality Assurance Committee in the appointed duties, are:

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

1.44 “Member” means Subscriber or a Covered Dependent.

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

1.46 “Neurobehavioral treatment” means interventions that focus on behavior and the variables that control behavior.

1.47 “Neurobiological disorder” means an illness of the nervous system caused by genetics, metabolic, or other biological factors.

1.48 “Neurocognitive rehabilitation” means services designed to assist cognitively impaired Member to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

1.49 “Neurocognitive therapy” means services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.

1.50 “Neurofeedback therapy” means services that utilize operant conditional learning procedures based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.

1.51 “Neuropsychological testing” means the administering of a comprehensive battery of test to evaluate neurocognitive behavior, and emotional strengths and weaknesses, and their relationship to normal and abnormal central nervous system functioning.

1.52 “Neuropsychological treatment” means interventions designed to improve or minimize deficits in behavioral or cognitive processes.

1.53 “Neurophysiological testing” means an evaluation of the function of the nervous system.

1.54 “Neurophysiological treatment” means interventions designed to improve or minimize deficits in behavioral and cognitive processes.

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

1.56 “Out-of-Pocket Expense” means the portion of Covered Services for which a Member is required to pay at the time services and treatments are received after the Deductible is met. Out-of-pocket Expenses apply to Covered Services only. Medical services and treatments, which are not covered by the Plan or are not Medically Necessary, are not included in determining Out-of-Pocket Expenses.

1.57 “Out-of-Pocket Expense Maximum” means the total dollar amount of Out-of-Pocket Expenses which a Member will be required to pay for Covered Serviced during a Contract Period after the Deductible has been met. Out-of-Pocket Maximums are determined for Covered Services and not for any medical services or treatments which are not Medically Necessary or not covered.

1.58 “Out-of-Pocket Maximums, Family” means the total amount of Out-of-Pocket Expenses which one family will be required to pay in any one Contract Period after the Deductible has been met.

1.59 “Outpatient day treatment services” means structured services provided to address deficits in physiological, behavioral, and/or cognitive functions. Such services may be delivered in settings that include transitional residential, community integration, or non-residential treatment settings.

1.60 “Participating Hospital” means an institution licensed by the State of Texas as a hospital which has contracted with Health Plan to provide Health Care Services to Members, and which is listed by Health Plan as a Participating Hospital. By contracting with Health Plan, a Participating Hospital has agreed to accept Health Plan allowed amount, along with Your Copayment, Coinsurance and Deductible, as payment in full for Health Care Services.

1.61 “Participating Physician” means anyone licensed to practice medicine in the State of Texas which has contracted with Health Plan to provide Health Care Services to Member and who is listed by Health Plan as a Participating Physician. By contracting with Health Plan, a Participating Physician has agreed to accept Health Plan’s allowed amount, along with Your Copayment, Coinsurance, and Deductible, as payment in full for Health Care Services.

1.62 “Participating Provider” means any person or entity that has contracted directly with Health Plan to provide Health Care Services to Members, and who is listed by Health Plan as a Participating Provider. By contracting with Health Plan, a Participating Provider has agreed to accept Health Plan’s allowed amount, along with Your Copayment, Coinsurance, and Deductible, as payment in full for Health Care Services. Participating Provider include but not limited to: Medical Group, Participating Hospital, Participating Physicians, Health Professionals, Urgent Care Facilities, and contracted pharmacies.

1.63 “Post-Acute transition services” means services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

1.64 “Post- Acute treatment services” means services provided after acute care confinement and/or treatment that are based on an assessment of the Member’s physical, behavioral, or cognitive functional defects, which include a treatment goal of achieving functional charges by reinforcing, strengthening, or reestablishing

previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.

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

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

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

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

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

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

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

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

1.72 "Qualified Medical Support Order" means a court or administrative judgment, decree or order whether temporary, final, or subject to modification for the benefit of a child that provides for health coverage of the child.

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

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

1.75 "Required Payments" means any payment or payments required of the Group, an applicant for coverage hereunder, or a Member, in order to obtain or maintain coverage under this health care Agreement, including

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

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

1.77 "Residential Treatment Center for Children and Adolescents" means a child-care institution that provides residential care and treatment for emotionally disturbed children and adolescents and that is accredited as a residential treatment center by the Council of Accreditation, the Joint Commission on Accreditation of Healthcare Organizations, or the American Association of Psychiatric Services for Children.

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

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

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

1.80 "Series of Treatment" is a planned, structured, and organized program to promote chemical free status, or modalities. Such a program is considered complete when the covered Member (1) is discharged on medical advice for inpatient detoxification, inpatient rehabilitation/Treatment, partial hospitalization or intensive outpatient care or a serious of these levels of Treatment without a lapse in Treatment, or (2) fails to materially comply with the Treatment program for a period of thirty (30) days.

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

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

1.83 "Son or Daughter" means

1. a child born to Subscriber or Subscriber's Legal spouse, or
2. a child who is Subscriber or Subscriber's legally adopted child with a legal adoption evidenced by a decree of adoption; who is the object of a lawsuit for adoption and Subscriber or Subscriber's Spouse are a party to such lawsuit; or who has been placed with Subscriber or Subscriber's Spouse for adoption.

1.84 "Specialty Pharmacy Drug" means any prescription drug regardless of dosage form, identified as a Specialty Pharmacy Drug on the drug formulary or a drug which requires at least one of the following in order to provide optimal patient outcomes:

1. specialized procurement handling, distribution, or is administered in a specialized fashion;
2. complex benefit review to determine coverage;
3. complex medical management requiring close monitoring by a physician or clinically trained individual;
4. FDA mandated or evidence-based medical guideline determined comprehensive patient and/or physician education; or
5. Has any dosage form with a total cost great than $1,000 per prescription.

1.85 "Subscriber" means the Eligible Student for or on behalf of whom the Premiums are paid.

1.86 "Telehealth Services" means a health service other than a telemedicine medical service, delivered by a licensed or certified health professional acting within the scope of the health professional acting within the scope of the health professional's license or certification who does not perform a telemedicine medicine service that requires the use of advanced telecommunications telecommunication technologies, other than by telephone or facsimile, including:

1. compressed digital interactive video, audio, or data transmission;
2. clinical data transmission using computer;
3. other technology that facilitates access to health care services or medical specialty expertise.

1.87 "Telemedicine Medical Services" means a health care service initiated by a physician or provided by a health professional acting under physician delegation or supervision, for purposes of patient assessment by a health professional, diagnosis or consultation by a physician, treatment or the transfer or medical data, that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including

1. compressed digital interactive video, audio, or data transmission;
2. clinical data transmission using computer;
3. other technology that facilitates access to health care services or medical specialty expertise.

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

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

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

## 2. ELIGIBILITY PROVISIONS

### 2.1 Classes of Individuals Eligible for Coverage

2.1.1 Eligible Students

To be eligible for coverage Subscriber must be a Full Time Student at Educational Institution during the Contract Period.

2.1.2 Eligible Dependent

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

### 2.2 General Eligibility Provisions

2.2.1 Dependent coverage requirement of Subscriber Enrollment

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

2.2.2 Applicability of Definitions

To be eligible for coverage as a Subscriber or dependent, the individual must meet all applicable definitions and provisions for participating described in the Agreement and in the Group's attachment to the application for this Agreement. Such definitions and provisions for participation must prohibit selection on an individual basis.

### 2.3 Enrollment and Effective Dates of Coverage

The Effective Date is the date the coverage for Member actually begins, it may be different from the Eligibility Date.

2.3.1 Timely Applications

To enroll in the Health Plan, Subscriber and Subscriber's Eligible Dependents must make appropriate and timely application, which includes:

1. a completed Enrollment Application which must be received by Health Plan during the enrollment period, or
2. a certification by the Group that:
    a. Subscriber and Subscriber's Eligible Dependent were enrolled with the Health Plan for the Coverage Period immediately preceding the current Coverage Period; and
    b. Subscriber and Subscriber's Eligible Dependent remain eligible under the terms of the Agreement; and
3. Payment of the Premium when due.

A MEMBER WHO FAILS TO PAY ANY REQUIRED PAYMENTS WHEN DUE SHALL BE DISENROLLED FROM THE HEALTH PLAN, IN ACCORDANCE WITH THE PROCEDURES SET FORTH IN THIS AGREEMENT.

2.3.2 Coverage Upon Initial Eligibility

If Subscriber applies for coverage for Subscriber or for Subscriber and Subscriber's Eligible Dependents, the Effective Date is determined as follow:

1. If subscriber is eligible on the Contract Date and the completed enrollment application is received by Health Plan 31 days prior to start of any semester, the Effective Date for Subscriber and Subscriber's Eligible Dependent's for who an application was submitted is the first day of the Semester before which the application was received.

2. If Subscriber becomes eligible after the Contract Date because of loss of other coverage and if Subscriber's completed enrollment application is received by Health Plan within the first 31 days following Subscriber's Eligibility Date, Subscriber's Effective Date is the first day of the month following the date the requirements of this Agreement are satisfied, unless another date is specified in this Agreement.

2.3.3 No Benefits for Services Prior to Effective Dates

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

## 2.4 Dependent Special Enrollment Period

2.4.1 Newborn Children

Coverage of Subscriber's or Subscriber's Spouse's newborn child will be automatic for the first 31 days following the birth of said child. For coverage to continue beyond this time, Subscriber must notify Group within 60 days of birth of Subscriber's desire to add the newborn child, and pay any required premium within that 60-day period or a period consistent with the next billing cycle. With such notice, the Effective Date for said Child will be the date of birth.

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

Coverage of Subscriber's or Subscriber's Spouse's adopted child will be automatic for the first 31 days following the date of adoption, the date Subscriber or Subscriber's Spouse becomes party to a lawsuit for adoption or the date the child was placed with Subscriber or Subscriber's Spouse for adoption. For coverage to continue beyond this time, Subscriber must notify Group within 60 days of the date the adoption becomes final, the date Subscriber or Subscriber's Spouse became a party to a lawsuit for adoption, or the date the child was placed with Subscriber or Subscriber's Spouse for adoption, and pay any required premium within that 60 day period or a period consistent with the next billing cycle. The Effective Date is the date of adoption, the date Subscriber or Subscriber's Spouse became a party to the lawsuit for adoption, or the date the Child was placed with Subscriber or Subscriber's Spouse for adoption.

2.4.3 Court Ordered Dependent Children

If a court has ordered Subscriber to provide coverage for a child, written application and the required Premium must be received within 31 days after Group received notice of the court order. The Effective Date will be the day application for coverage is received by Group or Health Plan, and the required Premium is received.

2.4.4 Court Ordered Coverage for a Spouse

If a court has ordered Subscriber to provide coverage for a spouse, written enrollment and the required premium must be received within 31 days after issuance of the court order. The Effective Date will be the first day of the month following the date the application for coverage and the required Premium is received.

2.4.5 Other Dependents

2.4.5.1 Written application must be received within 31 days of the date that a spouse or child first qualifies as an Eligible Dependent. The Effective Date will be the first day of the month following the date the application for coverage is received, so long as the required Premium is paid within the 31-day period.

2.4.5.2 In no event will Subscriber's Dependent's Effective Date be prior to Subscriber's Effective Date.

## 2.5 Student Special Enrollment Period

2.5.1 If a student acquires a dependent through birth, adoption, or through suit or placement for adoption, and Student previously declined coverage for reasons other than loss of other coverage, as described above, Student may apply for coverage for Subscriber, Subscriber's Spouse, and the newborn child, adopted child, or child involved in a suit or placed for adoption. If the written application is received within 31 days of the birth, adoption, or date on which the suit for adoption was filed or the child was placed with Subscriber and/or Subscriber's Spouse for adoption, the Effective Date for the child, Subscriber and/or Subscriber's Spouse will be the date of the birth, adoption, placement for adoption or date suit for adoption was sought.

2.5.2 If student marries and student previously declined coverage for reason other than loss of coverage as described above, Student may apply for coverage for Student and spouse. If the written application is received within 31 days of the marriage, the Effective Date for Subscriber and Subscriber's Spouse will be the first day of the month following receipt of the application of the Health Plan.

2.5.3 No eligible person who properly enrolls during a period of enrollment shall be refused enrollment because of health status related factors such as the existence of a pre-existing condition.

## 2.6 Preexisting Conditions

2.6.1 Benefits for Health Care Services for treatment of a Preexisting Condition will not be paid for a period of 12 months from Subscriber's or Subscriber's Covered Dependent's Effective Date.

2.6.2 The Preexisting Condition limitations shall not apply if Subscriber and/or Subscriber's Covered Dependent was continuously covered for an aggregate of 12 months under Creditable Coverage that was in effect up to a date not more than 63 days before the Effective Date, excluding any Waiting Period. For purposes of determining continuous coverage, gaps in coverage of not more than 63 days will be considered continuous.

2.6.3 The Preexisting Condition limitation shall be reduced by the amount of Creditable Coverage.

The Preexisting Condition limitation will not apply to any Covered Dependent age 18 and under.

## 2.7 Additional Requirements

2.7.1 It is Subscriber's responsibility to inform:

1. Group immediately of all changes that affect Subscriber's eligibility and that of Subscriber's Covered Dependents, including but not limited to, death;
2. The Health Plan immediately of all changes that affect administration of Health Plan benefits, including, but not limited to, addresses change.

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

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

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

2.7.5 Health Plan is entitled to require written proof acceptable to Health Plan that an applicant for enrollment satisfies requirement stated in this Agreement. Examples include, but are not limited to the following:

- declarations of informal marriage,
- birth certificate,
- valid Qualified Medical Support Order,
- proof of dependency,
- proof of accreditation, etc.

## 3. TERMINATION OF COVERAGE

### 3.1 Termination of Coverage for Members

Coverage under this Agreement shall terminate form Subscriber and Covered Dependent as follows

1. on the date which Subscriber or Covered Dependent cease to be eligible for coverage in accordance with this Agreement; or
2. upon the last day for which premium has been accepted by Health Plan in the event of nonpayment of premiums; or
3. thirty-one (31) days after written notice from Health Plan that Subscriber has failed to pay any Required Payment other than premium due; or
4. in the event of fraud or intentional misrepresentation by Subscriber or Covered Dependent, except as described under Incontestability, sixteen (16) day after written notice from Health Plan; or
5. the date Group coverage terminates.

### 3.2 Responsibility Upon Termination

Upon termination of coverage as described above, Health Plan shall have no further liability or responsibility under this Agreement.

### 3.3 Termination of Coverage for Group

This Agreement shall continue in effect for the Contract Period. This Agreement may be terminated for one of more of the following reasons:

1. Group fails to pay a Required Payment as required by this Agreement;
2. Fraud or intentional misrepresentation of a material fact by Group;
3. Health Plan elects to discontinue a particular type of coverage; or
4. Group elects to terminate this Agreement.

If termination or non-renewal is due to reason (1), Health Plan shall give Group thirty (30) days advance written notice. If termination is due to reason (2) above, Health Plan shall give Group at least fifteen (15) days advance written notice. If termination is due to reason (3), Helath Plan shall five Group at least ninety (90) days advance written notice and offer Group the option to purchase other coverage. If termination is due to reason (4), Group shall give Health Plan at least sixty (60) days advance written notice; however, if termination is due to a material change by Health Plan to any provisions required to be disclosed to Group or Member pursuant to state law or regulation which adversely affects benefits or services provide, Group shall give Health Plan at least thirty (30) days advance written notice.

### 3.4 Liability

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

## 4. REQUIRED PAYMENTS

### 4.1 Premiums

#### 4.1.1 Payment of Premiums

Premiums may be paid on am monthly (via Automatic Payment Service), quarterly, semi-annual or annual basis. Premiums received by Health Plan are considered fully earned and nonrefundable. Refund of premium will be considered only if the Subscriber ceases to be eligible for coverage. A Subscriber withdrawing from school to enter military service will be entitled to a pro-rata refund upon written request, and coverage shall end as of the date of entry into the military. Monthly Premiums are due in the office of the Health Plan, 1206 West Campus Drive, Temple, Texas 76502 on or before the date indicated in the monthly billing statement issued to Subscriber by Health Plan. The Subscriber is responsible for remitting all Premiums due under this Agreement to Health Plan when due. Only Members for who the stipulated Premium is actually received by Health Plan shall be eligible for coverage under this Agreement, Premiums are Required Payments.

### 4.2 Copayments, Coinsurance and Deductibles

Subscriber is responsible for payment any applicable Copayment, Coinsurance, and/or Deductibles for Health Care Services. Copayment or Coinsurance are due at the time the service is rendered. Copayments, Coinsurance and Deductibles are Required Payments.

### 4.3 Subrogation and Coordination of Benefit Payments

If Subscriber, Subscriber's Covered Dependents, or anyone on behalf of Subscriber or Subscriber's Covered Dependents receives benefits or monies subject to the coordination of benefits or subrogation provisions of the Agreement, Subscriber must submit to Health Plan the amount to which Health Plan is entitled. In the event Subscriber, Subscriber's Covered Dependents, or anyone on behalf of Subscriber or Subscriber's Covered Dependents should enter into an agreement for the payment of amounts due under the subrogation or coordination of benefits provision, any amount due is considered to be a Required Payment.

### 4.4 Cancellation of Coverage

If any Premium is not received by the Health Plan before or on the due date, Health Plan may terminate coverage under this Agreement. If payment is not received, Health Plan shall have no obligation to pay for any services provided to Subscriber or Subscriber's Covered Dependents after the due date, and Subscriber shall be liable for the cost of those services. The cost of such services shall be considered Required Payments prior to the issuance of any subsequent Health Plan coverage to Group.

## 5. Health Care Services

### 5.1 Using Member Identification Card

The ICSW membership card identifies Group's specific Health Plan Coverage. Each card contains personal information, such as Subscriber's Health Plan identification number. Any Member checking in to see a Provider for Covered Services should present his or her own membership identification card, and not the membership card of a family member or anyone else.

It is important to have a Member identification card whenever medical services or treatment are needed. ICSW will send ID cards within ten (10) days of issuance of a Certificate of Coverage. This cared will identify Subscribers and Covered Dependents as Health Plan Members. If a card is lost, contact us immediately and we will send a new one. A member should not at any time give their ID card to another person. IF a member lets someone else use their ID card, the Plan may confiscate the card, terminate that member's membership in the Plan, and deny the services wrongfully obtained. Said Member will be held financially responsible for such services.

## 6. CLAIMS PROCEDURE

### 6.1 Necessity of Filing Claims

Members are not required to file a claim with the Health Plan for payment for Health Care Services obtained from a Participating Provider. Health Plan's contracts with Participating Provider allow them to file claims of Allowed Amount on Member's behalf. For Health Care Services obtained from Participating Providers, Member is responsible for the Copayments, Coinsurance, and Deductibles as stated in the Schedule of Benefits.

For Health Care Services obtained from non-Participating Providers, Member may file a claim for reimbursement directly with Health Plan or assign the rights and benefits of this Policy to non-Participating Providers.

Except for payments to Participating Providers and payments made to providers that have accepted an assignment of benefits from a Member, benefits under this Agreement will be paid to:

1. the Subscriber;
2. the Subscriber's designated beneficiary;
3. the Subscriber's estate; or
4. if a Member is a minor or is otherwise not competent to give a valid release, the Member's parent, guardian, or other person actually supporting the insured.

### 6.2 Effect of Failure to File Claim Within 90 Days

Failure to submit written proof of and claim for payment within the 90 day period shall not invalidate or reduce Member's entitlement to reimbursement provided it was not reasonably possible for Member to submit such proof and claim within the time allowed and written proof of and claim for payment were filed as soon as reasonably possible. Written proof and claim for payment submission should consist of itemized receipts containing: name and address where services were received, date service was provided, amount paid for service, and diagnosis for visit. Claims for reimbursement should be sent to Insurance Company of Scott and White, Attn: Claims Dept., 1206 West Campus Dr., Temple, TX 76502. In no event will Health Plan have any obligation under this paragraph if such proof of and claim for payment is not received by Health Plan within one (1) year of the date the services were provided to Subscriber or Covered Dependent.

## 6.3 Acknowledgement of Claim

Not later than the fifteenth (15th) day after receipt of a claim, the Health Plan will acknowledge in writing receipt of the claim; begin any investigation of the claim; and request any necessary information, statements or forms. Any forms requested by Health Plan will be sent within that 15 day period. Additional requests for information may be made during the course of the investigation.

## 6.4 Acceptance or Rejection of Claim

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

## 6.5 Payment of Claims

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

## 6.6 Payment to Physician or Provider

Payment by Health Plan to the person or facility providing the services to a Member shall discharge Health Plan's obligations under this Section.

## 6.7 Limitations on Actions

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

## 6.8 Payment to Texas Department of Human Services

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

1. The Texas Department of Human Services is paying benefits under the financial and medical assistance service programs administered pursuant to the Texas Human Resources Code;
2. Subscriber has possession or access to the child pursuant to a court order, or Subscriber is not entitled to access or possession of the child but are required by the court to pay child support; and
3. When the claim is first submitted Subscriber notifies Health Plan that the benefits must be paid directly to the Texas Department of Human Services.

## 6.9 Payment to a Managing Conservator

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

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

You have paid any portion of a medical bill that would be covered under the terms of this Agreement.

## 7. EFFECT OF SUBROGATION AND COORDINATION OF BENEFITS

### 7.1 Subrogation/Lien/Assignment/Reimbursement

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

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

#### 7.1.1 ASSIGNMENT

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

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

#### 7.1.2 REIMBURSEMENT

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

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

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

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

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

7.1.4 OBLIGATIONS OF THE PLAN PARTICIPANT TO THE PLAN

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

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

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

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

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

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

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

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

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

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

### 7.1.5 MADE WHOLE DOCTRINE

The Plan's right of subrogation, lien, assignment or reimbursement as set forth herein will not be affected, reduced or eliminated by the "made whole doctrine" and/or any other equitable doctrine or law which requires that the plan participant be "made whole" before the Plan is reimbursed. The Plan has the right to be repaid 100% first from any settlement, judgment, remuneration, insurance proceeds or other source of funds a plan participant receives. The Plan has the right to be reimbursed first whether or not a portion of the settlement, judgment, remuneration, insurance proceeds or other source of funds are identified as a reimbursement for medical expenses. The plan has the right to be reimbursed first whether or not a plan participant makes a claim for medical expenses.

### 7.1.6 ATTORNEYS' FEES

The Plan will not be responsible for any expenses, fees, costs or other monies incurred by the attorney for the plan participant and/or his or her beneficiaries, commonly known as the common fund doctrine. The Plan participant is specifically prohibited from incurring any expenses, costs or fees on behalf of the Plan in pursuit of his rights of recovery against a third-party or Plan's subrogation, lien, assignment or reimbursement rights as set forth herein. No court cost, filing fees, experts' fees, attorneys' fees or other cost of a litigation nature may be deducted from the Plan's recovery without prior, express written consent of the Plan

A plan participant must not reimburse their attorney for fees or expenses before the Plan has been paid in full. The Plan has the right to be repaid first from any settlement, judgment, or insurance proceeds a plan participant receives. The Plan has a right to reimbursement whether or not a portion of the settlement, judgment, insurance proceeds or any other source or payment was identified as a reimbursement of medical expenses.

### 7.1.7 WRONGFUL DEATH/SURVIVORSHIP CLAIMS

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

### 7.1.8 DEATH OF PLAN PARTICIPANT

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

7.1.9 CONTROL OF SETTLEMENT PROCEEDS

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

7.1.10 PAYMENT

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

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

7.1.11 SEVERABILITY

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

7.1.12 INCURRED BENEFITS

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

7.1.13 NON-EXCLUSIVE RIGHTS

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

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

## 7.2 COORDINATION OF THIS PLAN'S BENEFITS WITH OTHER BENEFITS

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

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

**DEFINITIONS**

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) "Allowed amount" is the amount of a billed charge that a carrier determines to be covered for services provided by a nonpreferred health care provider or physician. The allowed amount includes both the carrier's payment and any applicable deductible, copayment, or coinsurance amounts for which the insured is responsible.

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

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

**ORDER OF BENEFIT DETERMINATION RULES**

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

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

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

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

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

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

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

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

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

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

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

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

(i) The plan of the parent whose birthday falls earlier in the Year is the primary plan; or

(ii) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

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

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

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

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

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

(I) the plan covering the custodial parent;

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

(III) the plan covering the noncustodial parent; then

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

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

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

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

(3) Active, Retired, or Laid-off Employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan that covers that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the plan that covers the same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

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

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

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

**EFFECT ON THE BENEFITS OF THIS PLAN**

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

allowable expense for that claim. In addition, the secondary plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

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

**COMPLIANCE WITH FEDERAL AND STATE LAWS CONCERNING CONFIDENTIAL INFORMATION**

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

### 7.3 Facility Of Payment

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

### 7.4 Right Of Recovery

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

## 8. RECORDS

### 8.1 Records Maintained by Health Plan

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

### 8.2 Necessity of Requested Information

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

8.2.1 Authorization for Health Care Information from Physicians and Providers

Health Plan is entitled to receive from any physician or provider of Health Care Services to Members information reasonably necessary in connection with the administration of this Agreement but subject to all applicable confidentiality requirements. By acceptance of Health Care Services under this Agreement, Members authorize every physician or provider rendering Health Care Services hereunder to disclose, as permitted by law upon request, all facts pertaining to Member's care, Treatment and physical condition to Health Plan to render reports pertaining to the same, and permit copying of such records and reports by Health Plan.

### 8.3 Notification of Changes in Status

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

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

## 9. COMPLAINT AND APPEAL PROCEDURE

### 9.1 Purpose

9.1.1 Health Plan recognizes that a Member, physician, provider, or other person designated to act on behalf of ICSW member may encounter an event in which performance under this Agreement does not meet expectations. It is important that such an event be brought to the attention of the Health Plan. The Health Plan is dedicated to addressing problems quickly, managing the administration of Health Care Services effectively, and preventing future complaints or appeals.

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

### 9.2 Complaints

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

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

9.2.3 Health Plan will investigate the Complaint and issue a response letter to the Complainant within thirty (30) days from receipt of the Complaint explaining the specific medical and/or contractual reasons for the resolution and the specialization of any physician or other provider consulted.

## 10. MISCELLANEOUS PROVISIONS

### 10.1 Confidentiality

In accordance with applicable law, any data or information pertaining to the diagnosis, Treatment, or health of Members or to an application obtained from Members or from any physician or provider by Health Plan shall be held in confidence and shall not be disclosed to any person except:

1. to the extent that it may be necessary to carry out purposes required by or to administer this Agreement with regard to the provision of Health Care Services, payment of Health Care Services, and Health Plan operations; or
2. upon Member's express authorization; or
3. pursuant to a law or in the event of claim or court order for the production of evidence or to discovery thereof; or
4. in the event of claim or litigation between Member and Health Plan wherein such data or information is pertinent, or
5. bona fide medical research or studies by Health Plan. Health Plan shall be entitled to claim the same privilege against such disclosures as the physician or provider who furnishes such information to it is entitled to claim.

### 10.2 Independent Agents

10.2.1 Health Plan's Participating Providers are independent contractors. Health Plan is not an agent of any Participating Provider, not is any Participating Provider an agent of the Health Plan.

10.2.2 Participating Providers shall make reasonable efforts to maintain an appropriate patient relationship with Members to whom they are providing care. Likewise, Members shall make reasonable efforts to maintain an appropriate patient relationship with the Participating Providers who are providing such care.

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

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

### 10.3 Changes in Coverage

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

### 10.4 Entire Agreement

This Agreement, attachments, Group's application, and Subscriber's completed and accepted Enrollment Application(s) constitute the entire contract between the parties, and all oral representations and warranties have been incorporated into this Agreement. No agent or other person, except the Executive Director of Health Plan, has the authority to waive any conditions or restrictions of this Agreement, to extend the time for making a

payment, or to bind Health Plan by making any promise or representation, or by giving or receiving any information. No changes to this Agreement shall be valid unless in writing and signed by the Executive Director of Health Plan; however, Health Plan may adopt policies, procedures and rules to promote the orderly and efficient administration of this Agreement.

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

### 10.5 Modification of Terms

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

### 10.6 Not a Waiver

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

### 10.7 Recovery

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

### 10.8 Notice

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

If to Health Plan:
Insurance Company of Scott and White
1206 W. Campus Dr.
Temple, Texas 76502

If to Subscriber:
To the latest address provided by Subscriber

If to a Group:
To the latest address provided by the Group.

## 10.9 Incontestability

Applicants for membership shall truthfully complete and submit to Health Plan an Enrollment Application. In absence of fraud, all statements made by the applicant shall be deemed representations and not warranties and no statement shall void the coverage or reduce benefits hereunder after this Agreement has been in force for two years from its effective date unless it was material to the risk assumed and contained in the Enrollment Application, a completed copy of which has been given to the Subscriber. But, in the event of a fraudulent representation, coverage shall terminate sixteen (16) days after written notice. Except as otherwise provided, all benefits hereunder are subject to the condition that all statements, representations and other information provided by Subscriber or Group are true, correct and complete.

## 10.10 Proof of Coverage

Health Plan will provide Subscriber with proof of coverage under this Agreement. Such evidence shall consist of an original copy of a Certificate of Coverage and an identification card as described below. Subscriber will also be provided with a current roster of Participating Providers as well as additional educational material regarding the Health Plan and the services provided under this Agreement. A list of Participating Providers will be updated and distributed annually, and is available on the Health Plan's website at www.ICSW.org. Although Health Plan makes every effort to keep its Participating Providers list current, they are subject to change.

## 10.11 Identification Card

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

## 10.12 Misstatement of Age

If Subscriber's or Covered Dependent's age has been misstated, and if the amount of premium is based on age, an adjustment of premiums shall be made based on that Member's true age.

If age is a factor in determining eligibility or amount of insurance and there has been a misstatement of age, the insurance coverages or amounts of benefits, or both, shall be adjusted in accordance with that Member's true age. Any such misstatement of age shall neither continue insurance otherwise validly terminated nor terminate insurance otherwise validly in force.

## 10.13 Office of Foreign Assets Control (OFAC) Notice

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

## 11. WHAT IS COVERED

Welcome to Insurance Company of Scott and White. **Insurance Company of Scott and White will pay up to the Allowed Amount for Health Care Services incurred by Members as a direct result of injury or sickness after satisfaction of any applicable Deductibles and Coinsurance.** Such payments will not exceed the lifetime limits of the policy or other applicable maximum shown in the Schedule of Benefits. All benefits are subject to the limitations and exclusions described in the Description of Benefits. Members may obtain services from physicians, hospitals and providers regardless of whether they are participating or non-participating. However, Participating Physicians, Participating Hospitals, and Participating Providers have agreed to accept an amount that does not exceed the Allowed Amount, after satisfaction of any applicable Deductibles and Coinsurance, as payment in full. Non-participating physicians, hospitals, and providers may bill Members for any difference between the Allowed Amount paid by Health Plan and their billed charges, if billed charges exceed the Allowed Amount.

To understand the benefits available under this Plan, Members should first review their Certification of Coverage, and this Agreement.

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

The Schedule of Benefits identifies Member's Coinsurance, Deductibles, and Copayments (individual and family), and other expenses Members are responsible to pay.

### 11.1 BENEFITS

#### 11.1.1 Medical Services

Members are entitled to reimbursement up to the Allowed Amount for Medically Necessary professional services of Physicians and Providers on an inpatient and outpatient basis. Medical Necessity is determined by the Physician or Provider, subject to the review of the Health Plan Medical Director.

#### 11.1.2 Hospital Services

Members are entitled to reimbursement up to the Allowed Amount for Medically Necessary services of any Hospital to which a Member is admitted.

#### 11.1.3 Emergency Care

11.1.3.1 Qualification of Emergency Care

Medically Necessary Emergency Care from a Physician or Provider to treat and stabilize an emergency medical condition is reimbursed up to the Allowed Amount. However, only those conditions meeting the terms of the definition of Emergency Care will qualify. Health Plan will provide for any medical screening examination or other evaluation required by Texas or federal law that takes place in a hospital emergency facility or comparable facility, and that is necessary to determine whether an emergency medical condition exists.

11.1.3.2 Urgent Care Services

Urgent Care services provide for the immediate treatment of medical condition that requires prompt medical attention but where a brief time lapse before receiving services will not endanger life or permanent teeth. Urgent Care services are reimbursed up to the Allowed Amount, an Member shall be required to pay the Copayment stated in the Schedule of Benefits for Treatment administered at an Urgent Care Facility. Neither a hospital nor an emergency room will be considered an Urgent Care Facility.

11.1.3.3 Emergency Transportation Services
Emergency transportation, when and to the extent it is Medically Necessary, is covered up to the Allowed Amount when transportation in any other vehicle would endanger the patient's health. Health Plan will not cover air transportation if ground transportation is medically appropriate and more economical. The ambulance equipment and personnel must meet Medicare standards. If these conditions are met, Health Plan will cover ambulance transportation to the closest appropriate hospital or skilled nursing facility or from a hospital or skilled nursing facility to the patient's home.

11.1.3.4 Payment of Benefits After Stabilization
Once Member's Condition is stabilized, benefits for further Covered Services will be provided pursuant to the Schedule of Benefits at the applicable level of benefits for the Allowed Amount.

**11.1.4 <u>Preventive Care Services</u>**

You and Your Covered Dependents are entitled to the Preventive Services without being subject to a Copayment or Deductible.

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

Under the Affordable Care Act, certain preventive services are paid at 100% (at no cost to the Member), depending on the billing and diagnosis.

The determination of whether a service is a Preventive Care Service may be influenced by the type of service for which your Physician or Provider bills the Health Plan. Specifically (10) if a recommended preventive service is billed separately from an office visit, then a plan may impose cost-sharing requirements with respect to the office visit, (2) if a recommended preventive service is not billed separately from an office visit and the primary purpose of the office visit is the delivery of the preventive service, then a plan may not impose cost-sharing requirements with respect to the office visit, and (3) if a recommended preventive service is not billed separately from an office visit and the primary purpose of the office visit is not the delivery of a preventive service, then Health Plan may impose cost-sharing requirements with respect to the office visit.

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

11.1.4.1 **COVERED PREVENTIVE SERVICES FOR ALL ADULTS**

- **Abdominal Aortic Aneurysm** one-time screening by ultrasonography for men ages 65 to 75 who have ever smoked
- **Alcohol Misuse** screening and counseling
- **Aspirin to prevent CVD: men**: the use of aspirin for men age 45 to 79 years, when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm of an increase in gastrointestinal hemorrhage
- **Aspirin to prevent CVD: women:** the use of aspirin for women age 55 to 79 years, when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage
- **Blood Pressure** screening for all adults age 18 and older
- **Cholesterol** screening for men age 35 and older for lipid disorders, men age 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease, women age 45 and older for

lipid disorders if they are at increased risk for coronary heart disease, and women age 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease

- **Colorectal Cancer** screening for adults at least 50 years of age and at normal risk for developing cancer, limited to: an annual fecal occult blood test and a flexible sigmoidoscopy once every five years; or a colonoscopy once every ten years
- **Depression** screening for adults when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up
- **Type 2 Diabetes** screening for adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg
- **Diet** intensive behavioral dietary counseling for adults with hyperlipidemia and other known risk factors for cardiovascular and diet related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians
- **Hepatitis B** screening in persons at high risk for infection.
- **Hepatitis C** screening in persons at high risk for infection and a one-time screening for HCV infection for adults born between 1945 and 1965.
- **HIV** screening for all adults at higher risk
- **Immunization** vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) :
  - Hepatitis A
  - Hepatitis B
  - Herpes Zoster
  - Human Papillomavirus
  - Influenza (Flu Shot)
  - Measles, Mumps, Rubella
  - Meningococcal
  - Pneumococcal
  - Tetanus, Diphtheria, Pertussis
  - Varicella

- **Lung Cancer** screening annually with low-dose tomography in adults ages 55 to 80 years who have a 30 pack per year smoking history and currently smoke or have within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.
- **Obesity** screening for all adults and intensive counseling and behavioral interventions to promote sustained weight loss for obese adults
- **Sexually Transmitted Infection (STI)** prevention counseling for adults at higher risk
- **Tobacco Use** screening for all adults and cessation interventions for tobacco users
- **Syphilis** screening for all pregnant women and all adults at higher risk.
- **Fall prevention in older adults, exercise or physical therapy** – exercise of physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased for falls.
- **Fall prevention in older adults, vitamin D**- vitamin D supplementation to prevent fall in community-dwelling adults age 65 years and older who are are at increased risk for falls.

11.1.4.2 **COVERED PREVENTIVE SERVICES FOR WOMEN INCLUDING PREGNANT WOMEN**

- **Anemia** screening on a routine basis for pregnant women
- **Bacteriuria** urinary tract or other infection screening for pregnant women at the later of 12 to 16 weeks' gestation or at the first prenatal visit
- **BRCA** screening for women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes; genetic counseling for women with positive screening results and, if indicated, BRCA testing.
- **Breast Cancer Low-dose Mammography** for women with or without clinical breast examinations

(CBE), for women age 35 and older, annually. Low-dose mammography means the X-ray examination of the breast using equipment dedicated specifically for mammography, including an X-ray tube, filter, compression devise, screens, films and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

- **Breast Cancer Chemoprevention** counseling for women at higher risk for breast cancer and at low risk for adverse effects of chemoprevention. For women, age 35 and older, without a prior diagnosis of breast cancer, but who are at increased risk for breast cancer and at low risk for adverse medication effects, clinician should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene. These risk-reducing medications are covered as preventive services, which qualify for the waiver of applicable cost-sharing requirements only if used for prevention. They are not considered preventive if used for the treatment of a Member already diagnosed with breast cancer.
- **Breastfeeding**-comprehensive support and counseling from trained providers access to breastfeeding supplies, for pregnant and nursing women. Health Plan shall make a particular mid-range make and model of breast pump available, and this benefit shall be limited to the cost to the Health Plan of that model of breast pump. If You or Your Covered Dependent wishes to purchase a different model, or to rent rather than purchase a breast pump, this benefit will be subject to this limit.
- **Cervical Cancer** and Human Papillomavirus screening for women, including the provider's charge for administration of the test, for any covered female age 18 or older, not to exceed one per Year for: a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration (FDA), alone or in combination with a test approved by the FDA for the detection of the human papillomavirus. A screening test must be performed in accordance with the guidelines adopted by the American College of Obstetricians and Gynecologists or another similar national organization of medical professionals.
- **Chlamydia Infection** screening for all sexually active non-pregnant women age 24 and younger and for older non-pregnant women who are at increased risk.
- **Contraception-**Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs coverage of contraception may be subject to step therapy and preauthorization requirements.
- **Domestic and interpersonal violence** screening and counseling for all women
- **Folic Acid** supplements containing 0.4 to 0.8 mg of folic acid for women who may become pregnant
- **Gestational diabetes** screening for women 24 to 28 weeks pregnant and at the first prenatal visit for those at high risk of developing gestational diabetes
- **Gonorrhea** screening for all sexually active women, including those who are pregnant, at higher risk for infection
- **Hepatitis B** screening for pregnant women at their first prenatal visit
- **Human Immunodeficiency Virus (HIV)** screening and counseling for sexually active women and all pregnant women, including those in labor, who are untested or whose status is unknown.
- **Low-dose aspirin (81 mg/d)** as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia
- **Osteoporosis** screening for women over age 65 or a qualified individual to detect low bone mass and to determine the Member's risk of osteoporosis and fractures associated with osteoporosis. A "qualified individual" is: a postmenopausal woman who is not receiving estrogen replacement therapy; an individual with vertebral abnormalities, primary hyperparathyroidism, or a history of bone fractures; or an individual who is receiving long-term glucocorticoid therapy or being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy
- **Rh Incompatibility** screening for all pregnant women and follow-up testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.
- **Tobacco Use** screening and interventions for all women, and expanded counseling for pregnant tobacco users
- **Sexually Transmitted Infections (STI)** counseling for sexually active women
- **Syphilis** screening for all pregnant women or other women at increased risk

- **Well-woman visits** to obtain recommended preventive services

11.1.4.3 **COVERED PREVENTIVE SERVICES FOR CHILDREN**

- **Alcohol and Drug Use** assessments for adolescents
- **Autism** screening for children at 18 and 24 months
- **Behavioral** assessments for children of all ages (one assessment for each of the following age ranges): Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- **Blood Pressure** screening for children (one screening for each of the following age ranges): Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- **Cervical Dysplasia** screening for sexually active females
- **Critical Congenital Heart Disease** screening using pulse oximetry for newborns, after 24 hours of age, before discharge from the hospital
- **Congenital Hypothyroidism** screening for newborns
- **Depression** screening for adolescents (12 to 18 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.
- **Developmental** screening for children under age 3, and surveillance throughout childhood
- **Dyslipidemia** screening for children at higher risk of lipid disorders (one screening for each of the following age ranges): Ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- **Fluoride Chemoprevention** supplements for children older than 6 months whose primary water supply is deficient in fluoride
- **Prophylactic medication for Gonorrhea** for the eyes of all newborns against gonococcal ophthalmia neonatorum
- **Hearing** screening for all newborns from birth through the date the child is 30 days old; and Medically Necessary diagnostic follow-up care to the screening test for a child from birth through the date the child is 24 months old
- **Height, Length, Weight, Head Circumference, Weight for Length, and Body Mass Index** measurements for children at recommended intervals
- **Hemoglobinopathies** or sickle cell disease screening for newborns
- **HIV** screening for adolescents at higher risk
- **Immunization** vaccines for children from birth to age 18 as recommended by the Advisory Committee on Immunization Practices (ACIP) :
    - Diphtheria, Tetanus, Pertussis
    - Haemophilus influenzae type b
    - Hepatitis A
    - Hepatitis B
    - Herpes zoster
    - Human Papillomavirus
    - Inactivated Poliovirus
    - Influenza (Flu Shot), including H1N1 influenza
    - Measles, Mumps, Rubella
    - Meningococcal
    - Polio
    - Pneumococcal polysaccharide
    - Rotavirus
    - Varicella
- **Iron** supplements for children ages 6 to 12 months at risk for anemia
- **Lead** screening for children at risk of exposure
- **Medical History** for all children throughout development (one history for each of the following age ranges) Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- **Newborn** blood screening

- **Obesity** screening for children age 6 and older and referral to comprehensive, intensive behavioral interventions to promote improvement in weight status
- **Oral Health** risk assessment for young children (one assessment for each of the following age ranges) Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.
- **Phenylketonuria (PKU)** screening for this genetic disorder in newborns
- **Sexually Transmitted Infection (STI)** prevention counseling and screening for adolescents at higher risk
- **Tobacco use intervention**, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.
- **Tuberculin** testing for children at higher risk of tuberculosis (one test for each of the following age ranges): Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- **Vision** screening for all children to detect amblyopia, strabismus, and defects in visual acuity in children younger than 5 years old.
- **Counseling for skin cancer:** counseling for children and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolent radiation to reduce risk for skin cancer.

In addition to the above referenced Preventive Care Services, the following State of Texas Mandated Benefits are also considered Preventive Care Services:

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

11.1.4.5 **COLORECTAL CANCER SCREENING EXAM**
You or Your Covered Dependents are eligible for an annual fecal occult blood test. In addition, if you are 50 years of age or older you may receive a flexible sigmoidoscopy every five years or a colonoscopy every ten years.

11.1.4.6 **EXAM FOR DETECTION AND PREVENTION OF OSTEOPOROSIS**
You or Your Covered Dependent are eligible for medically accepted bone mass measurement for the detection of low bone mass and to determine the risk of osteoporosis and fractures associated with osteoporosis.

11.1.4.7 **LOW DOSE MAMMOGRAPHY**
If You or Your Covered Dependent is a female 35 years or older, an annual screening by low-dose mammography is covered.

11.1.4.8 **CERVICAL CANCER SCREENING**
You and Your Covered Dependents, if female and over age 18, are eligible for a medically recognized annual diagnostic examination, including a conventional Pap smear screening or a screening using liquid-based cytology methods alone or in combination with a test for the detection of the human papillomavirus, for the early detection of cervical cancer.

11.1.4.9 **PHENYLKETONURIA (PKU) OR HERITABLE METABOLIC DISEASE**
Coverage for formulas necessary to treat phenylketonuria (PKU) or a heritable metabolic disease are available to You or Your Covered Dependent as prescribed by a Physician.

The determination of whether a service is a Preventive Care Service may be influenced by the type of service for which your Physician or Provider bills the Health Plan. Specifically (10) if a recommended preventive service is billed separately from an office visit, then a plan may impose cost-sharing requirements with respect to the office visit, (2) if a recommended preventive service is not billed separately from an office visit and the primary purpose

of the office visit is the delivery of the preventive service, then a plan may not impose cost-sharing requirements with respect to the office visit, and (3) if a recommended preventive service is not billed separately from an office visit and the primary purpose of the office visit is not the delivery of a preventive service, then Health Plan may impose cost-sharing requirements with respect to the office visit.

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

### 11.1.5 Mental Health Care and Treatment for Chemical Dependency

Medically Necessary Treatment of mental illness and emotional disorders is covered as follows:

- OUTPATIENT MENTAL HEALTH CARE

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

- INPATIENT MENTAL HEALTH CARE

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

- COPAYMNET FOR MENTAL HEALTH CARE

For outpatient mental health care, Members are required to pay the Copayment for each outpatient mental health care visit as stated in the Schedule of Benefits.

11.1.5.1 PSYCHIATRIC DAY TREATMENT FACILITY
Psychiatric Day Treatment Facility services are available for Medically Necessary mental health evaluations, diagnostic and therapeutic services up to the Allowed Amount. In order to be considered for coverage, the Physician attending a member must certify that treatment at such facility is in lieu of hospitalization. Two (2) days of Treatment at a Psychiatric Day Treatment Facility shall be counted as one (1) day of inpatient care for purposes of applying the stay in such a facility against the inpatient mental health care limits stated in the Schedule of Benefits.

11.1.5.2 RESIDENTIAL AND STABILIZATION MENTAL HEALTH TREATMENT
Alternative mental health Treatment benefits are available for Medically Necessary Treatment of mental and emotional disorders, including mental health evaluations, diagnostic and therapeutic services in a Residential Treatment Center for Children and Adolescents or a Crisis Stabilization Unit. Reimbursement will be up to the Allowed Amount.

11.1.5.2.1 QUALIFICATION OF RESIDENTIAL AND STABILIZATION MENTAL HEALTH TREATMENT
The above alternative mental health Treatment benefits may be covered by Health Plan under the following conditions:

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

2. the services rendered for which benefits are to be paid must be based on an Individual Treatment Plan; and
3. providers of services for which benefits are to be paid must be licensed or operated by the appropriate state agency or board to provide those services.

Two (2) days of Treatment at a Residential Treatment Center for Children and Adolescents or Crisis Stabilization Unit shall be counted as one (1) day of inpatient care for purposes of applying the stay in such a facility against the inpatient mental health care limits stated in the Schedule of Benefits.

11.1.5.3 SERIOUS MENTAL ILLNESS
Treatment for Serious Mental Illness, which includes Medically Necessary Medical Services and Hospital Services, are covered for Serious Mental Health Services reimbursed up to the Allowed Amount. Member will pay the same Copayments for the Treatment of "Serious mental illness" as for any other physical illness and Treatment for serious mental illness is limited to the number of inpatient and outpatient days stated above.

11.1.5.4 TREATMENT FOR CHEMICAL DEPENDENCY
Members may be covered for Treatment of Chemical Dependency for reimbursement up the Allowed Amount for Medically Necessary care and Treatment for Chemical Dependency on the same basis as physical illness generally, subject to the applicable limitations, exclusions and Coinsurance, Copayment and Deductible provisions of this Agreement, and the Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers, adopted by the Texas Department of Insurance.

### 11.1.6 Rehabilitative Therapy

Outpatient rehabilitative therapy services are available for services for physical, inhalation, speech, hearing, and occupational therapies. Reimbursement will be up to the Allowed Amount.

11.1.6.1 Copayment for Rehabilitative Therapy
Members are required to pay the applicable Coinsurance, Copayment, and Deductible for each outpatient therapy as indicated in the Schedule of Benefits.

### 11.1.7 Home Health Services (Extended Care)

Members are eligible for coverage for home health services, consisting of Medically Necessary nursing care and short-term therapy for reimbursement up to the Allowed Amount. Such nursing care and/or short term therapy must be provided by a licensed home health care agency. These services are available when they are an essential part of an active individual Treatment Plan, when there is a defined goal expected to be attained and Member is required to remain at home for medical reasons. Examples of such conditions include, but are not limited to, the following: duration of care, setting, such as inpatient institutional care rather than home care; type of care, such as nursing care or physical therapy, and frequency of care, such as daily or weekly. Home health services shall not be covered for Custodial Care or primarily for convenience, as determine by the Medical Director.

11.1.7.1 Copayment for Home Health Services
Members are required to pay the Coinsurance for each home health visit to or by a Health Professional as indicated in the Schedule of Benefits.

### 11.1.8 Home Infusion Therapy Benefit

As approved by Health Plan as Medically Necessary, Home Infusion Therapy services are available for high technology services, including line care, chemotherapy, pain management, infusion and antibiotic, antiviral or antifungal therapy. Included within the Home Infusion Therapy benefit are administrative and professional

pharmacy services and all necessary supplies and equipment to perform the home infusion. Not included in the Home Infusion Therapy benefit are medical professional services (physician, nursing, etc.), enteral formula, and covered durable medical equipment not related to the home infusion therapy some of which may be covered under other provisions of this Agreement, and subject to additional copayments. Specialty Pharmacy Drugs, administered through Home Infusion Therapy may be covered under your Prescription Drug Benefit, if any, and may be subject to additional copayments under that benefit.

11.1.8.1 Copayments for Home Infusion Therapy Benefit
You are required to pay Deductible, if any, Coinsurance and Copayments for each day of Home Infusion Therapy as stated in the schedule of benefits.

### 11.1.9 Hospice Services

Hospice services consist of Medically Necessary Hospice care that is approved in advance by Health Plan and provided by a licensed Hospice agency will be covered.

### 11.1.10 Maternity and Family Planning Services

11.1.10.1 MATERNITY SERVICES
Reimbursement up to the Allowed Amount will be provided for maternity services including physician obstetrical care, labor and delivery services, hospital room and board, and the care of routine and complicated pregnancies in conjunction with the delivery of a child or children by Members. Benefits for complications of pregnancy will be reimbursed at the same benefit level as any other physical illnesses.

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

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

11.1.10.3 FAMILY PLANNING SERVICES
Coverage for family planning services will be provided up to the Allowed Amount as follows:

- counseling;
- sex education and instruction in accordance with medically acceptable standards;
- contraceptive devices; and
- placement of contraceptive devices,
- vasectomies,
- tubal ligations.

11.1.10.4 REQUIRED PAYMENTS FOR MATERNITY AND FAMILY PLANNING SERVICES
Members are required to pay the applicable Coinsurance, Copayments, and Deductible for Maternity and Family Planning Services. For Maternity, services applicable inpatient Coinsurance and Deductible must be paid for delivery in an inpatient setting.

### 11.1.11 Durable Medical Equipment/Orthotics/Prosthetic Devices

As approved by Health Plan, Medically Necessary Durable Medical Equipment, Prosthetic, or Orthotic Devices may be covered under this Agreement, Health Plan shall determine the conditions under which such equipment and appliances shall be covered. The conditions include, but are not limited to the following, the length of time covered, the equipment covered, the supplier, and the basis of coverage; i.e. rental, purchase, or loan. Health Plan shall provide coverage for these benefits, up to the maximum benefit per Contract Year specified in the Schedule of Benefits.

11.1.11.1 Consumable Supplies
Consumable Supplies associated with the use of covered Durable Medical Equipment, Orthotic Devices, and Prosthetic Devices are covered under this Agreement only to the extent that such supplies are required in order to use the specific piece of Durable Medical Equipment, Orthotic Device, or Prosthetic Device. Repair, maintenance, and cleaning due to abnormal wear and tear or abuse are Your responsibility. Benefits for consumable supplies will be applied to the maximum benefits for the device with which the consumable supply is associated.

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

11.1.11.3 Prosthetic Devices
Prosthetic Devices may be covered under the conditions determined by Health Plan as Medically Necessary to replace defective parts of the body following injury or illness. Health Plan shall cover the initial device, replacements due solely to growth, other Medically Necessary replacements for medical reasons and normal repairs. For Limb Prosthetics, Health Plan shall provide coverage up to the Lifetime Maximums and subject to the applicable copayments specified in the Schedule of Benefits. For all other Prosthetics, Health Plan shall provide coverage up the maximum benefit per Contract Year, subject to the applicable Copayments, specified in the Schedule of Benefits.

11.1.11.4 Orthotic Devices may be covered under the conditions determined by Health Plan as Medically Necessary. Health Plan shall cover the initial device, Medically Necessary replacements for medical reasons and normal repairs. Health Plan shall provide coverage for Orthotic Devices, up to the Lifetime Maximums, subject to the applicable Copayments specified in the Schedule of Benefits.

### 11.1.12 Coverage for Prescription Drugs

Members may be entitled for Medically Necessary prescription drugs depending upon the type of drug, setting in which the drug is administered, and whether a Prescription Drug Benefit Rider is attached to this Agreement. This provision sets forth the circumstances in which prescription drugs are covered under this Agreement.

11.1.12.1 INPATIENT PRESCRIPTION DRUGS
Prescription Drugs, including Specialty Pharmacy Drugs, administered while admitted to an Inpatient facility will be covered up to the Allowed Amount, as part of the Inpatient benefit, and no additional Coinsurance or Deductible is required for prescription drugs so administered.

11.1.12.2 OUTPATIENT SPECIALTY PHARMACY DRUGS

Outpatient prescription drugs designated on the drug formulary as Specialty Pharmacy drugs are covered up to the Allowed Amount under this Agreement, subject to the Outpatient Specialty Pharmacy Coinsurance and Deductibles indicated in the Schedule of Benefits.

Members may contact Health Plan to obtain a copy of the Specialty Pharmacy Drugs appearing on the drug formulary.

All Specialty Pharmacy Drugs will require preauthorization by a Medical Director.

Coinsurance and Deductibles paid toward Non-Preferred Specialty Pharmacy drugs will not be considered Out-of-Pocket Expenses for purposes of meeting Out-of-Pocket Maximums.

11.1.12.3 OUTPATIENT NON-SPECIALTY PHARMACY DRUGS ADMINISTERED IN OUTPATIENT SETTING

Outpatient Prescription Drugs which do not meet the definition of Specialty Pharmacy Drugs and which are dispensed and administered to Members in the office of a Provider or in another Outpatient setting, will be covered as a part of the Medical Services benefit up to the Allowed Amount, and no additional Coinsurance or Deductible is required for outpatient prescription drugs so dispensed and administered. Outpatient Prescription Drugs which do not meet the definition of Specialty Pharmacy Drugs and which are dispensed and administered to Members in the office of a Provider or in another Outpatient setting with an Allowed Amount of $450 or more for a single dose, and refillable prescriptions whose total Allowed Amount during a twelve (12) month period could equal or exceed $1,000, will require preauthorization by a Medical Director.

Outpatient Prescription Drugs which do not meet the definition of Specialty Pharmacy Drugs and which are dispensed by a pharmacy and administered to a Member in the office of a Provider, or in another Outpatient setting, require approval of a Medical Director in order to be covered as a part of Your Medical Services benefit. Without the prior approval of a Medical Director, coverage for Outpatient Prescription Drugs which do not meet the definition of Specialty Pharmacy Drugs and are dispensed by a pharmacy and administered by a Provider will be excluded under this Agreement, unless covered by a Prescription Drug Benefit rider.

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

11.1.12.4 OUTPATIENT PRESCRIPTION DRUGS

Unless otherwise covered by a Prescription Drug Benefit Rider, this Agreement excludes Outpatient prescription drugs that:

1. do not meet the definition of Specialty Pharmacy Drugs,
2. are not dispensed and administered in the office of a Provider's or other Outpatient setting; or
3. are dispensed at a pharmacy and administered in the office of a Provider, or other Outpatient setting, without prior approval of a Medical Director.

11.1.12.5 DETERMINATION OF COVERAGE LEVEL FOR PRESCRIPTION DRUG BENEFITS

The determination of the coverage level of prescription drugs under this Agreement and the Prescription Drug Benefit Rider, if attached to this Agreement, shall be assigned in the following order:

1. Prescription Drug administered while admitted in an inpatient setting;
2. Outpatient Specialty Pharmacy Drug;
3. Outpatient Prescription Drug that is not a Specialty Pharmacy Drug, administered in the office of a Provider or other Outpatient setting; or

4. Outpatient Prescription Drug that is not a Specialty Pharmacy Drug and is not administered in the office of a Provider, or other Outpatient setting, if Prescription Drug Benefit Rider is attached to this Agreement.

NOTE: All Prescription Drug Coverage is subject to the Allowed Amount and the Exclusions and Limitations provision of this Agreement.

**11.1.13 Outpatient Radiological or Diagnostic Examination**

Outpatient Radiological and Diagnostic exams shall be covered as Medically Necessary. Examples of such services include:

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

11.1.13.1 COPAYMENTS/DEDUCTIBLES FOR OUTPATIENT RADIOLOGICAL OR DIAGNOSTIC EXAMINATIONS

You are required to pay the Deductible, if any, Coinsurance, and/or Copayments listed in the schedule of benefits for Outpatient Radiological or Diagnostic Examinations contained in this Section.

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

**11.1.14. Phenylketonuria (PKU) or a Heritable Disease**

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

**11.1.15 Breast Reconstruction Benefits**

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

11.1.15.1 COPAYMENTS/DEDUCTIBLES FOR BREAST RECONSTRUCTION
Members are required to pay the same Coinsurance, Copayments and Deductibles for Breast Reconstruction benefits as would be required for other benefits provided under this Agreement.

### 11.1.16 Minimum Inpatient Stay Following Mastectomy or Related Procedure

Health Plan coverage for the treatment of breast cancer includes coverage, up to the Allowed Amount, of a minimum of forty-eight (48) hours of inpatient care following a mastectomy and twenty-four (24) hours following a lymph node dissection for the treatment of breast cancer unless Member and the attending physician determines that a shorter period of inpatient care is appropriate.

### 11.1.17 Benefits for the Treatment and Diagnosis of Conditions Affecting Temporomandibular Joint

Coverage up to the Allowed Amount for Medically Necessary diagnostic or surgical treatment of conditions affecting the temporomandibular joint, including the jaw and craniomandibular joint is available to Members where the condition is the result of an accident, a trauma, a congenital defect, or a pathology.

### 11.1.18 Treatment for Craniofacial Abnormalities of a Child

Coverage up to the Allowed Amount for Covered Dependents younger than 18 years, includes reconstructive surgery for craniofacial abnormalities to improve the function or, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infection or disease. Cosmetic surgery is an excluded service to the extent that it is not necessary to improve function of, or to attempt to create a normal of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infection or disease for a Covered Dependent younger than 18 years.

### 11.1.19 Diabetes Supplies, Equipment, and Self-Management Training

If Member has been diagnosed with insulin dependent diabetes, non-insulin dependent diabetes, or abnormal elevated blood glucose levels induced by pregnancy or another medical condition, as Medically Necessary and prescribed by a Physician or Health Professional, such Member is eligible for coverage up to the Allowed Amount for Diabetes Supplies, Diabetes Equipment, and Diabetes Self-Management Training under this Agreement. Coverage for such Treatment shall be provided on the same basis as other analogous chronic medical conditions are covered, including, but not limited to the applicable Coinsurance, Copayments and Deductibles. Coverage up to the Allowed Amount shall also be provided for new or improved Diabetes Supplies or Diabetes Equipment, upon approval of the United States Food and Drug Administration, as Medically Necessary and prescribed by a Physician or Health Professional. All Diabetes Equipment and Supplies, including medications, and equipment for the control of diabetes shall be dispensed as written, including brand name products, unless substitution is approved by the Physician or Health Professional who issues the written order for the supplies or equipment.

11.1.19.1 COVERAGE FOR DIABETES SELF-MANAGEMENT TRAINING

Members are eligible for Coverage of Diabetes Self-Management Training up to the Allowed Amount for which a Physician or Health Professional has written an order to Member Diabetes Self-Management Training shall include the development of an individualized management plan that is created for and in collaboration with Member. Medical nutritional counseling and instructions on the proper use of Diabetes Equipment and Supplies is covered as part of the training. Coverage for Diabetes Equipment and Supplies shall be provided upon the initial diagnosis of diabetes, the written order of a Physician or Health Professional indicating that a significant change in the symptoms or condition of the insured requires changes in the insured's self-management regime, or the written order of a Physician or Health Professional that periodic or episodic continuing education is warranted by the development of new techniques and treatment for diabetes. The training must be provided by one of the following:

1) a diabetes self-management training program recognized by the American Diabetes Association;
2) a multidisciplinary team coordinated by a Certified Diabetes Educator (CDE) who is certified by the National Certification Board for Diabetes Educators. The team shall consist of at least a dietician and a nurse educator; other team members may include a pharmacist and a social worker. Other than a social

worker, all team members must have recent didactic and experiential preparation in diabetes clinical and educational issues;

3) a Certified Diabetes Educator (CDE); or

4) a Health Professional who has been determined by his or her licensing board to have recent didactic and experiential preparation in diabetes clinical and educational issues. All individuals providing Diabetes Self-Management Training must be licensed, registered, or certified in Texas to provide appropriate health care services.

11.1.19.2 COVERAGE UNDER PRESCRIPTION DRUG BENEFITS (AS APPROPRIATE)

Insulin, syringes, oral agents available with a prescription and Glucagon Emergency Kits shall be provided according to the terms of the Prescription Drug Benefit, except no annual dollar maximum benefit limitation shall apply. If this Agreement does not include a Prescription Drug Benefit, insulin, syringes, oral agents available with a prescription, and Glucagon Emergency Kits shall be provided according to the following subparagraph.

11.1.19.3 REQUIRED PAYMENTS MAXIMUMS FOR DIABETES EQUIPMENT AND SUPPLIES

All other Diabetes Equipment and Diabetes Supplies shall be provided, up to the Allowed Amount, according to the terms of this Agreement. Health Plan will not cover a renewal of a Diabetes Supply until 50% of the amount previously provided has been consumed. You are required to pay Coinsurance, Copayments and Deductibles for Diabetes Equipment, Diabetes Supplies, and Diabetes Self-Management Trainings at stated in the Schedule of Benefits

### 11.1.20 Transplant Services

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

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

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

1. the recipient of the organ is a Member, and
2. the donor/procurements costs are not covered by the donor's Health Benefit Plan.

If the donor's Health Benefit Plan does not cover donor/procurement costs, such costs will be covered.

### 11.1.21 Newborn Hearing Screening

Reimbursement up to the Allowed Amount for a screening for hearing loss for newborns is covered under this Agreement. This included necessary follow-up care related to the screening test from birth through Covered Dependent's second birthday. Copayment and Coinsurance apply to newborn hearing screenings and follow up care, but not Deductible or benefit maximums will be applied to newborn hearing screening or follow-up care.

### 11.1.22 Benefits for Acquired Brain Injury

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

- Cognitive rehabilitation therapy,
- Cognitive communication therapy,
- Neurocognitive therapy,
- Neurocognitive rehabilitation,
- Neurobehavioral testing,
- Neurobehavioral treatment, Neurophysiological testing
- Neurophysiological treatment,
- Neuropsychological treatment,
- Neuropsychological testing,
- Psychophysiological testing,
- Psychophysiological treatment,
- Neurofeedback therapy,
- Remediation required for and related to the treatment of an acquired brain injury,
- Post-acute transition services; and
- Community reintegration services, including outpatient day treatment services or other post-acute care treatment services.

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

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

11.1.22.1 COPAYMENTS FOR ACQUIRED BRAIN INJURY SERVICES

Deductible, if any, Coinsurance and/or Copayments for Covered Services for treatment of Acquired Brain Injury Services shall be the same as for Covered Services similar to the treatment for the Acquired Brain Injury service.

### 11.1.23 Telemedicine

Health Plan will not exclude Telehealth Services or Telemedicine Medical Services from coverage reimbursed up to the Allowed Amount, solely because such service was provided through telemedicine and not through a face-to-face consultation. Benefits for Telehealth Services or Telemedicine Medical Services are subject to the same deductible, copayments, and coinsurance requirements as for the same service provided through a face-to-face consultation.

### 11.1.24 Amino Acid-Based Elemental Formulas

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

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

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

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

11.1.24.2 Copayments and Limitations on Amino Acid-Based Elemental Formulas
You or Your Covered Dependents are required to pay the Deductible, if any, Coinsurance and/or Copayments as stated in the Schedule of Benefits for Amino Acid-Based Elemental Formulas. Benefits for Amino Acid-Based Elemental Formulas shall be limited to the Contract Year maximum as stated in the Schedule of Benefits.

### 11.1.25 Cardiovascular Disease Screening for High Risk Individuals

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

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

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

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

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

Such screening test must be performed by a Provider.

11.1.25.2 COPAYMENTS AND LIMITATIONS ON CARDIOVASCULAR DISEASE SCREENING

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

### 11.1.26 Routine Patient Care Cost for Clinical Trials

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

1. the Centers of Disease Control and Prevention of the United State Department of Health and Human Services;
2. the National Institutes of Health;

3. the United States Food and Drug Administration;
4. the United State Department of Defense;
5. the United States Department of Veterans Affairs; or
6. an institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

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

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

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

You or Your Covered Dependents are required to pay the Deductible, if any, Coinsurance and/or Copayments as stated in the Schedule of Benefits for Routine Patient Care Costs.

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

**11.1.27 Benefits for Services Not A Result of Injury or Sickness**
The requirement that the Covered Expenses be incurred as a result of Injury or Sickness will not apply to the following Covered Expenses:

1) Routine nursery care and Physician charges up to the Allowed Amount for a newborn child while the mother is confined following childbirth for:
   a. 48 hours of Hospital Confinement following an uncomplicated vaginal delivery; and
   b. 96 hours of Hospital Confinement following an uncomplicated cesarean section.

These charges will be considered separate from the mother's. They will be subject to any Deductible, Copayment, and Percentage Payable shown in the Schedule of Benefits. The determination as to whether a delivery is complicated shall be made by the attending Physician.

2) Post-delivery Care up to the Allowed Amount for the newborn if the attending Physician, in consultation with the mother, determines that less Hospital Confinement for services related to childbirth is needed for recovery. Such care is to be provided by a Physician registered nurse, or other appropriate licensed health care provider and may be provided at:
   a. the mother's home, a health care provider's office, or a health care facility; or
   b. another location determined to be appropriate under rules adopted by the Texas Department of Insurance commissioner.

## 12. Exclusions

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

**12.1 Abortions**
Elective abortions, which are not necessary to preserve Member's health, are excluded.

**12.2 Altered Sexual Characteristics**
Any procedures or treatments designed to alter physical characteristics of Member from Member'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.

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

**12.4 Cosmetic or Reconstructive Procedures or Treatments**
Unless otherwise covered under this Agreement, cosmetic or reconstructive procedures or other Treatments which improve or modify a Member's appearance are excluded. Examples of excluded procedures include, but are not limited to, liposuction, abdominoplasty, blepharoplasty, face lifts, osteotomies, correction of malocclusions, rhinoplasties, and mammoplasties. The only exceptions to this exclusion include certain procedures determined as Medically Necessary and approved by the Medical Director which are required solely because of any of the following: (1) an accidental bodily injury; (2) disease of the breast tissue; or (3) 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.

**12.5 Court Ordered Care**
Health Care Services provided only due to the order of a court of competent jurisdiction are excluded.

**12.6 Criminal Offenses, Injuries Sustained In**
Treatment or services required as the result of Member's voluntary participation in the commission of a felony which results in a guilty plea or conviction are excluded.

**12.7 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 Member is receiving Custodial Care does not require the Health Plan to cover Custodial Care.

**12.8 Dental Care**
All dental care is excluded.

**12.9 Disaster or Epidemic**

In the event of a major disaster or epidemic, services shall be reimbursed to the extent available at Providers within the limitations of facilities and personnel available; but neither Health Plan, nor any Provider shall have any liability for delay or failure to reimburse due to a lack of available facilities or personnel.

**12.10 Elective Treatment or Elective Surgery**

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

**12.11 Experimental or Investigational Treatment**

Any Treatments that are considered to be Experimental or Investigational are excluded.

**12.12 Family Member (Services Provided by)**

Treatments or services furnished by a Physician or Provider who is related to Member by blood or marriage, and who ordinarily dwells in Subscriber's household, or any services or supplies for which Member 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 insurance coverage, are excluded.

**12.13 Family Planning Treatment**

The reversal of an elective sterilization procedure; condoms, foams, contraceptive jellies and ointments are excluded.