Insurance Company of
SCOTT&WHITE
PART OF BAYLOR SCOTT & WHITE HEALTH

INDIVIDUAL
EXCLUSIVE PREFERRED PROVIDER PLAN
INSURANCE POLICY

THIS INSURANCE POLICY IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE.

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

THIS POLICY IS GUARANTEED-RENEWABLE SUBJECT TO ICSW'S RIGHT TO CHANGE THE APPLICABLE PREMIUM RATES UPON RENEWAL OR WITH 60 DAYS ADVANCE WRITTEN NOTICE.

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

NOTICE OF TEN-DAY RIGHT TO EXAMINE POLICY

It is important to us that you are satisfied with this policy and that it meets your insurance goals. If you are not satisfied, you may return it within 30 days after you receive it. Send it to: Insurance Company of Scott and White, 1206 West Campus Drive, Temple, TX 76502. Our toll-free number is 1-800-321-7947. You will receive a full refund of all premium paid, and your policy will be void from its Effective Date.

INSURANCE POLICY

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

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

Important Notices:

1) The initial rates agreed upon by You and Insurance Company of Scott and White are effective during the initial calendar year from and after the effective date of this Agreement. Thereafter, Insurance Company of Scott and White reserves the right to change rates upon 60 days' notice prior to renewal.

2) The coverage provided under this Agreement is indemnity insurance using an exclusive preferred provider network. The effective date and duration of this coverage is as requested in your application for this coverage and reflected in the Policy Schedule below.

3) The Schedule of Benefits enclosed with this Agreement indicates benefit percentages, deductibles, copayment amounts, maximums, and other benefit and payment issues which apply to the Plan. The schedule of benefits specifies network benefits for:

- Inpatient Hospital Services
- Emergency Room/Treatment Room
- Medical/Surgical Services
- Preventive Care
- Outpatient Medical Services
- Extended Care Services
- Physical Medicine Services

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

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

Jeffrey C. Ingrum
President and Chief Executive Officer
Insurance Company of Scott and White
1206 West Campus Dr.
Temple, Texas 76502

IMPORTANT NOTICE

To obtain information or make a complaint:

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

1-800-321-7941

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) 490-1007
Web: www.tdi.texas.gov
E-Mail: ConsumerProtection@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 información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de la Insurance Company of Scott and White's para obtener información o para presentar una queja al:

1-800-321-7947

Usted también puede escribir a la Insurance Company of Scott and White

1206 West Campus Dr.
Temple, TX 76502

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

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

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

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES: Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con el Insurance Company of Scott and White primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU PÓLIZA: Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

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1. DEFINITIONS

The following terms shall have the meaning stated. The various attachments to this Insurance Policy 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 "**Acquired Brain Injury**" means a neurological insult to the brain, which is not hereditary, congenital, or degenerative, in which the injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior

1.2 "**Adverse Determination**" means a determination by Health Plan that the Health Care Services furnished or proposed to be furnished to a Covered Person are not medically necessary or are experimental or investigational as defined in this Insurance Policy.

1.3 "**Age of Ineligibility**" means the age at which dependents are no longer eligible for coverage, subject to the definition of Eligible Dependent. Under this Agreement, the Age of Ineligibility is 26.

1.4 "**Agreement**" means this ICSW Insurance Policy and all attachments and riders hereto.

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

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

1.7 **"Autism Spectrum Disorder"** means a neurobiological disorder that is characterized by social and communication difficulties and included the previously used diagnosis such as Autism Disorder, Asperger's Syndrome, or Pervasive Developmental Disorder - Not Otherwise Specified.

1.8 "**Calendar Year**" means the period of time that begins on January 1 and ends on the next succeeding December 31.

1.9 **"Chemical Dependency (Substance Use Disorder)"** is the abuse of or psychological or physical dependence on or addiction to alcohol, a toxic inhalant or substance designated as a controlled substance in the Texas Health and Safety Code. A toxic inhalant is a volatile chemical or abusable glue or aerosol paint under the Texas Health and Safety Code.

1.10 **"Chemical Dependency Treatment Center"** is a facility which provides a program for the treatment of Chemical Dependency according to a written treatment plan approved and monitored by a Physician and which (a) contracts with a Hospital having a system of patient referral; or (b) is accredited by the Joint Commission on Accreditation of Hospitals; or (c) is licensed, certified or approved by the proper state agency.

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

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

1.13 "**Community reintegration services**" means services that facilitate the continuum of care as an affected Covered Person transitions into the community.

1.14 "**Coinsurance**" means the percentage, if any, shown in the Schedule of Benefits, of the cost of Health Care Services for which the Covered Person is responsible.

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

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

1.17 "**Complications of Pregnancy**" means Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and Non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

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

1.19 "**Contract Holder**" means the person with whom the Health Plan has entered into an agreement to provide health care services. Under this Insurance Policy, the Subscriber is the Contract Holder.

1.20 "**Contract Period**" means that period of time which begins at 12:00 midnight on the Contract Date and ends at 12:00 midnight of the year in which the contract was signed.

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

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

1.23 **"Covered Person"** means the Subscriber or the Subscriber's Covered Dependent.

1.24 "**Crisis Stabilization Unit"** is a 24 hour residential program that is usually short term in nature and provides: (1) intensive supervision; and (2) highly structured activities to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

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

1.26 **"Day Care Facility"** is an outpatient psychiatric facility that is part of, or affiliated with, a Hospital. It must be licensed according to state and local laws to provide outpatient care and treatment of Mental, Emotional, or Functional Nervous Disorders under the supervision of psychiatrists.

1.27 "**Deductible Calendar Year**" means the dollar amount, if any, shown in the Schedule of Benefits payable by the Covered Person for Health Care Services during the Calendar Year before benefits under the Health Benefit Plan will be payable.

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

1.29 "**Diabetic Equipment**" means blood glucose monitors, including those designed to be used by or adapted for blind individuals, biohazard disposal containers, insulin pumps (including repair and necessary maintenance of pump not otherwise covered under warranty, and rental fees for pumps during the repair or maintenance service) and associated attachments including insulin infusion devices, batteries, skin preparation items, adhesive supplies infusion sets, insulin cartridges, durable and disposable devices to assist in the injection of insulin and other required disposable supplies, and podiatric appliances for the prevention of diabetic complications.

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

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

1.32 "**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.

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

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

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

1) Your legal spouse.
2) Your Son or Daughter who is:
    a. under the Age of Ineligibility; or
    b. if the Age of Ineligibility or older
        - at the time of reaching the Age of Ineligibility, incapable of self-sustaining employment by reason of

physical disability or mental incapacity; and
- chiefly dependent upon you for support and maintenance.

3) Your grandson or granddaughter who is:
   a. A dependent of the Insured for federal tax purposes at the time of application of coverage for the grandchild is made;
   b. unmarried;
   c. under the Age of Ineligibility; or
   d. if the Age of Ineligibility or older
      - at the time of reaching the Age of Ineligibility, incapable of self-sustaining employment by reason of physical disability or mental incapacity; and
      - chiefly dependent upon you for support and maintenance; and
      - dependent upon you for federal income tax purposes.

4) Any child for whom You are obligated to provide health coverage by a Qualified Medical Support Order pursuant to the terms of that order.
5) Your Son or Daughter of any age who is:
   a. medically certified as disabled; and
   b. chiefly dependent upon You for support and maintenance.

1.35 "**Eligibility Date**" means the date You or Your Dependent are eligible for coverage under the Health Plan.

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

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

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

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

1) Well-designed and well conducted investigations published in recognized peer reviewed medical literature, such as the New England Journal of Medicine or the Journal of Clinical Oncology, when such papers report conclusive findings of controlled or randomized trials. The Medical Director shall consider the quality of the body of studies and the consistency of the results in evaluating the evidence;
2) Communications about the Treatment that have been provided to patients as part of an informed consent;
3) Communications about the procedure or Treatment that have been provided from the physician undertaking a study of the Treatment to the institution or government sponsoring the study;
4) Documents or records from the institutional review board of the hospital or institution undertaking a study of the Treatment;

5) Regulations and other communications and publications issued by the Food and Drug Administration and the Department of Health and Human Services; and
6) the Covered Person's medical records.

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

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

1.39 “**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 an exclusive provider plan that provides benefits for health care services.

1.40 "**Health Care Services**" means those Medically Necessary services which are included in this Agreement and any amendments or riders thereto.

1.41 "**Health Plan**" means Insurance Company of Scott and White.

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

1.43 “**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.

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

1.45 “**Independent Review Organization”** means an organization which provides external review of adverse determinations as administered by the Department of Health and Human Services.

1.46 "**Individual Treatment Plan**" means a Treatment plan prepared or approved by the Medical Director with specific attainable goals and objectives appropriate to both the Covered Persons and the Treatment modality of the program.

1.47 **"Infertility"** means the inability to: conceive after sexual relations without contraceptives for the period of one year, or if 35 years old or older, inability to conceive after 6 months; or maintain a pregnancy until fetal viability.

1.48 “**In Network**” means Covered Services and Treatments obtained from a Participating Physician, Participating Provider, or Participating Hospital.

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

1.50 "**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.

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

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

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

1.53 **"Mental, Emotional or Functional Nervous Disorders"** are neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind as defined by generally recognized independent standards of current medical practice.

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

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

1.56 "**Neurobiological disorder**" means an illness of the nervous system caused by genetic, metabolic, or other biological factors.

1.57 "**Neurocognitive rehabilitation**" means services designed to assist cognitively impaired Covered Persons to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

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

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

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

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

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

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

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

1.65 "**Out-of-Network**" means Covered Services and treatments obtained from a Provider other than a Participating Provider. See also definition of "In-Network".

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

1.67 "**Out-of-Pocket Maximums**" means the total dollar amount of Out-of-Pocket Expenses which a Covered Person will be required to pay for Covered Services during a Calendar Year. 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.

1.68 "**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 Calendar Year.

1.69 "**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.

1.70 "**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 Covered Persons at a discounted rate and which is listed by Health Plan as a Participating Hospital.

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

1.72 "**Participating Provider**" means any person or entity that has contracted directly or indirectly with Health Plan to provide Health Care Services to Covered Persons at a discounted rate. Participating Provider includes but is not limited to: Participating Hospitals, Participating Physicians, Health Professionals, Urgent Care Facilities, and contracted pharmacies, within the service area.

1.73 "**Physician**" means anyone licensed to practice medicine in the State of Texas

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

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

1.76 **"Post-Delivery Care"** means postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments. The term includes parent education, assistance and training in breast-feeding and bottle-feeding, and the performance of any necessary and appropriate clinical tests. The timeliness of the care shall be determined in accordance with recognized medical standards for that care.

1.77 **"Post-Stabilization"** – means covered services that are:

- Related to an emergency medical condition

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

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

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

Evidence-based items or services with an "A" or "B" rating from the U.S. Preventive Services Task Force (USPSTF);

Immunizations for routine use in children, adolescents and adults with a recommendation in effect from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Evidence-informed preventive care screenings for infants, children and adolescents provided in guidelines supported by the Health Resources and Services Administration (HRSA); and

Evidence-informed preventive care and screening for women provided in guidelines supported by HRSA and not otherwise addressed by the USPSTF

1.80 "**Primary Care Physician**" means a Participating Physician specializing in family medicine, community internal medicine, general medicine, or pediatrics.

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

1.82 **"Psychiatric Day Treatment Facility"** is an outpatient psychiatric facility which: (1) provides an organizational structure and individualized treatment plans separate from Hospital confinement programs, (2) provides no more than eight hours of treatment per patient in any 24-hour period, (3) is clinically supervised by a psychiatrist, and (4) is accredited by the Joint Commission on Accreditation of Hospitals.

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

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

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

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

1.87 "**Required Payments**" means any payment or payments required of a Covered Person, 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.

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

1.89 **"Residential Treatment Center for Children and Adolescents"** is a child-care institution which (1) provides residential care and treatment for emotionally disturbed children and adolescents; and (2) is accredited as a Residential

Treatment Center by: (a) the Council on Accreditation; (b) the Joint Commission on Accreditation of Hospitals; or (c) the American Association of Psychiatric Services for Children.

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

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

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

1.92 **"Serious Mental Illness"** means the following psychiatric Illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

1) schizophrenia;
2) paranoid and other psychotic disorders;
3) bipolar disorders (mixed, manic, hypomanic and depressive);
4) major depressive disorders (single episode or recurrent);
5) schizo-affective disorders (bipolar or depressive);
6) obsessive-compulsive disorders; and
7) depression in childhood and adolescence.

1.93 "**Service Area**" is that geographic area more fully described in the Service Areas attachment to this Agreement, in which Health Plan may offer this Agreement.

1.94 **"Services for Acquired Brain Injury"** means the work of testing, treatment and providing therapies to an individual with an acquired brain injury.

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

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

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

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 greater than $1,000 per retail maximum day's supply.

1.98 "**Subscriber**" means the person for whom the Enrollment Application has been made and who has been accepted as a Covered Person under the Health Plan.

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

1.100 **"Telehealth service"** means a health service, other than a telemedical service, delivered by a health professional licensed, certified, or otherwise entitled to practice in this state and acting within the scope of the health professional's license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunication or information technology.

1.101 **"Telemedicine"** means a health care service delivered by a physician licensed in this state, or a health professional acting under the delegation and supervision of a physician licensed in this state, and acting within the scope of the physician's or health professional's license to a patient at a different physical location than the physician or health professional using telecommunication or information technology.

1.102 **"Therapy for Acquired Brain Injury"** means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an acquired brain injury.

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

1.104 "**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 Covered Persons such services.

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

1.106 "**Usual and Customary Rate**" means the amount based on generally accepted industry standards and practices for determining the customary billed charge for a service and that fairly and accurately reflects market rates, including geographic differences in costs.

1.107 "**You**" means the Subscriber.

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

2. ELIGIBILITY PROVISIONS

2.1 Classes of Individuals Eligible for Coverage

2.1.1 Eligible Subscriber

To be eligible for coverage as a Subscriber, a person must apply for coverage and be age 18 or older.

2.1.2 Eligible Dependents

2.1.2.1 Dependents age 19 or older. A person age 19 or older must apply for coverage and be an Eligible Dependent as defined in the Definitions section of this Agreement.

2.1.2.2 Dependents age 18 or younger. A person age 18 or younger that is a dependent of a Subscriber applying for coverage:

1) must apply for coverage, and
2) must be an Eligible Dependent as defined in the Definitions section of this Agreement.

2.2 General Eligibility Provisions

2.2.1 Requirements for Eligibility

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

1) Work, live or reside in the Service Area,

2) In the case of an Eligible Dependent for whom You have been ordered to provide health coverage under a Qualified Medical Support Order, the Eligible Dependent may reside anywhere in the United States. If a Covered Dependent being covered under a Qualified Medical Support Order resides outside of the Service Area, Health Plan shall not enforce any otherwise applicable provisions which deny, limit, or reduce medical benefits because the child resides outside the Services Area. However, Health Plan may utilize an alternative delivery system to provide coverage or provide alternate coverage. If the coverage is not identical to coverage under this Agreement, it shall include benefits greater than or comparable to the coverage Health Plan provides to other Dependent children under this Agreement.

2.2.2 Dependent coverage requirement of Covered Employee Enrollment

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

2.3 Enrollment and Effective Dates of Coverage

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

2.3.1 Timely Applications

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

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

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

2.3.2 Annual Open Enrollment Period

An individual, other than a newborn child, an adopted child, a child for whom the Subscriber is a party to a suit seeking to adopt the child, or a child who is the subject of a court order, may apply for enrollment under the Health Plan only during the Annual Open Enrollment Period, unless otherwise allowed under the Special Enrollment Period' provision. The Annual Open Enrollment Period is the same time period as specified by federal law or regulations in which an individual can enroll in a qualified health plan in a state or federal marketplace.

2.3.3 Special Enrollment Period

An individual, who was eligible to enroll in the Health Plan during the Annual Open Enrollment Period, but who elected not to enroll, may apply for enrollment within the 60 days following the date the individual first acquires an Eligible Dependent, whether by marriage, birth, adoption or placement for adoption. Any Eligible Dependent may also be enrolled at that time.

An individual, including an Eligible Dependent, who was eligible to enroll in the Health Plan during the Annual Open Enrollment Period, but who elected not to enroll may apply for enrollment within the 60 days following the date of any of the following events:

1) The individual loses minimum essential coverage, including employer sponsored coverage, provided the coverage is not lost because of failure to pay premiums on a timely basis.
2) The individual's enrollment or non-enrollment in a qualified health plan through a state or the federally facilitated exchange (marketplace) is unintentional, inadvertent, or erroneous and is the result of error, misrepresentation, or inaction of an officer, employee or agent on such exchange or its instrumentalities.
3) An individual demonstrates to a state or the federally facilitated exchange that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the individual.
4) An individual is determined to be newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan.
5) An individual moves to ICSW's service area.

2.3.4 Dependent Special Enrollment Period

2.3.4.1 Newborn Children

Coverage of Your newborn child will be automatic for the first 31 days following the birth of Your child. For coverage to continue beyond this time, You must notify Health Plan within 31 days of birth, and pay any required premium within that 31-day period or a period consistent with the next billing cycle. With such notice, the Effective Date for Your newborn Child will be the date of birth.

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

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

2.3.4.3 Court Ordered Dependent Children

If a court has ordered You to provide coverage for a child, written application and the required Premium must be received within 31 days after issuance of the court order. The Effective Date will be the day application for coverage is received

by Health Plan, and the required premium is received. If You notify the Health Plan after the 31-day period, the Dependent Child's Effective Date will be the next Contract Anniversary.

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

2.3.5 Coverage for a Spouse Following Dissolution of Marriage

If you and your spouse dissolve your marriage by a valid decree of dissolution of marriage and your spouse was covered under this Agreement, then your ex-spouse will receive, without evidence of insurability, a policy providing coverage not greater than the terminated coverage. To obtain the policy, your ex-spouse must notify ICSW of the decree of dissolution of marriage and pay the appropriate premium for the policy. The effective date of the conversion policy shall be the effective date of this policy. If such dissolution of marriage occurs, the Subscriber under this policy at the time of the dissolution shall retain that status. Any covered dependents may be covered under either policy but not both.

2.3.6 Coverage for a Spouse following loss of eligibility of Subscriber

If Subscriber dies, or loses eligibility for any reason other than the termination of this Agreement, Subscriber's spouse who was covered under this agreement may become the Subscriber by notifying ICSW of event causing the Subscriber's loss of eligibility.

2.4 <u>Additional Requirements</u>

2.4.1 It is Your responsibility to inform Health Plan immediately of all changes that affect Your eligibility and that of Your Covered Dependents, including, but not limited to:

- marriage of a Dependent grandchild,
- death; and
- address changes.

2.4.2 No person may receive coverage under this Health Plan as both a Subscriber and a Dependent.

3. PROVIDERS OTHER THAN HEALTH PLAN PROVIDERS

In most instances, Health Care Services obtained from non-Participating Providers will not be covered by the health plan. However, in the following instances, You or Your Covered Dependents may be eligible for the In-Network level of benefits, even though the Health Care Services were provided by non-Participating Providers:

- Emergency Care;
- Services for a Covered Dependent Child who lives outside of the Service Area, whose coverage is required by a Qualified Medical Support Order; and
- Services obtained from a non-Participating Hospital, when You or Your Covered Dependent are confined in that hospital on the Effective Date. If You or Your Covered Dependent is stable enough to be transferred to a Participating Hospital on the Effective Date, and refuse to transfer, then the Health Care Services provided by the non-Participating Hospital shall be reimbursed at the Out-of-Network level of benefits.

4. TERMINATION OF COVERAGE

4.1 Termination of Coverage for Covered Persons

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

1) subject to the Grace Period, coverage terminates for a Covered Person when that Covered Person has failed to pay any Required Payment when due; or
2) in the event of fraud or intentional misrepresentation of material fact by Covered Person, except as described under Incontestability, or fraud in the use of services and facilities, coverage terminates immediately; or
3) coverage terminates for You and Your Covered Dependents one hundred eighty-one (181) days after written notice that Health Plan no longer offers coverage in the individual market.

4.2 Extension of Coverage for Health Benefits

If you or your dependent become totally disabled and your health benefits end, health expenses related to the injury or illness that caused the total disability may extend to cover specific situations for a period not to exceed three months. To be determined as totally disabled you or your dependent must not be able to be gainfully employed in a field for which either of you are specifically trained, unable to perform the regular duties of a job for which either of you are specifically trained, and not be able to perform the normal activities of a same gender healthy person within you or your dependents same age range.

If you or your dependent is determined to be pregnant at the time coverage cancels, pregnancy benefits will be covered at the same level they would normally be covered if the policy continued in force.

In the event of the insured's death the spouse of the insured, if covered under the policy, shall become the insured.

4.3 Responsibility Upon Termination

Covered Persons may terminate their coverage in the Health Plan for any reason upon giving written notice to the Health Plan. Disenrollment from the Health Plan will be effective on the first day of the month following the month Health Plan receives the written request.

4.4 Termination of Coverage

Upon termination of coverage as described above, Health Plan shall have no further liability or responsibility under this agreement. Any Required Payments paid in advance by or on behalf of Covered Person will be refunded and any unpaid Required Payments to date of service will be due and payable. Subscriber is responsible for all Required Payment due but unpaid.

4.5 Liability

Upon termination of coverage, Health Plan shall provide the Covered Person written notice of the availability of coverage through the Texas Health Insurance Pool, as well as the address and toll-free telephone number to contact the Texas Health Insurance Pool.

4.6 Effective Date

The effective date of termination will be the last day for which Premiums were timely paid.

4.7 Unpaid Premium

In the event insured has an open claim when this agreement terminates, at the time of payment of a claim under this agreement, any premium then due and unpaid or covered by any note or written order may be deducted from the payment.

5. REQUIRED PAYMENTS

5.1 Premiums

5.1.1 Payment of Premiums

Premiums are due in the office of the Health Plan, 1206 West Campus Dr., Temple, Texas 76502 on or before the date indicated in the monthly billing statement. The Subscriber is responsible for remitting all Premiums due under this Agreement to Health Plan when due. Only Covered Persons for whom the stipulated Premium is actually received by Health Plan shall be eligible for coverage under this Agreement. Premiums are Required Payments.

Payment of premiums for individual plans are a personal expense to be paid for directly by individual and family plan subscribers using personal funds. Personal funds do not include payment from a business account for a sole proprietorship or Limited Liability Corporation (LLC). In compliance with federal guidance, ICSW will accept third-party payment for premium from the following entities:

1. the Ryan White HIV/AIDS Program under title XXVI of the Public Health Services Act;
2. Indian tribes, tribal organizations, or urban Indian organizations; and
3. state and federal Government programs.

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

5.1.2 If You have a two-party or family Health Plan, the age rating variations permitted under federal regulations will be applied based on the portion of the premium attributable to each eligible family member covered under the Health Plan based on the age of each eligible family member at the time of the Health Plan issuance, renewal, or addition of an eligible family member based on special enrollment. The total premium for family coverage will be determined by summing the premiums for each Covered Person. With respect to eligible family members under the age of 21, the premiums for no more than the three oldest covered children will be taken into account in determining the total family premium.

5.1.3 Premium Changes

Pursuant to Texas law, Health Plan may change premium rates at any time upon sixty (60) days prior written notice. Not less than sixty (60) days prior to expiration of the Contract Period, You shall be advised of the premium rates applicable for the upcoming Contract Period Year. Additionally, Health Plan will not change rates more or less frequently than annually unless otherwise allowed by federal law.

5.1.4 Grace Period

A grace period of 10 days will be granted for the payment of each premium falling due after the first premium. During the grace period, this policy shall continue in force.

5.1.5 Reinstatement

You may request reinstatement of your policy from ICSW. If your policy has lapsed for nonpayment of premium and we accept a later payment without requiring an application, your policy shall be reinstated. If we require a written application, your policy will be reinstated upon our Temple, Texas Offices approval of the application. If we do not notify you of our disapproval in writing within 45 days of the date of your application, your policy shall be deemed reinstated. The reinstated policy shall cover only expenses incurred after the date of reinstatement. In all other respects you and ICSW shall have the same rights as provided under the policy immediately before the due date of the defaulted premium, subject to any provisions added in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

5.2 Copayments, Coinsurance and Deductibles

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

5.3 Subrogation Payments

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

5.4 Cancellation

The insurer may cancel this policy at any time by written notice delivered to the insured, or mailed to the insured's last address on record with the insurer, stating when the cancelation is effective, which may not be earlier than five days after the date the notice is delivered or mailed. After this policy has been continued beyond its original term, the insured may cancel the policy at any time by written notice delivered or mailed to the insurer, effective on receipt or on a later date specified in the notice. In the event of cancellation, the insurer will promptly return the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the State of Texas where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro rata. Cancellation is without prejudice to any claim originating before the effective date of the cancellation.

If any Premium is not received by the Health Plan before or on the due date, Health Plan may terminate coverage under this Agreement, subject to the Grace Period provision. If payment is not received, Health Plan shall have no obligation to pay for any services provided to You or Your Covered Dependents after the due date, and You 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 You or Your Covered Dependent.

6. HEALTH CARE SERVICES

6.1 Physician Selection

6.1.1 How to Select An In-Network Physician

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

6.1.2 How to Obtain Further Information About a Participating Physician

The following information about Participating Physicians is available by calling ICSW or visiting the ICSW website at www.swhp.org:

- education
- residency
- specialized training and fellowship(s)
- board certification
- experience, and
- clinical interests.

6.1.3 How to Access An In-Network Participating Physician

During regular office hours, You simply call the Physician's office and identify Yourself as a Covered Person of ICSW. The Physician's staff can answer questions or schedule an office appointment.

After regular office hours, the Physician's staff is still available to You. Just call the office and identify Yourself as an ICSW Covered Person. You will be asked to describe the medical condition You are experiencing. The staff will have Your Physician or the Physician on call contact You. He or she will discuss Your symptoms and give You direction. Each case is different. You may receive advice over the phone, be asked to come into the office or, in Emergency situations, You may be directed to the nearest Emergency room.

Always remember, Participating Physicians are available to You twenty-four (24) hours a day. You do not have to wait for regular office hours to get directions or advice.

6.1.4 Using Your Covered Person Identification Card

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

It is important to have Your Covered Person identification card with You whenever You need medical services or treatment. ICSW will send Your cards within ten (10) days of issuance of Your Insurance Policy. This card will identify You as a Health Plan Covered Person. If You lose Your card, contact us immediately and we will send You a new one. Do not at any time give Your card to another person. If You let someone else use Your card, the Plan may confiscate the card, terminate Your membership in the Plan, and deny the services wrongfully obtained. You will be held financially responsible for such services.

6.2 How to Access Your Benefits

6.2.1 In-Network Benefits

The key to this Exclusive Preferred Provider Plan is understanding the difference between In-Network and Out-of-

Network benefits. In-Network benefits provide You with more coverage for less money. You receive In-Network benefits whenever You see a Participating Provider for Your medical care. You do not have Out-of-Network benefits coverage with this plan.

For example, assume You plan to receive hospital services from a Participating Provider. By consulting Your Schedule of Benefits, you determine that the In-Network hospitalization is subject to a $2,000 deductible. Additionally, assume Hospital bills $15,000 and that the contracted rate is $3,000 for the service you are seeking. Your out of pocket amount would be as follows:

Deductible: $2,000

Billed Charges: No remainder because the in-network provider accepts the contracted rate

Total out-of-pocket cost: $2,000

Out of Pocket Maximum- $7,350 will be reduced by $2,000 bringing it to $5,350 for future claims

6.2.2 Your Rights

We will make available an updated list of local Participating Providers annually.

ICSW will provide written notice to You within a reasonable period of time of any Participating Provider's termination or breach of, or inability to perform under, any provider contract, if ICSW determines that You may be materially and adversely effected, and provide You with a current list of Participating Providers.

Texas Department of Insurance Notice

- An exclusive provider benefit plan provides no benefits for services you received from out-of-network providers, with specific exceptions as described in your policy and below.
- You have the right to an adequate network of preferred providers (known as “network providers”)
    - If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.
- If your insurer approves a referral for out-of-network services because no preferred provider is available, or if you have received out-of-network emergency care, your insurer must, in most cases, resolve the nonpreferred provider’s bill so that you only have to pay any applicable coinsurance, copay, and deductible amounts.
- You may obtain a current directory of preferred providers at the following website swhp.org or by calling 1-800-321-7947 for assistance in finding available preferred providers. If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.

6.3 Notice of Termination of Participating Provider

If You or Your Covered Dependents are receiving Health Care Services from a Participating Provider whose relationship with the Health Plan as a Participating Provider is terminated by the provider, Health Plan will assist that provider to give You reasonable notice of the termination. If Health Plan terminates a Participating Provider and we are aware that you are receiving care from that provider, You will receive notice of that termination from Health Plan on the effective date of the termination. However, if a provider is terminated for reasons related to imminent harm, Health Plan will notify You immediately.

6.4 Continued Treatment by Terminated Physician or Provider

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

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

6.5 Health Care Services Not Available From Contracting Providers

To the extent Health Care Services are covered under this Agreement, but a Participating Provider is not available to provide such Health Care Services within the Service Area, You will be reimbursed at the In-Network benefit level even though such services are obtained from a non-Participating Provider. This provision does not require reimbursement for Health Care Services from a non-Participating Provider at the In-Network benefit level if You or Your Covered Dependent resides out of the Service Area, and choose to receive Health Care Services from a non-Participating Provider for Your, or Your Covered Dependent's own convenience.

7. CLAIM PROCEDURE

7.1 Necessity of Filing Claims

Health Care Services obtained from a Participating Provider will not require you to file a claim for payment with Health Plan. Health Plan's contracts with Participating Provider allow them to file claims on your behalf. For Health Care Services obtained from Participating Providers, You will be responsible for the Copayments, Coinsurance, and Deductibles as stated in the Schedule of Benefits.

If you receive Health Care Services from facilities which do not routinely contract with Health Plan, for example in the case of an emergency, you may be asked to pay that person or facility directly. You are entitled to reimbursement for such payments to the extent those Health Care Services are covered under this Agreement provided (1) You submit written proof of and claim for payment to Health Plan at its office, (2) the written proof and claim for payment are acceptable to Health Plan, (3) Health Plan receives the written proof and claim for payment within 90 days of the date the Health Care Services were received by You and Your Covered Dependent, and (4) You have complied with the terms of this Agreement. Health Plan will provide claim form for You or Your Covered Dependent(s) to fill out and return to Health Plan.

7.2 Effect of Failure to File Claim Within 90 Days

Written proof of loss must be furnished to ICSW at our Temple, Texas, offices, in the case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss, before the 91st day after the termination of the period for which ICSW is liable and in case of claim for any other loss, before the 91st day after the date of such loss. Failure to submit written proof of and claim for payment before the 91st day shall not invalidate or reduce Your entitlement to reimbursement provided it was not reasonably possible for You to submit such proof and claim within the time allowed and written proof of and claim for payment were filed as soon as reasonably possible. Written proof and claim for payment submission should consist of itemized receipts containing: name and address where services were received, date service was provided, amount paid for service, and diagnosis for visit. Claims for reimbursement should be sent to Scott & White Health Plan, Attn: Claims Dept., 1206 West Campus Dr., Temple, TX 76502. Except in the event of legal incapacity, Health Plan has no obligation under this paragraph if such proof of and claim for payment is not received by Health Plan within one (1) year of the date the services were provided to You or Your Covered Dependent.

7.3 Acknowledgement of Claims

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

7.4 Acceptance or Rejection of Claim

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

7.5 Payment of Claims

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

Indemnity for loss of live will be payable in accordance with the beneficiary designation and the provisions respecting indemnity payments that may be prescribed in this Policy and effective at the time of payment. If such designation or

provision is not effective, the indemnity will be payable to the insured's estate. Any other accrued indemnities unpaid at the time of insured's death may, at the option of the insurer, be paid either in accordance with the beneficiary designation or to the insured's estate. All other indemnities will be payable to the insured.

7.6 Payment to Physician or Provider

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

7.7 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.

7.8 Payment to Texas Department of Human Services

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

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

7.9 Payment to a Managing Conservator

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

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

7.10 Physical Examination or Autopsy

Health Plan retains the right and opportunity to:

- Conduct a physical examination of an individual for whom a claim is made when and as often as the insurer reasonably requires during the pendency of the claim under the policy; and
- In the case of a death, require that an autopsy be conducted, unless the autopsy is prohibited by law.

8. SUBROGATION

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.

8.1 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.

8.2 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.

8.3 Plan's Actions

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

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

- the Plan may take any further action it deems necessary to protect its interest.

8.4 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.

8.5 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.

8.6 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.

8.7 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.

8.8 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.

8.9 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.

8.10 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.

8.11 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.

8.12 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.

8.13 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.

8.14 Right to Recovery

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

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

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

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

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

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

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

9. RECORDS

9.1 Records Maintained by Health Plan

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

9.2 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.

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

9.3 Notification of Changes in Status

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

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

10. COMPLAINT

10.1 Purpose

10.1.1 Health Plan recognizes that a Covered Person, physician, provider, or other person designated to act on behalf of ICSW Covered Person 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. Health Plan will not retaliate against You because You, Your Provider, or a person action on Your behalf files a complaint or appeals a decision made by Health Plan.

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

10.2 Complaints

10.2.1 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. If Health Plan receives a request for an adverse determination orally, Health Plan will also enclose an Adverse Determination Appeal Form, which you may return for prompt resolution of the Adverse Determination.

10.2.2 Health Plan will acknowledge, investigate, and resolve all Complaints within thirty (30) calendar days after the date of receipt. However, investigations 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. Dissatisfaction or disagreement with an Adverse Determination is considered an appeal and is not included in this process.

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

11. UTILIZATION REVIEW; EXTERNAL REVIEW

11.1 Utilization Review

Your Plan includes a program to evaluate inpatient and outpatient Hospital and Ambulatory Surgical Center admissions, and specified non-Emergency outpatient surgeries and diagnostic procedures and other services. This program ensures that Hospital and Ambulatory Surgical Facility care is received in the most appropriate setting, and that any other specified surgery or services are medically necessary. This program is known as utilization review.

Utilization review may be undertaken:

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

11.1.1 Prior Authorization

Certain services require prior authorization in order to be covered. Typically, Your Provider will request Prior Authorization on Your behalf. Failure to obtain Prior Authorization may result in a reduction or denial of benefits under this Agreement.
The Scott and White Health Plan Health Services Department has the responsibility of issuing Prior Authorization.

For a complete list of Health Care Services subject to Prior Authorization, visit our website at www.swhp.org or call Us at the contact number shown in the Toll-Free Notice.

11.1.2 Prior Authorization Review

You are always responsible for initiating prior authorization review. **There are penalties for some services if prior authorization review is not performed.** Note: These penalties are not counted toward the deductible or Your Out-of-Pocket Maximum.

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

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

The list of services that require prior authorization is available on health plan's web page, swhp.org.

11.1.3 Admission Review

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

11.1.4 Continued Stay Review

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

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

11.1.5 Retrospective Review

If neither prior authorization review, nor admission review nor continued stay review was performed, We will use retrospective review to determine if a scheduled or an Emergency admission to a hospital or any surgery at a hospital or ambulatory surgical center or an outpatient surgery or a diagnostic procedure was Medically Necessary. In the event services are determined to be Medically Necessary, benefits will be provided as described in the Plan. If it is determined that a hospital stay or any other service was not Medically Necessary, You are responsible for payment of the charges for those services. We will provide notice of Our adverse determination in writing to You and the provider of record within a reasonable period, but not later than 30 days after the date on which the claim is received, provided We may extend the 30-day period for up to 15 days if: We determine that an extension is necessary due to matters beyond Our control; and We notify You and the provider of record within the initial 30 day period, of circumstances requiring the extension and the date by which We expect to make a determination. If the period is extended because of Your failure or the failure or the provider of record to submit the information necessary to make the determination, the period for making the determination is tolled from the date We send Our notice of the extension to You or the provider until the earlier of: the date You or the provider responds to Our request; or the date by which the specified information was to have been submitted.

11.1.6 Appeal of Adverse Determination

Our determination that treatment or services You requested or received are not Medically Necessary or appropriate or are Experimental or Investigational, based on Our Utilization Review standards is an "adverse determination", which means that Your request for coverage of the treatment or service is denied. You, a person acting on Your behalf, or Your Physician may appeal the adverse determination to Us orally or in writing in accordance with Our internal appeal procedures. If the Appeal is received orally, ICSW will also enclose a one-page Appeal form, the return of which, while not required, will aid in the prompt resolution of the Appeal.

Within five working days of receipt of the oral or written request, We will acknowledge the request and advise if additional documents are needed to consider Your appeal. We will provide Our decision on Your appeal no later than thirty days after the later of the date We receive Your appeal or the date any additional information We request is

provided in order to consider Your appeal. Appeals involving the denial of emergency care or continued hospitalization shall be based on the medical immediacy of the condition, procedures, or treatment under review, within one working day, but not to exceed 72 hours from when We receive all information necessary to complete the appeal.

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

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

11.1.7 Review by Independent Review Organization (IRO)

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

11.2 Health Care Services that are not Medically Necessary

Subject to the notice requirements and prior to the issuance of an adverse determination, if We question the Medical Necessity or appropriateness or the Experimental or Investigational nature of a service, We will give the Physician who ordered it a reasonable opportunity to discuss with Our Medical Director Your treatment plan and the clinical basis of Our determination.

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

An Adverse Determination will include the reason for the Adverse Determination, the clinical basis for the Adverse Determination, a description of the criteria used in making the Adverse Determination, and a description of the Complaint and Appeals process, including Your right and the procedure to appeal to an independent review organization. If you have a life-threatening condition or in circumstances involving prescription drugs or intravenous infusions, the notice will include a description of Your right to an immediate review by an independent review organization and the procedures for obtaining that review. You and the Physician or Provider requesting the Health Care Service will be notified as follows:

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

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

The initial notice of Adverse Determination may be by telephone or electronic transmission to Your Provider within the timeframes outlined above, and will be followed by written notice to You and Your Provider no later than the third working day after the request is received.

11.3 Appeal of Adverse Determinations

11.3.1 A Covered Person, a person acting on behalf of the Covered Person, or the Covered Person's physician or health care provider may appeal an Adverse Determination orally or in writing to a Member Relations Coordinator. The timeframe for filing the written or oral response may not be less than 30 calendar days after the date of issuance of written notification of an adverse determination. In addition, if the timeframes for the "Appeal of Adverse Determination" are not met by Health Plan, the enrollee is entitled to an immediate Appeal to an Independent Review Organization. The Health Plan will not require an exhaustion of its internal appeals prior to external review if Health Plan fails to meet its internal appeals process timelines or the claimant with an urgent care situation files an external review

before exhausting the internal appeals process. Health Plan will send an acknowledgment letter of the receipt of oral or written Appeal of Adverse Determination from Complainants no later than five (5) business days after the date of the receipt of the Appeal. The acknowledgment letter will include a description of Health Plan's appeal procedures and time frames, as well as a reasonable list of documents needed to be submitted by the Complainant for the Appeal. If the Appeal is received orally, the Health Plan will also enclose a one-page Appeal form, the return of which, while not required, will aid in the prompt resolution of the Appeal.

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

11.3.2.1 a statement of the specific medical, dental or contractual reasons for the resolution;

11.3.2.2 the specific clinical basis for the denial;

11.3.2.3 a description of the source of the screening criteria that were utilized in making the determination;

11.3.2.4 the specialty of the physician or other health care provider making the denial;

11.3.2.5 notice of the appealing party's right to seek review of the denial by an Independent Review Organization as provided in this Insurance Policy;

11.3.2.6 notice of the independent review process;

11.3.2.7 a copy of the form to request a review by an independent review organization; and

11.3.2.8 procedures for filing a complaint.

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

11.3.4 Health Plan will provide an expedited Appeal procedure for emergency care denials, denials of care for Life-Threatening Conditions and denials of continued stays for hospitalized patients. The procedure will include a review by a Participating Provider who has not previously reviewed the case and who is of the same or a similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment under discussion for review. The time in which such expedited Appeal will be completed will be based on the medical immediacy of the condition, procedure or treatment, but may in no event exceed one (1) business day or 72 hours, in circumstances involving weekends and holidays, from the date all information necessary to complete the Appeal is received.

Notwithstanding any provisions to the contrary, in a circumstance involving an enrollee's life-threatening condition or in circumstances involving prescription drugs or intravenous infusions, the enrollee is entitled to an immediate Appeal to an Independent Review Organization and is not required to comply with procedures for an "Appeal of Adverse Determination" described in this Insurance Policy.

11.3.5 Health Plan reserves the right to refer any "Appeal of Adverse Determinations" directly to an Independent Review Organization prior to any determination being made through the internal review process described in this Insurance Policy.

11.4 Independent Review of Adverse Determinations

11.4.1 Health Plan will permit any party whose appeal of an Adverse Determination is denied to seek review of that determination by an Independent Review Organization Health Plan utilizes the external review process administrated by Maximus, which is overseen by the Department of Health and Human Services. The request for review must be submitted within four months after the date you receive notice of an adverse benefit determination.

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

11.4.2.1 any medical records of the enrollee that are relevant to the review;

11.4.2.2 any documents used by the plan in making the determination;

11.4.2.3 the written notification described in this document;

11.4.2.4 any documentation and written information submitted to the Health Plan in support of the appeal; and

11.4.2.5 a list of each physician or health care provider who has provided care to the enrollee and who may have medical records relevant to the Appeal.

11.4.3 Maximus will provide written notice of the final external review decision as expeditiously as possible and no that than:

- 45 days after the receipt of the request for external review;
- 72 hours for determinations that involve a medical condition that would seriously jeopardize Your life or health, would jeopardize Your ability to regain maximum function and You have requested an expedited review; or concerns an admission, availability of care, continued stay or health care services You received as Emergency Services, but have not been discharged from a facility;
- Within 72 hours for standard circumstances or 24 hours when exigent circumstances exist for pharmacy exceptions

Health Plan will comply with the Independent Review Organization's determination with respect to the medical necessity or appropriateness of health care items and services for an enrollee. . Exceptions for non-formulary prescription drugs will be provided for the duration of the prescription, including refills, or the duration of the exigency.

12. MISCELLANEOUS PROVISIONS

12.1 Confidentiality

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

12.2 Independent Agents

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

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

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

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

12.3 Changes in Coverage

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

12.4 Entire Agreement

This Agreement, attachments, and Your completed and accepted Enrollment Application(s) constitute the entire contract between the parties, and all oral representations and warranties have been incorporated into this Agreement. No agent or other person, except the President and Chief Executive Officer 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 President and Chief Executive Officer of Health Plan; however, Health Plan may adopt policies, procedures and rules to promote the orderly and efficient administration of this Agreement.

12.5 Severability

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

12.6 Modification of Terms

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

12.7 Not a Waiver

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

12.8 Venue

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

12.9 Recovery

If any action at law or in equity is brought to enforce or interpret the provisions of this Agreement, the prevailing party shall be entitled to recover its costs and expenses associated with such action (including, but not limited to, reasonable attorney's fees), in addition to any other relief to which the party may be entitled. Health Plan is also entitled to recover from You or Your Covered Dependents 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 coverage at the time services were provided (collectively, "Excess Payments"). Such Excess Payments are Required Payments. Failure to remit any Excess Payments to Health Plan may result in Health Plan's termination of coverage in accordance with this Agreement.

12.10 Notice

With the exception of electronic notices that member has elected to receive, 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 West Campus Dr.
Temple, Texas 76502

If to You:

To the latest address provided by You

12.11 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. Health Plan will not rescind based on misstatement of health information, but Health Plan may adjust premium rates if the misstatement concerns tobacco use. But, in the event of a fraudulent representation, coverage shall terminate immediately. Except as otherwise provided, all benefits hereunder are subject to the condition that all statements, representations and other information provided by You or Your Covered Dependents are true, correct and complete.

12.12 Proof of Coverage

Health Plan will provide You with proof of coverage under this Agreement. Such evidence shall consist of an electronic version of this Agreement and an identification card as described below. You will also be provided access to a current roster of Participating Providers as well as additional educational material regarding the Health Plan and the services provided under this Agreement. If at any time you wish to receive a hard copy (paper) version of either this Agreement or a current roster of Participating Providers, you may request it from the Insurance Company of Scott and White at the address and phone number listed on the cover of this Agreement.

12.13 Identification Card

Health Plan shall provide an identification card, either electronically or through U.S. mail, 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 Covered Person on whose behalf all Required Payments under this Agreement have actually been paid. Any person receiving services or other benefits to which the person is not then entitled pursuant to the provisions of this Agreement shall be subject to charges at the providers' then prevailing rates. If You permit the use of a Health Plan identification card by any other person, such card may be retained by Health Plan, and all rights of You and Your Dependents, covered pursuant to this Agreement, shall be terminated sixteen (16) days after written notice.

12.14 Conformity with State Law

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

12.15 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 covered person is not an allowable expense.

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

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

(2) If a person is covered by two or more plans that do not have negotiated fees and compute their benefit payments based on the usual and customary fees, allowed amounts, or relative value schedule reimbursement

methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(I)the plan covering the custodial parent;

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

(III) the plan covering the noncustodial parent; then
(IV) the plan covering the spouse of the noncustodial parent.

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

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

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

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

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

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

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

Effect On The Benefits Of This Plan

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

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

Compliance With Federal And State Laws Concerning Confidential Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. Organization responsible for COB administration will comply with federal and

state law concerning confidential information for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Each person claiming benefits under this plan must give Organization responsible for COB administration any facts it needs to apply those rules and determine benefits.

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

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

12.16 Office of Foreign Assets Control (OFAC) Notice

Notwithstanding the other provisions of this Policy 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).

12.17 Cost Share Variance

Upon termination of federal reimbursement, any applicable cost share variance will terminate the first of the month following thirty days written notice from the Health Plan.

13. DESCRIPTION OF BENEFITS

13. WHAT'S COVERED?

Welcome to Insurance Company of Scott and White. By offering You a plan for accessing Your medical care, the Plan provides the comprehensive care of an integrated health plan. This method of accessing Your medical care is known as In-Network and it is the key to determining what Your benefit level will be. An explanation of how to access Your benefits and how to determine Your coverage provided in the Insurance Policy.

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

The Description of Benefits will help identify what types of services are covered, when and how each benefit will be covered, and how You and Your Covered Dependents can 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 Your Coinsurance, Copayments, and Deductibles (individual and family), and other expenses You are responsible to pay.

13.1 COPAYMENTS AND DEDUCTIBLES

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

13.2 OUT-OF-POCKET MAXIMUM

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

13.3 BENEFIT LIMITATIONS

If You or Your Covered Dependent meets or exceeds a given benefit limitation during the Calendar Year, such enrollee will not be eligible for Covered Services for that particular service for the remainder of the Calendar Year in which the benefit limitation was met or exceeded.

13.4 CASE GUIDANCE PROGRAM

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

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

Participation in Case Guidance is strictly voluntary.

13.5 BENEFITS

13.5.1 MEDICAL SERVICES

You and Your Covered Dependents are entitled to reimbursement for Medically Necessary professional services of Physicians and Providers on an inpatient and outpatient basis. Medical Necessity is determined the Health Plan.

Covered Services incurred for treatment of Maternity Care and Complications of Pregnancy will be the same as for treatment of sickness. Services provided for treatment of Alzheimer's disease do not require proof of organic disease. Treatment of congenital defects of newborns will be treated on the same basis as any other covered illness or injury.

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

13.5.2 PREVENTIVE CARE SERVICES

Preventive care services will be provided for the following covered services, and In-Network preventive care will not be subject to Copayment, Coinsurance or Deductible.

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

For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention will be considered the most current. The preventive services described in items (a) through (d) may change as USPSTF, CDC, and HRSA guidelines are modified.

Examples of covered services include: routine annual physicals, immunizations, well-child care, cancer screening, mammography, bone density test, screening for prostate cancer and colorectal cancer, smoking cessation counseling services, and health diet counseling and obesity screening/counseling.

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

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

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

13.5.2.1 Routine Exams

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

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

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

13.5.2.2 Prostate Cancer Screening Exam

You or 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 ages and has a family history of prostate cancer or another prostate cancer risk factor.

13.5.2.3 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 sigmoidoscopy every five years or a colonoscopy every ten years.

13.5.2.4 Osteoporosis Detection and Prevention

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

A Qualified Individual means:

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

13.5.2.5 Low Dose Mammography

Benefits are available for annual screening by low-dose mammography for the presence of breast cancer for female Members who are 35 years of age and older. Low dose mammography means the X-ray examination of the breast using equipment dedicated specifically for mammography, including an X-ray tube, filter, compression device and screens, with an average radiation exposure delivery of less than one rad mid breast and with two views for each breast; digital mammography; or breast tomosynthesis.

13.5.2.6 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.

13.5.2.7 Ovarian Cancer Screening Tests

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

13.5.2.8 Phenylketonuria (PKU) or Heritable Metabolic Disease

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

13.5.2.9 Screening for Hearing Loss

Your Covered Dependent is eligible for screening for hearing loss from birth through 30 days of age and necessary diagnostic follow-up care related to the screening through 24 months of age.

13.5.3 HOSPITAL SERVICES

Subject to Deductibles, Copayments and Coinsurance listed in the Schedule of Benefits, You and Your Covered Dependents are entitled to the Medically Necessary services of any Hospital to which You or Your Covered Dependent may be admitted. Health Plan will cover the cost of a semi-private room, or the equivalent thereof, for covered hospital admissions for routine acute care. For more intense levels of care, that level of care which is Medically Necessary will be covered. Medically necessary services for an inpatient stay following a mastectomy shall be covered under this provision.

13.5.4 EMERGENCY CARE SERVICES

13.5.4.1 QUALIFICATION OF EMERGENCY SERVICES

Medically Necessary Emergency Care from a non-Participating Physician or Provider is covered at the same benefit level as Emergency Care from a Participating Physician or Provider by this Agreement, including the treatment and stabilization of an emergency medical condition. However, only those conditions meeting the terms of the definition of Emergency Care will qualify. Health Plan will provide for any medical screening examination or other evaluation required by Texas or federal law that takes place in a hospital emergency facility or comparable facility, and that is necessary to determine whether an emergency medical condition exists.

13.5.4.2 URGENT CARE SERVICES

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

13.5.4.3 EMERGENCY TRANSPORTATION SERVICES

Emergency transportation, when and to the extent it is Medically Necessary, is covered when transportation in any other vehicle would endanger the patient's health. Health Plan will not cover air transportation if ground transportation is medically appropriate and more economical. 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, unless another facility is approved by Health Plan, or from a hospital or skilled nursing facility to the patient's home.

13.5.4.4 PAYMENT OF BENEFITS AFTER-STABILIZATION

Once You or Your Covered Dependent's condition is stabilized, benefits for further Covered Services will be provided pursuant to the Schedule of Benefits at the applicable level of benefits, i.e., In-Network or Out-of-Network. Where stabilization of an emergency medical condition originates in a hospital emergency facility or comparable facility, Treatment following such stabilization in a non-Participating Hospital may require preauthorization by Health Plan. The treating physician or provider must make the request for post-stabilization care. Health Plan will approve or deny such request within the time appropriate to the circumstances relating to the delivery of services and the condition of the patient, but in no event to exceed one hour from the time of the request.

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

13.5.4.5 EMERGENCY CARE COVERAGE EXCEPTIONS/LIMITATIONS

In cases involving non-emergent/non-urgent Treatments performed or prescribed by non-Participating Physicians or non-Participating Providers, Health Plan will not cover any expenses associated with such Treatments. In no event shall Health Plan cover any Treatments which are excluded from coverage under this Agreement or complications of those Treatments.

13.5.4.6 HOSPITALIZATION AT A NON-PARTICIPATING HOSPITAL

If You or Your Covered Dependent is hospitalized at a non-Participating Hospital in order to be reimbursed at the In-Network benefit level, You must notify Health Plan within forty-eight (48) hours of admission or as soon thereafter as it is reasonably possible, and Health Plan shall provide information about its obligations under this Agreement. Failure to provide notification may result in no payment of benefits unless it is shown not to have been reasonably possible to give such notice.

13.5.5 REHABILITATIVE AND HABILITATIVE THERAPY

Outpatient rehabilitative and habilitative therapy services are available for services for physical, manipulative, inhalation, speech, hearing, and occupational therapies.

13.5.5.1 EARLY CHILDHOOD INTERVENTION SERVICES

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

13.5.5.2 COPAYMENT FOR REHABILITATIVE AND HABILITATIVE THERAPY

You are required to pay the applicable Coinsurance,-Copayment and Deductible for each outpatient therapy as indicated in the Schedule of Benefits.

13.5.5.3 MANIPULATIVE THERAPY/CHIROPRACTIC SERVICES

You and Your Covered Dependents are eligible for outpatient manipulative therapy from providers licensed to perfrom that therapy, including Chiropractors .

13.5.6 HOME HEALTH SERVICES

You and Your Covered Dependents are eligible for coverage for home health services, consisting of Medically Necessary nursing care and Short-term Therapy. 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 You or Your Covered Dependent 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 determined by the Medical Director.

13.5.6.1 COPAYMENT/COINSURANCE FOR HOME HEALTH SERVICES

You are required to pay Deductible, if any, Coinsurance and/or Copayments for each home health visit to or by a Health Professional as indicated in the Schedule of Benefits.

13.5.7 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 provision of this Agreement, and subject to additional copayments. Specialty Pharmacy Drugs administered through Home Infusion Therapy will be covered under Your Specialty Pharmacy Drug benefit, if applicable, and will be subject to the appropriate copayment under that benefit. Prescription 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.

13.5.7.1 COPAYMENTS FOR HOME INFUSION THERAPY BENEFITS

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.

13.5.8 HOSPICE SERVICES

Hospice services will be covered for Medically Necessary Hospice care but must be approved in advance by Health Plan and provided by a licensed Hospice agency.

13.5.9 FAMILY PLANNING SERVICES

13.5.9.1 FAMILY PLANNING SERVICES

Family planning and services shall be provided as Medically Necessary. Examples of such services include:

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

13.5.10 PREGNANCY AND MATERNITY CARE

All comprehensive benefits described in this Plan are available for maternity services. Comprehensive Hospital benefits for routine nursery care of a Newborn child are available so long as the child qualifies as an Eligible Dependent as defined in the section of this Plan titled "Who is Eligible for Coverage?"

The mother and her Newborn child shall be entitled to inpatient Hospital coverage for a period of 48 hours following an uncomplicated vaginal delivery; and 96 hours following an uncomplicated delivery by caesarian section. If a decision is made between a mother and doctor to discharge a mother or Newborn child from inpatient care before the 48 or 96 hour time period, coverage for timely Post Delivery Care is available.

13.5.11 DIAGNOSIS OF INFERTILITY

The diagnosis of infertility is covered under this Policy as any other medical condition. This benefit does not include treatment for Infertility.

13.5.12 DURABLE MEDICAL EQUIPMENT/ORTHOTICS/PROSTHETIC MEDICAL APPLIANCES

As approved by Health Plan, Medically Necessary Durable Medical Equipment, Prosthetic Devices, 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 Calendar Year specified in the Schedule of Benefits.

13.5.12.1 CONSUMABLE SUPPLIES

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

13.5.12.2 DURABLE MEDICAL EQUIPMENT

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

13.5.12.3 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, replacement of the device if replacement is not due to misuse or loss of the device, and normal repairs. Prosthetic device coverage is limited to the most appropriate model of prosthetic device that adequately meets Your needs as determined by Your Provider. 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 Calendar Year, subject to the applicable Copayments, specified in the Schedule of Benefits.

13.5.12.4 ORTHOTIC DEVICES

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

13.5.12.5 HEARING AIDS AND COCHLEAR IMPLANTS

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

- filling and dispensing services and the provision of ear molds as necessary to maintain optimal fit of hearing aids
- any treatment related to hearing aids and cochlear implants, including coverage for habitation and rehabilitation as necessary for educational gains; and

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

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

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

13.5.13 COVERAGE OF PRESCRIPTION DRUGS

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

13.5.13.1 COVERED DRUGS, PHARMACEUTICALS AND OTHER MEDICATIONS

The only covered drugs, pharmaceuticals or other medications (herein collectively referred to as "drug" or "drugs") covered hereunder are those which, under Federal or State law, may be dispensed only pursuant to an order from a licensed Health Professional with appropriate law enforcement agency registrations.
As medically appropriate, the Medical Director may require the substitution of any drug for another drug or form of Treatment which, based upon the recommendations of the Pharmacy and Therapeutics Committee or the Pharmacy and Therapeutics subcommittee, and the Medical Director's professional judgment, provides equal or better results at a lower cost. Special dietary formulas for individuals with phenylketonuria or other heritable diseases are also covered under this prescription drug benefit. Heritable diseases are inherited diseases that may result in mental or physical retardation or death. Phenylketonuria is an inherited condition that may cause severe mental retardation if not treated.

13.5.13.2 COVERAGE FOR OFF-LABEL USE OF DRUGS

Drugs prescribed to treat You, or Your Covered Dependent's, covered chronic, disabling or life-threatening illness are potentially coverable, subject to other formulary restrictions, under this prescription drug benefit if the drug has been approved by the Food and Drug Administration for at least one indication and is recognized for treatment of the indication for which the drug is prescribed in either a prescription drug reference compendium or substantially accepted peer reviewed medical literature. If the indication for which the drug is prescribed is not an FDA approved indication of the drug being prescribed, the health plan reserves the right to exempt the drug from coverage for that off label use within the prescription benefit plan. Coverage of the drug includes coverage of medically necessary services associated with the administration of the drug, but does not include coverage for experimental drugs not otherwise approved for any indication by the Food and Drug Administration or coverage for a drug that the Food and Drug Administration has not approved, or prescription drug reference compendia or peer reviewed medical literature has not deemed as a medically- accepted use for the proposed indication.

13.5.13.3 EVIDENCE BASED FORMULARY DEVELOPMENT

Health Plan provides coverage for prescription drugs in accordance with an evidence based formulary developed by physicians and pharmacists comprising the Pharmacy and Therapeutics Committee. A formulary is a list of drugs for which Health Plan provides coverage. The Pharmacy and Therapeutics Committee meets at least quarterly to review the scientific evidence, economic data, and a wide range of other information about drugs for potential formulary placement and coverage. Based upon that review, the committee selects the drugs it believes to be the safest and most efficacious of those drugs which meet the desired goals of providing appropriate therapy at the most reasonable cost. Once such determination is made, the Health Plan may obtain or access contracts with the manufacturer of the drugs for rebates. The committee will not select a drug for the formulary until enough clinical evidence is available to allow the committee to determine the drug's comparable safety and efficacy. The committee defines this timeframe as 180 days of availability. The committee determines which drugs to add or delete, supply and dosage limitations, sequence of use, and all other aspects about the Health Plan formulary. Health Plan will provide written notice of the modification to the drug formulary to the commissioner and each affected individual health benefit plan holder, not later than the 60th day before the date the modification is effective.

13.5.13.4 REQUEST FOR FORMULARY INFORMATION

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

13.5.13.5 FORMULARY LISTS

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

Prescription drugs designated on the drug formulary as Specialty Pharmacy drugs that are dispensed at a participating pharmacy and self-administered or administered in the office of a Participating Provider are covered under this Agreement, subject to the Specialty Pharmacy Copayments, Coinsurance, and Deductibles indicated in the Schedule of Benefits.

You or Your Covered Dependent may contact Health Plan to obtain a copy of the Specialty Pharmacy Drugs appearing on the drug formulary.

Drugs on the health plan formulary and Specialty Pharmacy Drugs may require preauthorization by a Medical Director or be subject to medical coverage requirements.

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

1. One of the following:
    a. Failure or contraindication or intolerance to at least three equivalent formulary drugs. If only one or two equivalents are available, the failure or contraindication or intolerance to all available equivalent formulary drugs; or
    b. No formulary drug is appropriate to treat condition; and
2. One of the following:
    a. Both the requested drugs is FDA-approved for the conditions being treated and additional requirements listed in the "Indications and Usage" section of the prescribing information (or package insert) have been met; or
    b. If request is an off-label indication, meets coverage criteria.

To request coverage for a non-formulary medication, You, Your Covered Dependents, or the prescribing Health Professional must submit a request for prior authorization or request for an appeal to the Health Plan for consideration of coverage. If the request is denied, You and the Health Professional may appeal the denial (see Section 10, COMPLAINT AND APPEAL PROCEDURES/UTILIZATION REVIEW REQUIREMENTS, of the Certificate of Coverage).

13.5.13.6 INPATIENT PRESCRIPTION DRUGS

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

13.5.13.7 SPECIALITY PHARMACY DRUGS

Certain classes of Specialty Pharmacy Drugs must be dispensed from one of the participating Specialty Pharmacy providers. Such classes of Specialty Pharmacy Drugs dispensed by a participating Specialty Pharmacy provider will be subject to the formulary Copayment for Specialty Pharmacy Drugs specified in the Schedule of Benefits. Failure to obtain

these specific classes of Specialty Pharmacy Drugs from the participating Specialty Pharmacy provider may result in denial of coverage for such Specialty Pharmacy Drug. You or Your Covered Dependent may contact the Health Plan to obtain a copy of the classes of Specialty Pharmacy Drugs which must be obtained from the Participating Specialty Pharmacy Providers.

13.5.13.8 OFFICE OR CLINIC ADMINISTERED NON-SPECIALTY PHARMACY DRUGS

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

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

13.5.13.9 AUTHORIZATION REQUIREMENTS

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

If coverage for a particular drug or quantity of drug is denied, You and Your Health Professional may appeal the denial (see Section 10, COMPLAINT AND APPEAL PROCEDURES/UTILIZATION REVIEW REQUIREMENTS, of the Certificate of Coverage).

Your Provider may submit a request for an exception to step therapy protocol. If an exception request is not denied within 72 hours of the request, the request will be considered granted. If the prescribing provider feels that a denial would result in death or serious harm, the request will be considered granted if not denied within 24 hours of the request.

13.5.13.10 EXCLUSIONS

This Prescription Drug Benefit excludes the following:

a. drugs which do not require a Health Professional's order for dispensing (sometimes commonly referred to as "over-the-counter" drugs),except insulin and if drug is listed on the Health Plan formulary;
b. anything which is not specified as covered or not defined as a drug, such as therapeutic devices, appliances, machines including syringes, except disposable syringes for insulin dependent Members, support garments, etc., except if drug is listed on the Health Plan formulary;
c. Experimental or Investigational drugs or other drugs which, in the opinion of the Pharmacy and Therapeutics Committee or Medical Director, have not been proven to be efficacious. NOTE: Denials based upon experimental or investigational use are considered Adverse Determinations and are subject to the Appeal of Adverse Determination and Independent Review provisions of Your Health Care Certificate of Coverage,
d. drugs not approved by the Food and Drug Administration for use in humans or for the condition, dose, duration, route, and frequency being treated;
e. drugs used for cosmetic purposes;
f. drugs used for Treatments or medical conditions not covered by this Agreement;
g. drugs used primarily for the Treatment of infertility;
h. vitamins not requiring a prescription;
i. any initial or refill prescription dispensed more than one (1) year after the date of the Health Professional's order;
j. drugs given or administered to You or a Covered Dependent while at a hospital, skilled nursing facility, or other facility;
k. blood, blood plasma, and other blood products;
l. a prescription that has an over the counter alternative;

m. initial or refill prescriptions the supply of which would extend past the termination of this Agreement, even if the Health Professional's order was issued prior to termination; or
n. drugs for the treatment of sexual dysfunction, impotence, or inadequacy.

13.5.13.11 REFILL LIMITATIONS

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

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

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

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

13.5.13.12 MAINTENANCE DRUGS

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

Maintenance drugs that meet the following criteria may be qualify for synchronization refiles and pro-rated cost share amount for partial supplies. Prescriptions that:

- Meet prior authorization criteria;
- Are used for treatment and management of a chronic illness;
- May be prescribed with refills;
- Are a formulation that can be effectively dispenses in accordance with medication synchronization plan; and
- Are not a Schedule II or III controlled substance containing hydrocodone

13.5.13.13 COPAYMENTS, COINSURANCE, DEDUCTIBLE

You must pay the Copayment or Coinsurance per quantity and days' supply dispensed per prescription as stated in the Schedule of Benefits. Any Deductible, Coinsurance and/or Copayments for prescription drugs shall be considered Out-of-Pocket Expenses for purposes of meeting Your Out-of-Pocket Maximum. You will not be required to pay at the point of sale an amount greater than the lesser of: the applicable copayment; the allowed amount for the prescription drug; or cost of the drug that would be applicable to a person without a health benefit plan, or other drug discount.

13.5.13.14 ORAL ANTICANCER MEDICATIONS

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

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

13.5.14 OUTPATIENT RADIOLOGICAL OR DIAGNOSTIC EXAMINATIONS

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

13.5.14.1 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

13.5.15 BREAST RECONSTRUCTION BENEFITS

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

13.5.15.1 COPAYMENTS/DEDUCTIBLES FOR BREAST RECONSTRUCTION

You 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.

13.5.16 MINIMUM INPATIENT STAY FOLLOWING MASTECTOMY OR RELATED PROCEDURE

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

13.5.17 TREATMENT FOR CRANIOFACIAL ABNORMALITIES

Coverage, includes reconstructive surgery for craniofacial abnormalities to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infection or disease. Cosmetic surgery is an excluded service to the extent it is not necessary to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infection or disease. Health Plan is not required to provide dental services,

unless Your Schedule of Benefits indicates that you otherwise have benefits for dental services. Coverage for dental benefits are subject to the dental rider, if any, attached to this Agreement.

13.5.18 DIABETIC SUPPLIES, EQUIPMENT, AND SELF-MANAGEMENT TRAINING

If You or a Covered Dependent has been diagnosed with insulin dependent diabetes, non-insulin dependent diabetes, or abnormal elevated blood glucose levels induced by pregnancy or another medical condition, as Medically Necessary and prescribed by a Physician or Health Professional, You or Your Eligible Dependent are eligible for coverage for Diabetic Supplies, Diabetic Equipment, and Diabetic Self-Management Training under this Agreement. Coverage for such Treatment shall be provided on the same basis as other analogous chronic medical conditions are covered, including, but not limited to the applicable Coinsurance, Copayments and Deductibles. Diabetes coverage shall include the following services at the applicable copayment for other services under this Agreement:

- office visits and consultations with providers for monitoring and treatment of diabetes, including office visits and consultations with appropriate specialists;
- Immunizations for influenza and pneumococcus;
- Inpatient and provider services when confined to a hospital, rehabilitation facility or skilled nursing facility; and
- Impatient and outpatient lab and diagnostic imaging services.

Coverage shall also be provided for new or improved Diabetic Supplies or Diabetic Equipment, upon approval of the United States Food and Drug Administration, as Medically Necessary and prescribed by a Physician or Health Professional. All Diabetic 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.

13.5.18.1 COVERAGE FOR DIABETES SELF-MANAGEMENT TRAINING

You and Your Covered Dependents are eligible for Coverage of Diabetes Self-Management Training for which a Physician or Health Professional has written an order to You or Your Covered Dependent. Diabetes Self-Management Training shall include the development of an individualized management plan that is created for and in collaboration with You or Your Covered Dependent. 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.

13.5.18.2 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. If Your Agreement does not include the Prescription Drug Benefit, insulin, syringes, oral agents available with a prescription, and Glucagon Emergency Kits shall be provided according to the following subparagraph.

13.5.18.3 REQUIRED PAYMENTS MAXIMUMS FOR DIABETIC EQUIPMENT AND SUPPLIES

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

13.5.19 TRANSPLANT SERVICES

Covered transplants, using human tissue of FDA approved artificial devices, that are not considered Experimental or Investigational, subject to Preauthorization requirements, for the Covered Person's condition may include:

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

Donor/procurement costs for covered transplants for matching, removal, and transportation of the organ are a covered benefit. Transplant services require prior authorization.

13.5.20 BENEFITS FOR ACQUIRED BRAIN INJURIES

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
1) differences in the expertise of the Provider performing the evaluation;
2) changes in technology; and
5) advances in medicine.

13.5.20.1 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.

13.5.21 AMINO ACID-BASED ELEMENTAL FORMULAS

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

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

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

13.5.21.2 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 Calendar Year maximum as stated in the Schedule of Benefits.

13.5.22 CARDIOVASCULAR DISEASE SCREENING FOR HIGH RISK INDIVIDUALS

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

13.5.22.1 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.

13.5.22.2 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.

13.5.23 ROUTINE PATIENT CARE COSTS FOR CLINICAL TRIALS

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

A) The study or investigation is approved or funded by one or more of the following:

i. the Centers of Disease Control and Prevention of the United State Department of Health and Human Services;
ii. the National Institutes of Health;
iii. the Agency for Health Care Research and Quality;
iv. the Centers for Medicare & Medicaid Services;
v. cooperative group or center of any of the entities described in clauses (i) – (iv) or the Department of Defense or the Department of Veteran Affairs;
vi. a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
vii. 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.
viii. any of the following, if the study or investigation conducted by such Department has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
    I. the United States Department of Defense;
    II. the United States Department of Veterans Affairs; or
    III. the United States Department of Energy.

(B) The study or investigation is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition or under an investigational new drug application reviewed or approved by the Food and Drug Administration.

(C) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

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

care through the Research Institution, agrees to accept reimbursement at the rates that are established under the plan, as payment in full for the routine patient care provided in connection with the clinical trial.

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

13.5.23.1 COPAYMENTS AND LIMITATIONS ON COVERAGE FOR ROUTINE PATIENT CARE COSTS

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.

13.5.23.2 CANCELLATION OR NONRENEWAL PROHIBITED

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

13.5.24 TELEMEDICINE AND TELEHEALTH SERVICES

Health Plan will not exclude coverage for covered health care service or procedure delivered by a preferred or contracted health professional solely because the covered health care service or procedure is not provided through an in-person consultation. You are required to pay Copayments, Coinsurance, and Deductible for Telemedicine as required for other medical benefits.

13.5.25 SERVICES FOR MENTAL, EMOTIONAL OR FUNCTIONAL NERVOUS DISORDERS (including Serious Mental Illness)

In order to qualify for inpatient benefits, services for Mental, Emotional or Functional Nervous Disorders must meet the following conditions of service:

1) Services must be for the treatment of a Mental, Emotional or Functional Nervous Disorder.
2) The Covered Person must be under the direct care and treatment of a Physician for the condition being treated.
3) Services must be those which are regularly provided and billed by a Hospital.
4) Services are provided only for the number of days required to treat the Covered Person's condition.
5) Services must be received in a Hospital, Psychiatric Day Care Facility, Crisis Stabilization Unit or Residential Treatment Center.

Each two days of treatment in a Psychiatric Day Care Facility, Crisis Stabilization Unit or Residential Treatment Center will be considered equal to one day of treatment in a Hospital or inpatient program.

13.5.26 CHEMICAL DEPENDENCY (SUBSTANCE USE DISORDER)

Covered Services shown below for the treatment of Chemical Dependency:

- Inpatient Hospital services as stated in the Hospital provision of this section for detoxification or rehabilitation.
- Hospital services for partial hospitalization.
- Inpatient and outpatient services in a Chemical Dependency Treatment Center.
- Physician's visits during a covered inpatient stay or for intensive outpatient treatment.

13.5.27 AUTISM SPECTRUM DISORDER

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

Coverage is provided for Covered Expenses incurred for treatment of a Covered Person who has been diagnosed with

Autism Spectrum Disorder. Treatment will include generally recognized services contained in a treatment plan recommended by the Child's primary Physician. An individual providing treatment for Autism Spectrum Disorder must be:

1. A health care practitioner:
   a) who is licensed, certified or registered by an appropriate agency in the state of Texas;
   b) whose professional credential is recognized and accepted by an appropriate agency of the United States; or
   c) who is certified as a provider under the TRICARE military health system; or

2. an individual acting under the supervision of a health care practitioner described under paragraph 1.

Generally recognized services will include, but are not limited to:

1) evaluation and assessment services;
2) applied behavior analysis;
3) behavior training and management;
4) speech, physical, and occupational therapy; and
5) medications or nutritional supplements used to address symptoms of the Autism Spectrum Disorder.

Medical services for Autism Spectrum Disorder are paid on the same basis as any other medical condition.

13.5.28 VISION

An annual eye exam conducted by a licensed ophthalmologist or optometrist.

13.5.29 PEDIATRIC VISION

Your Covered Dependent Children age 18 and under are entitled to eye exams and prescription eyewear when such eyewear is prescribed by a Participating Physician, optometrist, therapeutic optometrist, or ophthalmologist and is obtained at a Health Plan participating optical dispensary. This benefit consists of:

- one comprehensive eye examination that focuses on eyes and overall wellness every Calendar Year:
- for prescription glasses,
  - glass or plastic single vision, lined bifocal, lined trifocal, or lenticular lenses once every calendar year (including fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses, polycarbonate prescription lenses with scratch resistant coating, low vision items, ultraviolet protective coating, polycarbonate lenses, blended segment lenses, intermediate vision lenses, standard progressives, premium progressives, photochromic glass lenses, plastic photosensitive lenses, polarized lenses, standard anti-reflective coating, premium AR coating, ultra AR coating, or Hi-index lenses); and
  - frames once every calendar year; or
- contact lenses once every calendar year
- medically necessary contact lenses for the following conditions: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, anirida, corneal disorders, post-traumatic disorders, and irregular astigmatism.

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

13.5.29.1 COPAYMENT FOR PEDIATRIC VISION BENEFITS

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

13.5.30 DENTAL SERVICES

Dental services are not provided except for: care or treatment due to accidental injury to sound natural teeth and supporting tissue; or dental care or treatment necessary due to congenital disease or anomaly.

13.5.31 CONTRACEPTIVE DEVICES

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

14. EXCLUSIONS AND LIMITATIONS

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

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

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

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

14.4 Chiropractic Care
Chiropractic Services, other than those described in the Manipulative Therapy/Chiropractic Services provision, are excluded.

14.5 Cosmetic or Reconstructive Procedures or Treatments
Cosmetic or reconstructive procedures or other Treatments which improve or modify a Covered Person's appearance are excluded, except breast reconstruction incident to mastectomy for breast cancer and reconstructive surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infection or disease for a Covered Dependent. Examples of excluded procedures include, but are not limited to, gastric stapling or other Treatments relating to obesity, 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 because of any of the following: (1) an accidental bodily injury; (2) disease of the breast tissue; (3) a congenital or birth defect which was present upon birth; or (4) surgical Treatment of an illness or condition. As medically appropriate and at the discretion of the Medical Director, any Treatment which would result in a cosmetic benefit may be delayed until such time as You or Your Covered Dependent has completed other alternative, more conservative Treatments recommended by the Medical Director.

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

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

14.8 Criminal Offenses, Injuries Sustained In
Treatment or services required as the result of You or Your Covered Dependent's, voluntary participation in the commission of a felony which results in a guilty plea or conviction are excluded.

14.9 Custodial Care
Custodial Care as follows is excluded:

- Any service, supply, care or treatment that the Medical Director determines to be incurred for rest, domiciliary, convalescent or Custodial Care;

- Any assistance with activities of daily living which include activities such as walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking drugs; or
- Any Care that can be performed safely and effectively by a person who does not require a license or certification or the presence of a supervisory nurse.

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

14.10 Dental Care
All dental care is excluded, except for dental surgery due to cranio facial abnormalities or accidental injury.

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

14.12 Exceeding Benefit Limits
Any Services provided to an Enrollee who has exceeded the any Benefit Maximum or limit is excluded from Coverage.

14.13 Experimental or Investigational Treatment
Any Treatments that are considered to be Experimental or Investigational are excluded but may be appealed under the appeal of Adverse Determination provision of this Agreement.

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

14.15 Family Planning Treatment
The reversal of an elective sterilization procedure.

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

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

14.18 Infertility Treatment

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

- in vitro fertilization
- artificial insemination;
- gamete intrafallopian transfer;
- zygote intrafallopian transfer, and similar procedures;
- drugs whose primary purpose is the Treatment of infertility;
- reversal of voluntarily induced sterility;
- surrogate parent services and fertilization;
- donor egg or sperm;

14.19 Miscellaneous

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

14.20 Non-Covered Benefits/Services

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

14.21 Non-Payment for Charges exceeding Allowed Amount

No payment will be made for any portion of the charges for a service or supply in excess of the Allowed Amount as determined by SWHP.

14.22 Personal Comfort Items

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

14.23 Physical and Mental Exams

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

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

14.24 Prescription Drugs
Over-the-counter drugs are not covered, except as covered under the Preventive Care Services benefit. Unless covered by the Prescription Drug Benefit, coverage for drugs is limited to:

- those pharmaceutical products prescribed or ordered by a Participating Physician or Referral Physician, utilized by the Covered Person while in the hospital, approved by the Food and Drug Administration (FDA) to sell for the use in humans, and used for the purpose approved by the FDA.
- Specialty Pharmacy Drugs as provided in the Outpatient Specialty Pharmacy Drugs provision of this Agreement.
- Non-Specialty Pharmacy Drugs that are dispensed and administered in the office of a Participating Provider, or other Outpatient setting, pursuant to the Coverage of Prescription Drugs provision of this Agreement.
- Non-Specialty Pharmacy Drugs that are dispensed at a pharmacy and administered in the office of a Participating Provider, or other Outpatient Setting, with prior approval of a Medical Director pursuant to the Coverage of Prescription Drugs provision of this Agreement.

14. 25 Surgery for Refractive Correction

14. 26 Rehabilitation Services
Rehabilitation services and therapies are subject to the limitations set forth above under the Rehabilitative Therapy provision.

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

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

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

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

14.31 Temporomandibular Joint (TMJ)
Services and supplies (except for Medically Necessary diagnostic and surgical procedures) for treatment or related services to the temporomandibular (jaw) joint or jaw-related neuromuscular conditions with oral appliances, oral splints, oral orthotics, devices, prosthetics, dental restorations, orthodontics, physical therapy or alteration of the occlusal relationship of the teeth or jaws to eliminate pain or dysfunction of the temporomandibular joint and all adjacent or related muscles and nerves are excluded.

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

14.33 Treatment Received in State or Federal Facilities or Institutions

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

14.34 War, Insurrection or Riot

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

14.35 Weight Loss

Any services or supplies provided for reduction of obesity or weight, including surgical procedures, even if You or Your Dependent has other health conditions which might be helped by a reduction of obesity or weight, are not covered.

14.36 Work Related Injury

Treatments rendered to a Covered Person for the care of a work related or occupational injury or disease are excluded**.**

SERVICE AREA

Austin
Bell
Blanco
Bosque
Brazos
Burleson
Burnet
Caldwell
Coke
Coleman
Collin
Concho
Coryell
Crockett
Dallas
Denton
Ellis
Erath
Falls
Fayette
Freestone
Grimes
Hamilton
Hill
Hood
Irion
Johnson
Kimble
Lampasas
Lee
Leon
Limestone
Llano
Madison
Mason
McCulloch
McLennan
Menard
Milam
Mills
Reagan
Robertson
Rockwall
Runnels
San Saba
Schleicher
Somervell
Sterling
Sutton
Tarrant
Tom Green
Travis
Waller
Washington
Williamson

SCHEDULE OF BENEFITS
Year: January 1, 2019

Benefit	Network Provider Covered Person Responsibility
Calendar Year Deductible Applies to Out-of-Pocket Maximum The Calendar Year Deductible will be indexed annually based on applicable Federal guidelines	Individual / Family $7,500 / $15,000
Family Deductible is Cumulative The Deductible applies to Out-of-Pocket Maximum Any individual Covered Person can receive benefits after that Covered Person has satisfied his or her Calendar Year Deductible	Payments for Network services will only apply toward Network Deductible
Out-of-Pocket Maximum (Year) **No carryover will be allowed** The maximum amount of Out-of-Pocket Expenses to be incurred by you and Your Covered Dependents	$7,900 Individual/$15,800 Family Once the Out-of-Pocket Maximum above is reached, then Covered Services will be covered at 100% The Out-of-Pocket Maximum will be indexed annually based on applicable Federal guidelines
Medical Services that are not Preventive Care Services Copayment for each Outpatient visit to or by a Primary Care Physician	
First Office Visit per Member per Year	$35 copay first 2 visits, then deductible, then $35 copay
Subsequent Office Visits per Member per Year	20% after deductible
Copayment for each Outpatient visit to or by a Network Provider other than a Primary Care Physician	20% after deductible
Copayment per vial of serum for allergy treatments	$35 copay 1st two visits, then deductible, then $35 copay
Copayment for Outpatient Surgery performed in a hospital without admission	20% after deductible
Copayment for Outpatient Diagnostic Procedures	20% after deductible
Copayment for other Outpatient Services	20% after deductible
Preventive Care Services	No charge

Benefit	Network Provider Covered Person Responsibility
Hospital Services Copayment for each day of Inpatient Services	20% after deductible
Maximum number of days per admission for which dollar Copayment is due	Not applicable
Copayment for other Inpatient Services	20% after deductible
Skilled Nursing Facility Maximum number of Skilled Nursing Facility days per Year covered by Health Plan	25 days
Emergency Care Services Copayment for each episode of Emergency Care	20% after deductible
Copayment for Diagnostic Procedures in conjunction with Emergency Care Services	20% after deductible
Urgent Care Services Copayment for Treatment received at an Urgent Care Facility	$35 copay first 2 visits, then deductible, then $35 copay
Copayment for Diagnostic Procedures in conjunction with Urgent Care Services	Included with visit copay
Emergency Transportation Services Copayment for Emergency Transportation Services	20% after deductible
Emergency Medical Services Copayment for Emergency Medical Services provided by ambulance personnel for which transport is unnecessary or is declined by Member	20% after deductible
Outpatient Mental Health Care	
Copayment for each Outpatient Mental Health Care visit to or by a Health Professional	20% after deductible
Inpatient Mental Health Care	
Copayment for each day of Inpatient Services, Psychiatric Day Treatment Facility Services, and Alternative Mental Health Treatment benefits	Same as Inpatient Services
Number of Inpatient days per Year for which the above Copayments are due	Not applicable
Copayments for remaining number of covered days per Year	20% after deductible
Serious Mental Illness Copayment for each day of Inpatient Services for Serious Mental Illness benefits	Same as Inpatient Services
Copayment for each Outpatient Mental Health Care visit to or by a Health Professional	20% after deductible

Benefit	Network Provider Covered Person Responsibility
Treatment For Chemical Dependency Copayment for each Outpatient Chemical Dependency visit to or by a Network Provider other than a Primary Care Physician	20% after deductible
Copayment for each day of Inpatient Chemical Dependency Services	Same as Inpatient Medical Services
Maximum number of days per Inpatient Chemical Dependency admission for which Copayment is due	Not applicable
Rehabilitative and Habilitative Therapy Copayment for each Outpatient Therapy visit to or by a Network Provider other than a Primary Care Physician	20% after deductible
Rehabilitative and Habilitative Therapy Limits Maximum number of Rehabilitative and Habilitative Therapy visits per Year covered by Health Plan	35 visits
Home Health Services Copayment for each Home Health visit to or by a Network Provider other than a Primary Care Physician	20% after deductible
Home Health Services Maximum number of Home Health Services visits per Year covered by Health Plan	60 visits
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)	20% after deductible
Maximum number of days of Home Infusion Therapy services for which Copayment is due	Not applicable
Hospice Services Copayment for each day of Hospice services	20% after deductible
Maximum number of days per Hospice admission for which Copayment is due	Unlimited days
Maternity Services Copayment for each outpatient visit to or by a Network Provider other than a Primary Care Physician	20% after deductible
Copayment for Diagnostic Procedures in conjunction with Maternity Services	20% after deductible
Copayment for each day of Inpatient Services	20% after deductible
Maximum number of days per admission for which a Copayment is due	Not applicable

Benefit	Network Provider Covered Person Responsibility
Family Planning Services Copayment for each Outpatient visit to or by a Network Provider other than a Primary Care Physician	20% after deductible
Copayment for Outpatient Diagnostic Procedures in conjunction with Family Planning Services	20% after deductible
Copayment for each day of Inpatient Services	20% after deductible
Maximum number of days per admission for which a Copayment is due	Not applicable
Durable Medical Equipment/Orthotics/Prosthetic Medical Appliances	
Copayment for Durable Medical Equipment, Orthotics and Prosthetic Devices and all other related covered services	20% after deductible
Copayment for Durable Medical Equipment	20% after deductible
Copayment for Orthotic Devices and Prosthetic Devices	20% after deductible
Copayment for each Outpatient visit to or by a Network Provider other than a Primary Care Physician	20% after deductible
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	20% after deductible
Radiology Daily Copayment Maximum	Not applicable
Breast Reconstruction Benefits Copayment for Breast Reconstruction benefits	Same as other Outpatient and Inpatient Services
Inpatient Stay Following Mastectomy	Same as other Outpatient and Inpatient Services
Treatment and Diagnoses of Conditions affectingTemporomandibular Joint	20% of charges
Treatment for Craniofacial Abnormalities of a Child	Same as other benefits

Benefit	Network Provider Covered Person Responsibility
Diabetic Supplies, Equipment, and Self-Management Training Copayment for Preferred Level test strips for blood glucose monitors	Same as Prescription Drugs or Durable Medical Equipment and Supplies, as appropriate
Copayment for Non-Preferred Level test strips for blood glucose monitors	Same as Prescription Drugs or Durable Medical Equipment and Supplies, as appropriate
Copayment for Diabetic Equipment and Diabetic Supplies	Same as Prescription Drugs or Durable Medical Equipment and Supplies, as appropriate
Copayment for Diabetes Self-Management Training	20% after deductible
Transplant Services	Same as other Inpatient and Outpatient benefits
Acquired Brain Injury	20% after deductible
Autism Spectrum Disorder (if diagnosed before age 10) Copayment for each visit to or by a Health Professional for generally recognized service prescribed by enrollee's Primary Care Provider	Same as other benefits
Telemedicine	Similar to other benefits
Amino Acid-Based Elemental Formulas	
Copayment for Amino Acid-Based Elemental Formulas	20% after deductible
Note: Coverage for Amino Acid-Based Elemental Formulas are available only on the orders of a Physician	
Cardiovascular Disease Screening Test Copayment for CT scan measuring coronary artery calcification	Same as other CT scans after deductible
Copayment for Ultrasonography measuring carotid intima-media thickness and plaque	Same as other Ultrasound after deductible
Maximum benefit per Member every 5 years for cardiovascular disease screening test	1 screening per member every 5 years
Routine Patient Care Costs for Clinical Trials Copayments for Routine Patient Care Costs by Enrollee in Clinical Trial	Same as other benefits
Vision (All Ages)	20% after deductible Maximum of one eye examination per Year

Benefit	Covered Person Responsibility
Prescription Drug Program Prescription Copayment, Coinsurance, and deductible apply to the Out-of-Pocket Maximum	
Generic Drugs	$15 copay, deductible does not apply
Preferred Brand Drugs	$50 copay after deductible
Non-preferred Generic and non-preferred Brand drugs	$100 copay after deductible
Specialty Drugs	$500 copay after deductible
Maintenance Prescriptions Available when obtained through a Baylor Scott & White Pharmacy or when using the mail-order prescription service	Generic and Brand preferred and non-preferred copayment will be 2 times the amount applicable indicated above 90-day supply maximum
Mail Order Prescription Service: 90-day supply maximum Note: Non-maintenance drugs obtained through the mail order prescription service will be limited to a 30-day supply maximum.	

Language Assistance/ Asistencia de idiomas

INSURANCE COMPANY OF Scott&White
PART OF BAYLOR SCOTT & WHITE HEALTH

English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-321-7947 (TTY: 711).

Spanish:
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-321-7947 (TTY: 711).

Vietnamese:
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-321-7947 (TTY: 711).

Chinese:
注意：如果 使用繁體中文, 可以免費獲得語言援助服務。請致電 1-800-321-7947 (TTY：711)。

Korean:
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-321-7947 (TTY: 711) 번으로 전화해 주십시오.

Arabic:
هاتف الصم والبكم: 711 .ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-321-7947-800 (رقم

Urdu:
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال 1-800-321-7947 (TTY: 711). کریں

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-321-7947 (TTY: 711).

French:
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-321-7947 (ATS : 711).

Hindi:
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध है। 1-800-321-7947 (TTY: 711) पर कॉल करें।

Persian:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما 1-800-321-7947 (TTY: 711) تماس بگیرید. با فراهم می باشد.

German:
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-321-7947 (TTY: 711).

Gujarati:
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-321-7947 (TTY: 711).

Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-321-7947 (телетайп: 711).

Japanese:
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-321-7947 (TTY:711) まで、お電話にてご連絡ください。

Laotian:
ໂປດຊາບ: ຖ້າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍ ລິການຊ່ ວຍເຫ ຼືອດ້ ານພາສາ, ໂດຍບໍ ່ເສັ ຽຄ ່າ, ແມ ່ນມ ີພ້ ອມໃຫ ້ທ ່ານ. ໂທຣ 1-800-321-7947 (TTY: 711).

INSURANCE COMPANY OF
Scott&White
PART OF BAYLOR SCOTT & WHITE HEALTH

Nondiscrimination Notice

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-321-7947 (TTY: 711).

Insurance Company of Scott and White complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Insurance Company of Scott and White does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Insurance Company of Scott and White:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Written information in other formats (large print and accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Insurance Company of Scott and White Compliance Officer at 1-214-820-8888 or send an email to SWHPComplianceDepartment@BSWHealth.org

If you believe that Insurance Company of Scott and White has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Insurance Company of Scott and White, Compliance Officer
1206 West Campus Drive, Suite 151
Temple, Texas 76502

Compliance HelpLine; 1-888-484-6977 or https://app.mycompliancereport.com/report.aspx?cid=swhp

You can file a grievance in person or by mail, online, or email. If you need help filing a grievance, the Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/civil-rights/filing-a-complaint/index.html.