EXCLUSIVE PROVIDER BENEFIT PLAN

HEALTH CARE

CERTIFICATE OF COVERAGE

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

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

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

LE EPO COV 01/2019

CERTIFICATE OF COVERAGE

In consideration of the completed and received Application and timely payment of the Required Payments, Insurance Company of Scott and White agrees to provide or arrange to provide the benefits specified in this Agreement, in accordance with and subject to the terms stated herein and all applicable local, state and federal laws. This Agreement, Application, forms and any attachments to them form the entire contract.

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

Important Notices:

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

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

In witness whereof Insurance Company of Scott and White has caused this Health Care Agreement 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 numbers for information or to make a complaint at

1-800-321-7947

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

1206 West Campus Dr.
Temple, TX 76502

You may contact the Texas Department of Insurance to obtain information on companies, coverages, 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 Certificate of Coverage may contain additional definitions which pertain to the Health Care Services set forth in this Agreement. Capitalized words are defined terms throughout this Agreement.

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 member are not medically necessary as defined in this Certificate of Coverage or are Experimental or Investigational. Denial of concurrent review of the provision of prescription drugs, intravenous infusions, or a request for exception to step therapy protocols is considered an adverse determination.

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

1.4 "**Agreement**" means this Insurance Company of Scott and White Certificate of Coverage and all attachments and riders herein. This Plan is subject to the terms and conditions of the Policy that We have issued to the Group.

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

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

1.9 "**Autism Spectrum Disorder**" means a neurological disorder that is characterized by social and communication difficulties and includes the previously used diagnoses such as Autism Disorder, Asperger's Syndrome, and Pervasive Development Disorder- Not Otherwise Specified.

1.10 "**Certificate of Coverage**" is the document issued to each Covered Employee describing the benefits under the Group Policy.

1.11 "**Chemical Dependency**" means the abuse of, psychological or physical dependence on, or addiction to alcohol or a Controlled Substance.

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

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

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

1.14 "**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.

1.15 "**Coinsurance**" means the percentage of Covered Expenses You are responsible for paying (after the applicable Deductibles are satisfied). Coinsurance does not include charges for services that are not Health Care Services or charges in excess of Covered Expenses. These charges are Your responsibility and are not included in the Coinsurance calculation.

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

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

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

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

1.20 "**Contract Holder**" means the person or entity with whom the Health Plan has entered into an agreement to provide Health Care Services. Under this Certificate of Coverage, the Group is the Contract Holder.

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

1.22 "**Copayment**" means the dollar amount or the percentage of the cost of Health Care Services, if any, shown in the Schedule of Benefits payable by the Covered Person to the provider of care. Copayments do not count toward any Deductible.

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

1.24 "**Covered Employee**" is the Eligible Employee whose Application has been received by ICSW for coverage under the Plan.

1.25 "**Covered Expenses**" are the expenses incurred for Health Care Services. Covered Expenses for Health Care Services received from Network Providers will not exceed the contracted rate. In addition, Covered Expenses may be limited by other specific maximums described in this Plan. Covered Expenses are subject to applicable

Deductibles and other benefit limits. An expense is incurred on the date the Covered Person receives the service or supply. In some cases, Covered Expenses may be less than the amount that You are actually billed.

1.26 "**Covered Person**" means both the Covered Employee and all other Covered Dependents who are covered under this Plan.

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

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

1.29 "**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.

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

1.31 "**Diabetic Equipment**" means blood glucose monitors, including noninvasive glucose monitors and glucose monitors designed to be used by or adapted for the legally blind; insulin pumps, both external and implantable, and associated appurtenances, which include 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; repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer's warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance; and podiatric appliances, including up to two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes.

1.32 "**Diabetic Self-Management Training**" means any of the following training or instruction 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.

1.33 "**Diabetic Supplies**" means test strips specified for use with a corresponding blood glucose monitor, visual reading and urine test strips and tablets which test for glucose, ketones and protein, lancets and lancet devices, insulin and insulin analog preparations, injection aids, including devices used to assist with insulin injection and needleless systems, insulin syringes, prescriptive and nonprescriptive oral agents for controlling blood sugar levels, biohazard disposal containers, and glucagon emergency kits.

1.34 "**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.

1.35 "**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.

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

1) Your legal spouse, under Texas law.
2) Your Son or Daughter who is:
    a. Under the Age of Ineligibility; or
        i. if the Age of Ineligibility or older
            1. medically certified as disabled and dependent upon You; or
            2. 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:
    a. qualifies as a dependent of the Eligible Employee for federal income tax purposes at the time of application;
    b. is unmarried; and
    c. is under the Age of Ineligibility; or
        i. if the Age of Ineligibility or older
            1. incapable of self-sustaining employment by reason of physical disability or mental incapacity; and
            2. chiefly dependent upon You for support and maintenance; and
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.

1.37 **"Eligible Employee"** means an Employee who works on a full-time basis and consistently works at least thirty (30) hours a week. This term may also include a sole proprietor, a partner, or an independent contractor so specified as an employee under the Group's Health Plan. The term does not include:

1) an Employee who works on a part-time, temporary, seasonal or substitute basis; or
2) an Employee who is covered under:
    - another Health Benefit Plan;
    - a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established according to Employee Retirement Income Security Act of 1974 (29 U. S. C. Section 1001 et seq.);
    - Medicaid; even if the Employee elects not to be covered;
    - another federal program such as TRICARE or Medicare, even if the employee elects not to be covered; or
    - a benefit plan established in another country, even if the Employee elects not to be covered.

1.38 "**Eligibility Date**" means the date the Covered Person satisfies the definition of either Eligible Employee or Dependent and is in a class eligible for coverage under the Health Plan.

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

1) placing his or her health in serious jeopardy;
2) serious impairment to bodily functions;
3) serious dysfunction of any bodily organ or part;

4) serious disfigurement; or
5) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

1.40 "**Employee**" means an individual employed by an Employer.

1.41 "**Employer**" means Group.

1.42 "**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 on:

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 that have been provided from the physician undertaking the 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 Treatment;
5) Regulations and other communication and publications issued by the Food and Drug Administration and the Department of Health and Human Services; and
6) The Member's medical records.

As used above "peer reviewed medical literature" means one or more U.S. scientific publications which require that manuscripts be submitted to acknowledged experts inside or outside the editorial office for the considered opinions or recommendations regarding publication of the manuscript. In addition, in order to qualify as peer reviewed medical literature, the manuscript must 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 of the terms of similar meaning shall be considered to be Experimental or Investigational.

1.43 "**Group**" means Your Employer which is the party contracting with Health Plan to purchase coverage for its Eligible Employees who become Covered Employees on an aggregate basis. Your Employer must pay the applicable Premium Contribution for the plan selected for each Eligible Employee who elects to be covered. Your Employer must be located within the Service Area. A Group must maintain a Minimum Group Size of at least two Eligible Employees.

1.44 "**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.

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

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

1.47 "**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.

1.48 "**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.

1.49 "**ICSW, We, Our and Us**" means Insurance Company of Scott and White an insurance company regulatedby the Texas Department of Insurance.

1.50 "**Independent Review Organization**" means an organization which provided external review of adverse benefit determinations as administered by the Department of Health and Human Services.

1.51 "**Individual Treatment Plan**" means a Treatment plan prepared or approved by the Covered Person's Network Physician with specific attainable goals and objectives appropriate to both the Covered Persons and the Treatment modality of the program.

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

1.53 **Late Enrollee**" means an Employee or Dependent, eligible for enrollment in Health Plan, who requests enrollment in Health Plan after the expiration of the initial enrollment period established under the terms of the first Health Benefit Plan for which that Employee or Dependent is eligible through the Employer or after the expiration of an Open Enrollment Period.

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

1.55 "**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.

1.56 "**Medically Necessary**" means those Health Care Services which, in the opinion of Covered Person's healthcare provider whose opinions are subject to the review, approval or disapproval, and actions of the Medical Director or the Quality Assurance Committee in their appointed duties, are:

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 or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's illness, injury, or disease.

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

1.58 "**Minimum Group Size**" means the minimum number of Eligible Employees required to be employed by the Employer in order to avoid termination of this Agreement. The Minimum Group Size is 2 Eligible Employees. A failure to meet Minimum Group Size for at least six (6) consecutive months shall be grounds for termination of this Agreement.

1.59 "**Network Hospital**" means an institution licensed by the State of Texas as a hospital which has contracted or arranged with ICSW to provide Health Care Services to Covered Persons and which is listed by ICSW as a Network Provider.

1.60 "**Network Physician**" means anyone licensed to practice medicine in the State of Texas and who has executed a contract with ICSW to provide Health Care Services.

1.61 "**Network Provider**" means any person or entity that has contracted, directly or indirectly, with Health Plan to provide Health Care Services to Covered Persons. Network Providers include but are not limited to: Network Hospitals, Network Physicians, and other contracted health care providers, within the Service Area.

1.62 "**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.

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

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

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

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

1.67 "**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.

1.68 "**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.

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

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

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

1.72 "**Non-Network Hospital**" means a hospital that has not contracted with ICSW as a Network Hospital at the time services are rendered.

1.73 "**Non-Network Physician**" means a physician who has not contracted with ICSW as a Network Physician at the time services are rendered.

1.74 "**Non-Network Provider**" means a provider who has not contracted with ICSW as a Network Provider at the time services are rendered.

1.75 "**Open Enrollment Period**" means the period each Year, at the time mutually designated by Health Plan and Group of not less than thirty-one (31) consecutive days which any eligible person who meets the eligibility provisions

of this Agreement, including a Late Enrollee, on behalf of himself or his Eligible Dependents, may elect to become enrolled under this Agreement. A completed Application form must be received by Health Plan within the Open Enrollment Period and all other requirements of this Agreement must be met.

1.76 "**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.

1.77 "**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.

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

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

1.80 "**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.

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

1.82 "**Plan**" means the set of benefits described in the Certificate of Coverage booklet and in the amendments to this booklet (if any). This Plan is subject to the terms and conditions of the Policy We have issued to the Group. If changes are made to the Policy or Plan, an amendment or revised booklet will be issued to the Group for distribution to each Covered Employee affected by the change.

1.83 "**Policy**" is the insurance contract issued by Insurance Company of Scott and White to the Group as a means of providing certain benefits to the Eligible Employees and their Eligible Dependents.

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

1.85 "**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.

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

1.87 **"Post-Stabilization"**- means covered services that are:

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

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

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

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

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

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

1.92 "**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.

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

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

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

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

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

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

1.99 "**Required Payments**" means any payment or payments required of the Group, an applicant for coverage hereunder, or 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.

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

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

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

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

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

1.104 "**Service Area**" is that geographic area more fully described in the Insurance Company of Scott and White Service Area Attachment.

1.105 "**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 by a Texas court or court of another state, 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.

1.106 "**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;
5) or has any dosage form with a total cost greater than $1,000 per prescription.

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

1.108 **"Telehealth services"** 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, certifications, or entitlement to a patient at a different physical location than the health professional using telecommunication or information technology.

1.109 **"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 telecommunications or information technology.

1.110 "**Totally Disabled**" means, with respect to the Covered Employee, the complete inability of that individual to perform all of the substantial and material duties and functions of the individual's occupation and any other gainful occupation in which the individual earns substantially the same compensation earned before the disability and, with respect to a Covered Dependent, confinement as a bed patient in a hospital.

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

1.112 "**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.

1.113 "**Urgent Care Facility**" means any licensed Facility that provides physician services for the immediate treatment only of an injury or disease.

1.114 "**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.

1.115 "**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.

1.116 "**Year**" means the 12-month period beginning on the date shown on Your schedule of Benefits at 12:01 a.m. Central Time.

1.117 "**You**" means the Covered Employee.

1.118 "**Your**" means relating or pertaining to the Covered Employee.

2. ELIGIBILITY PROVISIONS

2.1. CLASSES OF INDIVIDUALS ELIGIBLE FOR COVERAGE

2.1.1 Eligible Employees

Except for continuation coverage, to be eligible for coverage You must be an Eligible Employee of the Contract Holder.

2.1.2 Eligible Dependents

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

2.2. GENERAL ELIGIBILITY PROVISIONS

2.2.1 Requirements for Eligibility

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

1) Work, live or reside in the Service Area,
2) Eligible Dependents may reside anywhere. 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, including, but not limited to, any provision which restricts benefits to Emergency Care only while outside the Service 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 be at least actuarially equivalent to the coverage Health Plan provides to other Dependent children under this Agreement. Eligible Dependents, not subject to a Qualified Medical Support Order, may be limited to Network restrictions.

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 Covered Employee upon whose coverage the dependent's eligibility is based must remain covered 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. The following paragraphs describe the operation of the Effective Date and Eligibility Date.

2.3.1 Timely Applications

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

1) a completed Application which must be received by Health Plan during the enrollment period, 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.

IF A GROUP FAILS TO PAY A REQUIRED ELIGIBLE EMPLOYEE'S PAYMENT WHEN DUE, THE GROUP MAY LOSE COVERAGE UNDER THE HEALTH PLAN, IN ACCORDANCE WITH THE PROCEDURES SET FORTH IN THIS AGREEMENT.

2.3.2 Coverage Upon Initial Eligibility

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

1) If You are eligible on the Contract Date and the Application is received by the Health Plan prior to or within 31 days following such date, the Effective Date for You and Your Eligible Dependents for whom an Application was submitted is the Contract Date;
2) If You and Your Eligible Dependents enrolled during an Open Enrollment Period, the Effective Date is the date mutually agreed to by Group and Health Plan. If there is no such date, the Effective Date is the first day of the calendar month following the end of the Open Enrollment Period.
3) If an Eligible Employee is subject to a Waiting Period, and if Application is received within 31 days following the end of the Waiting Period, the Effective Date is the first day of the month following the date the Waiting Period ended.
4) If You become eligible after the Contract Date and if Your Application is received by Health Plan within the first 31 days following Your Eligibility Date, Your Effective Date is the first day of the month following the date You satisfy the requirements of this Agreement, unless another date is specified in this Agreement.

2.3.3 Effective Dates – Late Enrollee

If Your Application is not received within 31 days from the Eligibility Date, You will be considered a Late Enrollee. If an Application for Your Dependent is not received within the time period specified in the appropriate Dependent Special Enrollment Period provision in Section 2.3.6 of this Agreement, Your Dependent will be considered a Late Enrollee. As a Late Enrollee, You or Your Dependent are ineligible for coverage until the next Open Enrollment Period.

2.3.4 Avoidance of Late Enrollee Designation by Loss of Other Health Insurance Coverage

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

1) You are covered under a Health Benefit Plan, self-funded health benefit plan or had other health insurance coverage at the time this coverage was previously offered; and
2) You declined coverage under the Health Plan in writing, on the basis of coverage under another Health Benefit Plan or self-funded health benefit plan;
3) You provide written proof that Your prior Health Benefit Plan or self-funded plan:
   a. Was covering You under a continuation right that has been exhausted; or
   b. Was terminated as a result of divorce, death, termination of employment or a reduction in the number of hours of employment, or employer contributions toward such coverage were terminated; or
   c. Was ended as a result of termination of the other plan's coverage; and
4) You request to apply no later than 31 days after the date coverage ends under the prior Health Benefit Plan or self-funded health benefit plan. Your Effective Date will be the first day of the month following receipt of the Application by the Health Plan.

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

2.4 <u>DEPENDENT SPECIAL ENROLLMENT PERIOD</u>

2.4.1 Newborn Children

Coverage of Your newborn child will be automatic for the first 31 days following the birth of Your child. Required Premium will be calculated from the date of birth of Your newborn. For coverage to continue beyond this time, You must notify Your Employer 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. If You notify the Health Plan after that 31-day period, Your newborn child will be considered a Late Enrollee.

2.4.2 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 will be considered a Late Enrollee.

2.4.3 Court Ordered Dependent Children

If a Court enters a Qualified Medical Support Order against You, coverage for the child subject to the Qualified Medical Support Order will be automatic for the first 31 days after receipt or notice of the Qualified Medical Support Order by Your Group. For coverage to continue beyond this time, a written Application and the required Premium must be received within 31 days after Your Group receives notice of the court order. With such notice, the Effective Date for the child subject to the Qualified Medical Support Order will be the date of receipt or notice of the Qualified Medical Support Order by Your Group. If Your written application and required premium is received by the Health Plan after the 31-day period, the Dependent Child will be considered a Late Enrollee.

2.4.4 Court Ordered Coverage for a Spouse

If a court has ordered You to provide coverage for a spouse, written enrollment and the required Premium must be received within 31 days after issuance of the court order. The Effective Date will be the first day of the month following the date the Application for coverage and the required Premium is received. If Application is not made within the initial 31 days, Your spouse will be considered a Late Enrollee.

2.4.5 Employee or Dependent Loss of Coverage under a Governmental Program

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

2.4.6 Employee or Dependent Becomes Eligible for State Premium Assistance

If You or Your Dependent becomes eligible for premium assistance, with respect to the Health Plan, under Title XIX of the Social Security Act (Medicaid) or under Chapter 62 of the Texas Health and Safety Code (CHIP), written enrollment and the required Premium must be received within 60 days after the date on which You or Your Dependent became eligible for premium assistance. If application is not made within the initial 60 days, You or Your Dependent, as applicable, will be considered a Late Enrollee.

2.5 OTHER DEPENDENTS

2.5.1 Written Application must be received within 31 days of the date that a spouse or child first qualifies as an Eligible Dependent. The Effective Date will be the first day of the month following the date the Application for coverage is received, so long as the required Premium is paid within the 31-day period. If Application is not made within the initial 31 days, then Your Dependent will be considered a Late Enrollee.

2.5.2 If You ask that Your Dependent be covered after having canceled his or her coverage while Your Dependent was still entitled to coverage, Your Dependent's coverage will become effective in accordance with the provisions for Late Enrollees.

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

2.6 EMPLOYEE SPECIAL ENROLLMENT PERIOD

2.6.1 If You acquire a Dependent through birth, adoption, or through suit or placement for adoption, and You previously declined coverage for reasons other than loss of other coverage, as described above, You may apply for coverage for Yourself, Your spouse, and the newborn child, adopted child, or child involved in a suit or placed for adoption. If the written Application is received within 31 days of the birth, adoption, or date on which the suit for adoption was filed or the child was placed with You for adoption, the Effective Date for the child, You and/or Your spouse will be the date of the birth, adoption, placement for adoption or date suit for adoption is sought.

2.6.2 If You marry and You previously declined coverage for reasons other than loss of coverage as described above, You may apply for coverage for Yourself and Your spouse. If the written Application is received within 31 days of the marriage, the Effective Date for You and Your spouse will be the first day of the month following receipt of the Application by the Health Plan.

2.6.3 No eligible person who properly enrolls during a period of enrollment shall be refused enrollment because of health status related factors. An eligible person who fails to enroll when first eligible during a period of enrollment is a Late Enrollee.

2.7 ADDITIONAL REQUIREMENTS

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

2.7.2 It is Your responsibility to inform:

1) Your Group immediately of all changes that affect Your eligibility and that of Your Covered Dependents, including, but not limited to:
   - marriage of a Dependent grandchild, and
   - death;
2) the Health Plan immediately of all changes that affect administration of Your, and Your Covered Dependents, Health Plan benefits, including, but not limited to:
   - address changes.

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

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

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

3. PROVIDERS OTHER THAN HEALTH PLAN PROVIDERS

3.1 HEALTH PLAN NOT LIABLE FOR EXPENSES OF PROVIDERS OTHER THAN HEALTH PLAN PROVIDERS

This is an Exclusive Provider Organization plan, which provides benefits for services received from a doctor, hospital, or other Health Care Provider that participates in the plan's network. It does not cover services received from health care providers who do not participate in the network. Services are not covered under this Agreement until such date that the Health Plan assumes full responsibility for the Member's care except as follows:

- for Emergency Care or services for a Covered Dependent child who lives outside of the Service Area;
- when no preferred provider is reasonably available within the designated service area for which the policy was issued and services were pre-approved or preauthorized based upon the unavailability of a preferred provider;
- for a Member who is confined in a hospital, which is not a Participating Hospital or under the care of a physician or provider who is not a Participating Provider on the date coverage under this Agreement would otherwise become effective.

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

3.2 CONTRACT STATUS OF PROVIDERS

You should be aware of the contract status of the providers from whom you receive treatment, especially participating hospitals, as some facility-based physicians or other health care practitioners such as neo-natologists, anesthesiologists, pathologists, radiologists, and assistant surgeons may not be included in Health Plan's network and may balance bill for amounts above the Usual and Customary Rate paid by Health Plan. In order to determine the contract status of providers you may consult the provider manual on the Health Plan website at www.swhp.org, or contact a Health Plan Customer Service Representative at 800-321-7947.

Texas Department of Insurance Notice:

- An exclusive provider benefit plan provides no benefits for services you receive from out-of-network providers, with specific exceptions as described in your policy below.
- You have the right to an adequate network of preferred providers (also 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: www.swhp.org or by calling 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.

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) except for continuation privileges, on the date on which You and/or Your Covered Dependents cease to be eligible for coverage in accordance with this Agreement, however:
   - coverage will remain in force until the end of the calendar month in which the Group notifies Us that the Covered Person is no longer eligible; and
   - the Group will be liable to Us for any premium, including Premium for dependent coverage, for the period of coverage until the end of the calendar month in which the Group provides Us such notice; and
   - if the Covered Person ceases to be eligible for coverage under the Policy within 7 calendar days before the end of the month; and
   - the Contract Holder will be deemed to have notified Us in the month in which the individual cease to be part of the Group if We receive notice within the first 3 business days of the subsequent month.
2) the end of the last period for which Premium payment has been made to Us; or
3) the date of fraud or intentional material misrepresentation by You or Your Covered Dependent, except as described under Incontestability, or fraud in the use of services or facilities. Coverage may be terminated retroactively due to fraud or intentional misrepresentation upon thirty (30) days written notice from Health Plan; or
4) the date Group coverage terminates.

4.2 TERMINATION OR NON RENEWAL OF COVERAGE FOR GROUP

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

1) Group fails to pay a Required Payment as required by this Agreement;
2) Fraud or intentional misrepresentation of a material fact by Group;
3) Group fails to comply with the terms and conditions of this Agreement;
4) No Eligible Employees of the Group work or reside in the Service Area;
5) Health Plan elects to cease providing coverage to all small employers or large employers in its Service Area;
6) Health Plan elects to discontinue a particular type of coverage.

4.3 NOTICE OF TERMINATION OR NON-RENEWAL OF GROUP

If termination or non-renewal is due to reason (1) or (3) above, Health Plan shall give Group thirty (30) days advance written notice, unless termination or non-renewal under (3) above is for failure to comply with the Minimum Group Size requirement, in which case, termination shall be upon the first day of the next month following the end of the 6 consecutive month period during which the Group failed to maintain the Minimum Group Size. If termination is due to reason (2) above, Health Plan shall give Group at least fifteen (15) days advance written notice. If termination is due to reason (4) above, Health Plan shall give Group at least sixty (60) days advance notice. If termination is due to reason (5), Health Plan shall give all affected Groups at least 180 days advance written notice. If termination is due to reason (6), Health Plan shall give Group at least ninety (90) days advance written notice and offer Group the option to purchase other coverage.

4.4 LIABILITY

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

5. CONTINUATION OF COVERAGE OPTION

5.1 LOSS OF ELIGIBILITY

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

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

5.2 COBRA CONTINUATION OF COVERAGE

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

5.3 ADDITIONAL CONTINUATION PROVISIONS

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

1) Continuation of group coverage must be requested in writing to Your Employer or Contract Holder not later than the 60th day following the later of:
   a. the date the group coverage will terminate; or
   b. the date the Covered Person is given notice of the right of continuation by either the Employer or the Contract Holder.
2) A Covered Person electing continuation coverage must pay to the Employer or Contract Holder on a monthly basis, the Premiums, plus 2% of the total health Premium when due. The continuation Premium must be made not later than the 45th day after the date of the initial election for continuation coverage and on the due date of each payment thereafter. Following the first payment made after the initial election for continuation coverage, Premium payment is considered timely if made on or before the 30th day after the date on which the payment is due.
3) Continuation coverage will continue until the earliest of:
   a. if Covered Person is not eligible for continuation coverage under COBRA, 9 months after the date the election for continuation coverage is made;

b. if Covered Person is eligible for continuation coverage under COBRA, 6 additional months following any period of continuation under COBRA;
c. the date on which failure to make payments would terminate coverage;
d. the date the member is or could be covered by Medicare;
e. the date on which the Covered Person is covered for similar services and benefits by another health plan; or
f. the date on which this Agreement terminates as to all Covered Persons.

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

6. REQUIRED PAYMENTS

6.1 COPAYMENTS, COINSURANCE AND DEDUCTIBLES

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

6.2 SUBROGATION AND COORDINATION OF BENEFITS PAYMENTS

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

7. HEALTH CARE SERVICES

7.1 HEALTH CARE SERVICES WITHIN THE SERVICE AREA

You and Your Covered Dependents shall be entitled to the Health Care Services specified in the Schedule of Benefits subject to the conditions and limitations stated in the Schedule of Benefits and this Agreement that are considered to be Medically Necessary by the Medical Director.

7.2 LIMITATIONS AND EXCLUSIONS

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

7.3 REFUSAL TO ACCEPT TREATMENT

Should You or Your Covered Dependent refuse to cooperate with or accept the recommendations of providers with regard to health care for You or Your Covered Dependent, providers may regard such refusal as a failure of the patient relationship and as obstructing the delivery of proper medical care. In such cases, providers shall make reasonable efforts to accommodate You or Your Covered Dependent. However, if the provider determines that no alternative acceptable to the provider exists, You shall be so advised. If You or Your Covered Dependent continues to refuse to follow the recommendations, then neither Health Plan nor the provider shall have any further responsibility under this Agreement to provide care for the condition under Treatment, provided that nothing in this paragraph is intended to limit Your rights under this Certificate, including Your right to an appeal of an adverse determination or to seek a second opinion on a course of recommendation.

7.4 COORDINATION OF HEALTH CARE SERVICES

7.4.1 Selection of Physician

Physicians may be selected from the list of Physicians published by the Health Plan. The ability to select a particular Network Physician as a Physician is subject to that physician's availability. A current, updated list of Physicians may be found on Health Plan's website, www.swhp.org.

7.4.2 Changing Your Physician

You or Your Covered Dependents may change Your Physician at any time.

7.5 CONTINUITY OF TREATMENT

7.5.1 Notice of Termination of Treating Physician or 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 no less than 30 days advance notice of the termination. If Health Plan terminated a Participating Provider and We are aware that you are receiving care from that provider, You will receive notice of 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.

7.5.2 Continued Treatment by Terminated Physician or Provider

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

identify the special circumstance and submit a request to Health Plan's Medical Director that You or Your Dependent be permitted to continue Treatment under the Network Provider's care. The Network Provider must agree not to seek payment from You or Your Covered Dependent of any amounts for which You would not be responsible if the Health Professional or Network Physician were still under contract with the Health Plan. If the request is granted, the Health Plan's obligation to pay for the services of the Network 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 a 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 (24th) week of pregnancy at the time of termination, Health Plan's obligation to reimburse a terminated Network Provider for services extends through delivery of the child, immediate postpartum care and the follow-up checkup within the first six weeks of delivery.

7.5.3 Total Disability

If a Covered Person is totally disabled on the date of termination of the Policy, coverage will be extended. Benefits will continue to be paid under the terms of the Policy for Eligible Expenses due to the disabling condition. Extension of benefits will continue until the earlier of: a) the date payment of the maximum benefit occurs, b) the date the Covered Person ceases to be totally disabled, or c) the end of 90 days following the date of termination. This extension of benefits is not applicable if the Policy is replaced by another carrier providing substantially equivalent or greater benefits.

7.6 HEALTH CARE SERVICES NOT AVAILABLE FROM CONTRACTING PROVIDERS

To the extent the Health Plan would have covered such services under the terms of this Agreement, Medically Necessary Health Care Services which are prescribed by a Network Physician but which are not available from a Network Provider shall be authorized within a time appropriate to the circumstances relating to the delivery of services and the condition of the patient, but in no event to exceed five (5) business days after receipt of reasonably requested documentation, to be received from a physician or provider who does not contract with the Health Plan upon the request of the Network Physician and the approval of the Medical Director. If approved, Health Plan shall reimburse the non-contracting physician or provider at the usual or customary charge, or an agreed upon amount, for the services rendered, less any patient copayment, deductible, and coinsurance percentage that the insured would have paid had the insured received services from a preferred provider, regardless of whether the service is provided within the designated service area, including:

- a medical screening examination or other evaluation required by state or federal law to be provided in a hospital emergency facility of a hospital, freestanding emergency medical care facility, or comparable facility that is necessary to determine whether a medical emergency condition exists;
- necessary emergency care services, including the treatment and stabilization of an emergency medical condition; and
- following treatment or stabilization of an emergency medical condition, services originating in a hospital emergency facility or freestanding emergency medical care facility or comparable emergency facility.

8. CLAIM PROCEDURE

8.1 NECESSITY OF FILING CLAIMS

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.

8.2 EFFECT OF FAILURE TO FILE CLAIM WITHIN 90 DAYS

Failure to submit written proof of and claim for payment within the 90 day period shall not invalidate or reduce 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 Insurance Company of Scott & White, Attn: Claims Dept., 1206 West Campus Drive Temple, TX 76502. Unless You do not have the legal capacity to provide proof of loss, Health Plan will not have any obligation under this paragraph if such proof of and claim for payment is not received by Health Plan within one (1) year of the date the services were provided to You or Your Covered Dependent.

8.3 ACKNOWLEDGEMENT OF CLAIM

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

8.4 ACCEPTANCE OR REJECTION OF CLAIM

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

8.5 PAYMENT OF CLAIMS

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

8.6 PAYMENT TO PHYSICIAN OR PROVIDER

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

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

8.7 LIMITATIONS TO 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.

8.8 PAYMENT TO TEXAS DEPARTMENT OF HUMAN SERVICES

Health Plan shall pay to the Texas Department of Human Services the actual costs of medical expenses the Texas Department of Human Services pays through medical assistance on your behalf, if under this Certificate of Coverage, You or a covered person is entitled to payment for the medical expenses.

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 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.

8.9 PAYMENT TO A MANAGING CONSERVATOR

Benefits paid on behalf of a Covered Dependent child may be made to 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 Network 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.

8.10 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.

9. EFFECT OF MEDICARE, SUBROGATION AND COORDINATION OF BENEFITS

9.1 EFFECT OF MEDICARE

Regardless of any other provisions of this Agreement to the contrary, on and after the first day You or a Covered Dependent become entitled to coverage under Medicare and Medicare would be the primary payor of benefits, Your or Your Covered Dependent shall be reduced by the amount that would have been paid by Part B unless:

1) You and Your Covered Dependent shall qualify for, and remain continuously qualified for, coverage under both Part A and Part B of Medicare; and
2) You shall pay the required premiums for Medicare coverage; and
3) You shall cooperate fully in the coordination of Your health care benefits, including coverage under Medicare, in accordance with the other terms of this Agreement, and perform such acts as shall be necessary and desirable to facilitate the maximum reimbursement by Medicare to Health Plan, and Network Providers for the services provided.

9.2 SUBROGATION/LIEN/ASSIGNMENT/REIMBURSEMENT

If the Health 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 Health Plan will be subrogated to all rights of recovery of Covered Employee or Covered Dependent, to the extent of such benefits provided or the reasonable value of services or benefits provided by the Health Plan up to the maximum amount allowed by Texas law. The Health Plan, once it has provided any benefits, is granted a lien on the proceeds of any payment, settlement, judgment, or other remuneration received by Covered Employee or Covered Dependent 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 only if You or Your immediate family did not pay the premiums for the coverage;
- no fault insurance coverage, such as personal injury or medical payments protection only if You or Your immediate family did not pay the premiums for the coverage;
- 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 Covered Employee or Covered Dependent as compensation, restitution, remuneration for injuries sustained or illness suffered as a result of the negligence or liability, including contractual, of any individual or entity;
- any source that reimburses, arranges, or pays for the cost of care.

9.2.1 Assignment

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

No Covered Employee or Covered Dependent 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 Health Plan and/or the Plan administrator.

9.2.2 Reimbursement

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

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

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

9.2.3 Health Plan's Actions

The Health 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 Covered Employee's or Covered Dependent's behalf, against the responsible party or his insurance company and/or anyone listed herein;
- cease paying the Covered Employee's or Covered Dependent's benefits until the Covered Employee or Covered Dependent provides the Health Plan with the documents necessary for the Health Plan to exercise its rights and privileges; and
- the Health Plan may take any further action it deems necessary to protect its interest.

9.2.4 Right to Recover

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 Maximums 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 covered dependents to discuss any outstanding balance owed to the Plan.

Obligations of the Covered Employee or Covered Dependent to the Health Plan

- If a Covered Employee or Covered Dependent receives services or benefits under the Health Plan, the Covered Employee or Covered Dependent must immediately notify the Health Plan of the name of any individual or entity against whom the Covered Employee or Covered Dependent 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 Covered Employee or Covered Dependent intends to make a claim. For example, if Covered Employee or Covered Dependent is injured in an automobile accident and the person who hit the Covered Employee or Covered Dependent was at fault, the person who hit the Covered

Employee or Covered Dependent is a person whose act or omission has caused the Covered Employee's or Covered Dependent's illness or injury.

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

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

- The Covered Employee or Covered Dependent authorizes the Health Plan 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 Covered Employee or Covered Dependent and/or Health Plan. The Covered Employee or Covered Dependent agrees to fully cooperate with the Health Plan in the prosecution of such a claim. The Covered Employee or Covered Dependent agrees and fully authorizes the Health Plan to obtain and share medical information on the Covered Employee or Covered Dependent necessary to investigate, pursue, sue, compromise and/or settle the above-described claims. The Health Plan is specifically granted by the Covered Employee or Covered Dependent the authorization to share this information with those individuals or entities responsible for reimbursing the Health Plan through claims of subrogation, lien, assignment or reimbursement in an effort to recoup those funds owed to the Health Plan. This authorization includes, but is not limited to, granting to the Health Plan the right to discuss the Covered Employee's or Covered Dependent'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 Health Plan to investigate, pursue, sue, compromise, prosecute and/or settle the above-described claims, the Covered Employee or Covered Dependent agrees to sign such medical authorization or any other necessary documents needed to protect the Health Plan's interests.

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

- The Covered Employee or Covered Dependent agrees to obtain consent of the Health 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 Covered Employee or Covered Dependent also agrees to refrain from taking any action to prejudice the Health Plan's recovery rights.

- Furthermore, it is prohibited for Covered Employee or Covered Dependent 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 Covered Employee or Covered Dependent to waive a claim for medical expenses incurred by a Covered Employee or Covered Dependent who are minors.

- To the extent that a Covered Employee or Covered Dependent makes a claim individually or by or through an attorney for an injury or illness for which services or benefits were provided by the Health Plan, the Covered Employee or Covered Dependent agrees to keep the Health 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 Health Plan to pursue the Covered Employee's or Covered Dependent's claim against any party for damages or claims or causes of action that the Covered Employee or Covered Dependent might have against such party as a result of injury or illness.

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

9.2.5 Made Whole Doctrine

The Health 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 Covered Employee or Covered Dependent be "made whole" before the Health Plan is reimbursed. The Health Plan has the right to be repaid up to the maximum allowed under Texas law first from any settlement, judgment, remuneration, insurance proceeds or other source of funds a Covered Employee or Covered Dependent receives. The Health 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 Health Plan has the right to be reimbursed first whether or not a Covered Employee or Covered Dependent makes a claim for medical expenses.

9.2.6 Attorneys' Fees

The Health Plan will not be responsible for any expenses, fees, costs or other monies incurred by the attorney for the Covered Employee or Covered Dependent and/or his or her beneficiaries, commonly known as the common fund doctrine. The Covered Employee or Covered Dependent is specifically prohibited from incurring any expenses, costs or fees on behalf of the Health Plan in pursuit of his rights of recovery against a third-party or Health 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 Health Plan's recovery without prior, express written consent of the Plan.

A Covered Employee or Covered Dependent must not reimburse their attorney for fees or expenses before the Health Plan has been paid in full. The Health Plan has the right to be repaid first from any settlement, judgment, or insurance proceeds a plan participant receives. The Health 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.

9.2.7 Wrongful Death/Survivorship Claims

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

9.2.8 Death of Covered Employee or Covered Dependent

Should a Covered Employee or Covered Dependent die, all obligations set forth herein shall become the obligations of his/her heirs, survivors and/or estate

9.2.9 Control of Settlement Proceeds

A Covered Employee or Covered Dependent 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 Covered Employee or Covered Dependent agrees that they have actual control over the settlement proceeds from the underlying tort or first party claim from which they are to reimburse the plan whether or not they are the individual or entity to which the settlement proceeds are paid.

9.2.10 Payment

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

The fact that the Health Plan does not assert or invoke its rights until a time after a Covered Employee or Covered Dependent, acting without prior written approval of the authorized Health 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 Covered Employee or Covered Dependent of his/her obligation to reimburse the Health Plan in the full amount of the Plan's rights.

9.2.11 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 Certificate of Coverage. The Certificate of Coverage shall be construed and enforced as if such invalid or illegal sections had never been inserted.

9.2.12 Incurred Benefits

The Health 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 Health Plan discovers that the Covered Employee or Covered Dependent has been involved in an injury or accident and may be compensated by one of the sources set forth herein. Should this occur, the Covered Employee or Covered Dependent is deemed to have incurred the full billed charges or the full cost of the benefits or services rendered**.**

9.2.13 Non-exclusive Rights

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

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

9.3 COORDINATION OF THIS PLAN'S BENEFITS WITH OTHER BENEFITS

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

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

Definitions

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

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

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

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

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

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

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

9.4 FACILITY OF PAYMENT

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

9.5 RIGHT OF RECOVERY

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

10. RECORDS

10.1 RECORDS MAINTAINED BY HEALTH PLAN

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

10.2 NECESSITY OF REQUESTED INFORMATION

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

10.2.1 Authorization for Health Care Information from Physicians and Providers

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

10.3 NOTIFICATION OF CHANGES IN STATUS

You shall notify Health Plan immediately in writing of any fact which may affect 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;
- coverage under another plan which may be subject to coordination of benefits; and
- eligibility for recovery from a third party of benefits which may be subject to subrogation.

11. COMPLAINT PROCEDURE

11.1 PURPOSE

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

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

11.2 COMPLAINTS

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

11.2.2 Health Plan will acknowledge, investigate, and resolve all Complaints within thirty (30) calendar days after the date of receipt. However, investigation and resolution of Complaints concerning emergencies or denials of continued stays for hospitalization shall be concluded in accordance with the immediacy of the case and will not exceed one (1) business day from receipt of the Complaint. Dissatisfaction or disagreement with an Adverse Determination is considered an appeal and is not included in this process.

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

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 Network Providers are independent contractors. Health Plan is not an agent of any Network Provider, nor is any Network Provider an agent of the Health Plan.

12.2.2 Network 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 Network 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 Network Providers. No Contract Holder or Covered Person shall be liable for any acts or omissions of any Network 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 Network 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. Any retroactive changes in eligibility or coverage by a Group for any of its Covered Persons must be approved by the Health Plan, and the liability of Health Plan to refund Premiums for any Covered Person whose coverage is terminated or changed to a different category shall be no greater than two months premium paid by or on behalf of the Covered Person. Health Plan may consider any amounts paid for Covered Services for any period for which the Covered Person's premium was refunded as a Required Payment.

12.4 ENTIRE AGREEMENT

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

12.5 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 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 Contract Holder or Covered Person any overpayment or other inappropriate payment, including, but not limited to, a payment for non-Covered Services or services rendered to a person who was ineligible for group coverage at the time services were provided (collectively, "Excess Payments"). Failure by the Contract Holder or Covered Person to remit any Excess Payments to Insurance Company of Scott and White may result in legal action by Insurance Company of Scott and White.

12.9 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 Drive
Temple, Texas 76502

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

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

12.10 INCONTESTABILITY

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

1) it is in a written Application signed by You,

2) a signed copy of the Application is or has been furnished to You, and

3) within the first two years of the issue date, it is an intentional misrepresentation that is material to Our agreement to issue this Policy, or after two years, the application contains a fraudulent misstatement.

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

12.11 PROOF OF COVERAGE

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

12.12 IDENTIFICATION CARD

Health Plan shall issue an identification card which will provide information regarding the type of coverage held and such other information as required by law or relevant regulations. Such cards are the property of the Health Plan and are for identification purposes only. Possession of a Health Plan identification card confers no right to services or other benefits under this Agreement. To be entitled to such services or benefits the holder of the card must, in fact, be a 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.

12.13 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.

13. DESCRIPTION OF BENEFITS

13.1 WHAT'S COVERED

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

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

You and Your Covered Dependent's entitlement to Health Care Services is contingent upon such services being determined as Medically Necessary, not Experimental or Investigational, and prescribed or ordered by, a licensed physician or provider. Health Care Services are also contingent upon all definitions, terms, conditions, and limitations on Health Care Services set forth in all parts of this Agreement being met. In order to receive these Health Care Services, You must pay the Copayments, Coinsurance and Deductibles specified in the Schedule of Benefits and any amendments and riders to this Agreement. You may select a Primary Care Physician for You and Your Eligible Dependents.

13.2 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 an additional Copayment. If special Copayment rules apply, those rules will be explained in that specific benefit section.

13.3 OUT-OF-POCKET MAXIMUM

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

13.4 BENEFIT LIMITATIONS

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

13.5 UTILIZATION REVIEW

Certain services require Preauthorization in order to be covered. Typically, Your Provider will request Preauthorization on Your behalf. Preauthorized services based on Medical Necessity and Experimental/Investigational Procedures will only be denied or reduced if the physician or provider has materially misrepresented the proposed services or has substantially failed to perform the preauthorized services.

13.5.1 Services Requiring Preauthorization

Some procedures and surgeries require Preauthorization. Failure to obtain Preauthorization may result in a reduction or denial of benefits under this Agreement.

The Insurance Company of Scott and White Health Services Division has the responsibility of issuing Preauthorization.

For a complete list of Health Care Services subject to Preauthorization, visit Our website at www.swhp.org or call Us at the contact information shown in the Toll-Free Notice. Failure to obtain Preauthorization will result in the lesser of $500 or 50% reduction in benefits, or denial in the case of Health Care Services, other than Emergency Care, provided by an In-Network Provider. If We deny payment to an In-Network Provider based on failure to obtain Preauthorization, the penalty applies to the In-Network Provider, but You will not be balance billed for such Health Care Services.

Approval will be provided only when:

- The services are Medically Necessary as determined by ICSW;
- The services are not Experimental and Investigational; and
- The services are determined by ICSW to be eligible under this Plan.

Utilization Review may be undertaken:

- At least three working days before a non-Emergency Hospital or Ambulatory Surgical Center admission or any of the specified services, if specified on the Schedule of Benefits. This is known as preauthorization (see below).
- Before a Hospital or Ambulatory Surgical Center admission or any of the specified services, if specified on the Schedule of Benefits. This is known as admission review (see below).
- During a Hospital stay. This is known as continued stay review (see below).
- Following discharge from a Hospital or an Ambulatory Surgical Center or after any of the specified services are performed, if specified on the Schedule of Benefits, or when a claim for benefits is made. This is known as a retrospective review (see below).

Preauthorization

You are always responsible for initiating preauthorization. To initiate preauthorization, instruct Your Physician to call Us at the telephone number shown in the Contact Information section of this Policy at least 3 calendar days prior to any admission or scheduled date of a proposed service requiring preauthorization.

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

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

Non-Urgent Preauthorization

When You submit a request for benefits for services not included in Post-Stabilization Treatment or Life Threatening Condition authorization or Concurrent Hospitalization Care authorization, a determination will be issued and transmitted not later than the third calendar day after the date the request is received by ICSW.

Concurrent Hospitalization Care Preauthorization

If the proposed services are for concurrent hospitalization care, a determination will be issued and transmitted within 24 hours of receipt of the request, followed within three working days after the transmittal of the determination by a letter notifying You or the individual acting on Your behalf and the provider of record of an adverse determination.

Post-Stabilization Treatment or Life Threatening Condition Authorization
If the proposed services involve post-stabilization treatment, or a life-threating condition, a determination will be issued and transmitted within the time appropriate to the circumstances relating to the delivery of the services and Your condition, but in no case to exceed one hour from receipt of the request. The determination shall be provided to the provider of record. At the time of notification of an adverse determination, You or an individual acting on Your behalf and Your provider of record shall be provided notice of the independent review process and a copy of the request for a review by an independent review organization form. A life-threatening condition means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. The existence of a life-threatening condition shall be determined on the basis that a prudent layperson possessing an average knowledge of medicine and health would believe that the enrollee's disease or condition is a life-threatening condition.

Admission Review
If preauthorization is not performed, We will determine at the time of admission if the Hospital or Ambulatory Surgical Center admission or specified non-Emergency outpatient surgery or diagnostic procedure is Medically Necessary.

13.5.2 Continued Stay or Course of Treatment Review

1. Continued Stay. We also will determine if a continued Hospital or Skilled Nursing Facility stay is Medically Necessary. We will provide notice of Our determination within 24 hours by either telephone or electronic transmission to the provider of record, followed by written notice within three working days to You and Your provider of record. If We are denying post-stabilization care subsequent to Emergency treatment, We will notify the treating Physician or other provider within one hour after the request for approval is made. If We issue an Adverse Determination in response to a request for post-stabilization treatment or a request for treatment involving a life-threatening condition, We will provide the Covered Person, and the Covered Person's provider of record, notification relating to Independent Review of Adverse Determinations.

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.

2. Concurrent Care Decisions. Request for Approval of Additional Benefits. If, while You are undergoing a Course of Treatment for an Illness or Injury for which ICSW has approved benefits, You would like to request an approval of benefits for additional treatments (extension of benefits):

- You must make a request to ICSW for the additional benefits prior to the end of the initially prescribed and approved Course of Treatment.
- If ICSW receives Your request for additional benefits at least 24 hours prior to the end of the initially prescribed and previously approved Course of Treatment, We must notify You of Our decision regarding Your request within 24 hours of receipt of the request, if Your request is for urgent care benefits.
- If ICSW denies Your request for additional benefits, in whole or in part, We must explain the reason for the Adverse Determination and the Plan provisions upon which the decision was based.
- You may appeal the Adverse Determination according to the rules for an appeal.

3. Concurrent Care Decisions. Reduction or End of Benefits. If, after approving a request for benefits in connection with Your Illness, Injury, disease or other condition, ICSW decides to reduce or end these benefits, in whole or in part:

- ICSW must notify You sufficiently in advance of the reduction in, or end of benefits to allow You the opportunity to appeal that decision before the reduction in, or end of, benefits occurs. The notice will explain the reason for reducing or ending Your benefits and the plan provisions upon which the decision was made.

- If ICSW receives Your appeal for benefits prior to the reduction in, or end of, benefits, We must notify You of Our decision regarding Your appeal within 24 hours of receipt of the appeal. If ICSW denies Your appeal of the decision to reduce or end Your benefits, in whole or in part, We must explain the reason for the Adverse Determination and the plan provisions upon which the decision was based.
- You may further appeal the Adverse Determination according to the rules for appeal.
- ICSW may not deny or reduce previously preauthorized benefits based on medical necessity, appropriateness, experimental, or investigational nature, unless the physician or provider has materially misrepresented the proposed services or failed to perform the proposed services.

13.5.3 Retrospective Review/Non-Urgent Care - Post Service (after care has been received)

If neither preauthorization, 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 an 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.

Note: Under ERISA rules, a post-service claim is any claim for benefits that is not a pre-service claim.

Note: All days referred to are defined as calendar days.

When You submit a claim:

- ICSW must notify You in writing within 30 days of receipt of Your claim as to what We determine Your benefits to be. This period may be extended one time for up to 15 days provided We determine that an extension is necessary due to matters beyond Our control, and notify You prior to the expiration of the initial 30 day period as to the circumstances requiring the extension of time and the date by which We expect to render a decision.
- In no case may ICSW take more than 45 days to make a determination on Your claim.
- If Your claim does not contain all the necessary information, ICSW must notify You in writing within 30 days of receipt of Your claim as to what information is needed to make a determination on Your claim.
- You have 45 days from receipt of this notice to provide to ICSW the information needed to make a determination on Your claim. The time period during which ICSW is waiting for receipt of the necessary information is not counted toward the time frame during which ICSW must make a benefit determination.

If Your claim is denied in whole or in part:

- ICSW must provide written notice of the Adverse Determination to You within the time frame stated above after receiving all the information needed to make a determination on Your claim, if the information is received in a timely manner. The notice will explain the reason for the Adverse Determination and the plan provisions upon which the denial decision is based.
- You have 180 days from receipt of ICSW's Adverse Determination on Your claim to appeal ICSW's decision. You must submit Your appeal orally by calling Customer Service 800-321-7947, or in writing to ICSW 1206 West Campus Drive, Temple, Texas 76502.
- Within five (5) working days of receipt of a written request for an appeal, ICSW will acknowledge the request. The acknowledgement will provide the procedures for the appeal, advise if additional documents are necessary and, when the appeal is received orally, provide a one-page appeal form to the Covered Person.
- Within 30 days of receipt of Your oral or written appeal, ICSW must notify You in writing of its decision on Your appeal.
- If an appeal is denied, ICSW's notice will include a clean and concise statement of the clinical basis for the denial and right to seek review of the denial from an Independent Review Organization as outlined below. If a Covered Person has a life threatening condition, or in circumstances involving prescription drugs or

intravenous infusions, he/she has the right to an immediate review by an Independent Review Organization and he/she is not required to first request an internal review by ICSW.

- If Your appeal does not result in a reversal of the Adverse Determination and, Your Employer's Plan is subject to ERISA, You may bring a civil action under ERISA section 502(a) in federal court.

Note: You, Your beneficiary, or a duly authorized representative may appeal any Adverse Determination on a claim for benefits with ICSW and request a review of the Adverse Determination. In connection with such a request, documents pertinent to the administration of the Plan may be reviewed free of charge, and issues outlining the basis of the appeal may be submitted. You may have representation throughout the appeal and review procedure.

13.5.4 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 physician 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 Covered 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 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 working days in other circumstances.

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

13.5.5 Appeal of Adverse Determinations

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

Health Plan will issue a response letter to the patient or a person acting on behalf of the patient, and the patient's physician or health care provider, explaining the resolution of the Appeal; and provide written notification to the

appealing party of the determination of the Appeal, as soon as practical, but in no case later than thirty (30) calendar days after the date the Health Plan receives the oral or written Appeal or one-page Appeal form from the Complainant. If the Appeal is denied, the written notification shall include a clear and concise statement of:

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

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

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

Notwithstanding any other law, 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 Certificate of Coverage.

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 Certificate of Coverage.

13.5.6 Independent Review of Adverse Determinations

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 administered 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.

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

- 45 days after the receipt of the request for external review;
- 72 hours for determination that involve a medical condition that would seriously jeopardized 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 the Covered Person and the Experimental or Investigational nature of health care items and services for the Covered Person. Exceptions for non-formulary prescription drugs will be provided for the duration of the prescription, including refills, or the duration of the exigency.

13.5.7 Binding Arbitration

If You are enrolled in a plan provided by Your employer that is subject to ERISA, any dispute involving an Adverse Determination must be appealed under claims procedure rules outlined above. After the Covered Person has followed the appeal procedures, any dispute regarding an adverse benefit determination may be submitted to voluntary binding arbitration, if both parties agree.

For a Covered Person enrolled in an Employer plan subject to ERISA, any dispute regarding an adverse benefit determination, or any dispute which does not involve an adverse benefit determination; or for a Covered Person enrolled in an Employer plan not subject to ERISA, any dispute, may be subject to binding arbitration if:

- the mediation or arbitration will be conducted pursuant to the applicable commercial rules of the American Arbitration Association and applicable Texas statutes governing such mediation or arbitration; and
- will be binding if both parties agree to mediation or arbitration; and
- mediation or arbitration will occur in the county where the Covered Person, or if applicable the beneficiary, resides; and
- if the amount in dispute exceeds the jurisdictional limits of the small claims court.

Under this coverage, if binding arbitration is agreed to by both parties, the arbitration findings will be final and binding. We will pay the cost of arbitration. Any disputes regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

13.6 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.

13.7 BENEFITS

13.7.1 MEDICAL SERVICES

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

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

- physical exams for medical or diagnostic purposes (other than preventive exams),
- newborn hearing screenings,
- necessary diagnostic follow-up care,
- office visits,
- consultations by specialists,
- Treatment for diseases of the eye,
- outpatient surgery,
- dialysis,
- injections,
- chemotherapy and radiation therapy for cancer,
- allergy tests, and
- home health care.

13.7.1.1 Other Outpatient Services

Medical Services that are not specifically listed on the description above which may result in separate additional Copayments or limits if so listed in the Schedule of Benefits.

13.7.1.2 Copayments

Medical Services are subject to the applicable Copayment listed in the Schedule of Benefits. For Medical Services provided during an Office Visit, You or Your Covered Dependent may be responsible for both an office visit Copayment and a Copayment for the other Medical Services rendered in connection with the Office Visit. This is particularly true when You are subject to a percentage Copayment and may vary depending upon Your health care provider's method of billing.

13.7.2 PREVENTIVE CARE SERVICES

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

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

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

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

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

The determination of whether a service is a Preventive Care Service may be influenced by the type of service for which your Physician or Provider bills the Health Plan. Specifically (1) if a recommended preventive service is billed

separately from an office visit, then a plan may impose cost-sharing requirements with respect to the office visit, (2) if a recommended preventive service is not billed separately from an office visit and the primary purpose of the office visit is the delivery of a preventive service, then a plan may not impose cost-sharing requirements with respect to the office visit, and (3) if a recommended preventive service is not billed separately from an office visit and the primary purpose of the office visit is not the delivery of a preventive service, then Health Plan may impose cost-sharing requirements with respect to the office visit.

Coverage of Counseling for a particular condition or disease as a Preventive Care Service does not equate to treatment of that particular condition or disease. While the counseling visit may be considered to be a Preventive Care Service and thus not subject to Deductibles or 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.

13.7.2.1 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 examinations of a newborn child.

13.7.2.2 Prostate Cancer Screening Exam

You and Your Covered Dependents, if male, are eligible for an annual screening exam to detect prostate cancer. The benefits provided under this subparagraph include the following once per Calendar Year: (1) a physical examination to detect prostate cancer, (2) a prostate-specific antigen test for a male Member who is at least 50 years of age with not symptoms or who is at least 40 years of age and has a family history or prostate cancer or another prostate cancer risk factor.

13.7.2.3 Colorectal Cancer Screening

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

13.7.2.4 Exam for Detection and Prevention of Osteoporosis

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

13.7.2.5 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 or 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 screen, with an average radiation exposure deliver of less than one rad mid breast and two views of each breast; digital mammography; or breast tomosynthesis.

13.7.2.6 Ovarian Cancer Screening Test

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

13.7.2.7 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 Dependents as prescribed by a Participating Physician.

13.7.3 HOSPITAL SERVICES

You and Your Covered Dependents are entitled to the Medically Necessary services of any Network 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.

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

- semi-private room,
- inpatient meals and special diets, when medically necessary,
- inpatient medications and biologicals,
- intensive care units,
- nursing care, including special duty nursing, when medically necessary,
- short term rehabilitation therapy services in the acute hospital setting,
- inpatient lab, x-ray and other diagnostic tests,
- skilled nursing facility care,
- inpatient medical supplies and dressings,
- anesthesia,
- inpatient oxygen,
- operating room and recovery room,
- inpatient physical therapy,
- inpatient radiation therapy,
- inpatient inhalation therapy,
- administration of whole blood and blood plasma.

13.7.4 EMERGENCY CARE SERVICES

13.7.4.1 Qualification of Emergency Services

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

13.7.4.2 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.

13.7.4.3 Emergency Transportation Services

Emergency transportation, when and to the extent it is Medically Necessary, is covered when transportation in any other vehicle would endanger the patient's health. Health Plan will not cover air transportation if ground transportation is medically appropriate and more economical. If these conditions are met, Health Plan will cover ambulance transportation to the closest appropriate hospital or skilled nursing facility.

13.7.4.4 Emergency Medical Services

Emergency medical services provided by ambulance personnel for which transport is unnecessary or is declined by Covered Person will be subject to the Copayment listed in the Schedule of Benefits. If the ambulance transports the Covered Person after receiving emergency medical services from ambulance personnel, the Emergency Medical Services Copayment is waived.

13.7.4.5 Hospitalization at Other Than Network Hospital

If You or Your Covered Dependent is hospitalized at other than a Network Hospital, You must notify Health Plan within twenty-four (24) hours of admission or as soon thereafter as it is reasonably possible, and Health Plan shall provide information about its obligations under this Agreement. For any period after You could reasonably be expected to transfer to a Network Hospital, payments will be made at the Non-Network level of benefits

13.7.4.6 Transportation to Participating Facility After Stabilization

Once You or Your Covered Dependent's condition is stabilized and as medically appropriate, the Health Plan upon authorization of a Medical Director may facilitate transportation to an In-Network facility when medically appropriate. Where stabilization of an emergency condition originates in a hospital emergency facility or comparable facility, Treatment following such stabilization may require approval by Health Plan. The treating physician or provider must make the request for post-stabilization care. Health Plan will approve or deny such request within the time appropriate to the circumstances related to the delivery of services and the condition of the patient but in no event to exceed one hour for the time of the request.

13.7.5 MENTAL HEALTH CARE

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

13.7.5.1 Outpatient Mental Health Care

For the Treatment of mental illness, You or Your Covered Dependents are entitled to outpatient diagnostic and therapeutic.

13.7.5.2 Inpatient Mental Health Care

For the Treatment of mental illness, You or Your Covered Dependents are entitled to inpatient diagnostic and therapeutic.

13.7.5.3 Copayments and Deductibles on Mental Health Care

For Outpatient mental health care, You are required to pay the Copayment for each outpatient mental health care visit to or by a health care provider.

The Deductible, Coinsurance and Copayment will be the same as for any other physical illness.

You are required to pay the Copayment for each day of inpatient mental health care with a Network Provider as stated in the Schedule of Benefits.

The Deductible, Coinsurance and Copayment will be the same as for any other physical illness.

13.7.5.4 Psychiatric Day Treatment Facility

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

13.7.5.5 Residential and Stabilization Mental Health Treatment

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

1) as determined by a Physician specializing in psychiatry, You or Your Covered Dependents have a serious mental illness which substantially impairs thought, perception of reality, emotional process, or judgment or grossly impairs behavior as manifested by recent disturbed behavior and which would otherwise necessitate confinement in a hospital if such care and Treatment were not available through a Crisis Stabilization Unit or Residential Treatment Center for Children and Adolescents; and
2) providers of services for which benefits are to be paid must be licensed or operated by the appropriate state agency or board to provide those services.

13.7.5.6 Serious Mental Illness

Treatment for Serious Mental Illness, which includes Medically Necessary Medical Services and Hospital Services, shall be provided under this Agreement as indicated in the Schedule of Benefits.

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

13.7.5.7 Copayments for Serious Mental Illness

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

13.7.6 TREATMENT FOR CHEMICAL DEPENDENCY

13.7.6.1 Treatment for Chemical Dependency

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

13.7.6.2 Copayments and Deductibles for Chemical Dependency

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

13.7.7 REHABILITATION AND HABILITATIVE THERAPY

13.7.7.1 Rehabilitative and Habilitative Therapy

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

13.7.7.2 Early Childhood Intervention Services

Medically Necessary Covered Rehabilitative and Habilitative 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.

13.7.8 HOME HEALTH SERVICES

Home health services consist of Medically Necessary nursing care that is recommended by a designated physician, approved in advance by the Medical Director, and 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 are required to remain at home for medical reasons. The designated physician and Medical Director shall determine the conditions under which all Medically Necessary services shall be provided. Examples of such conditions include, but are not limited to, the following: duration of care; setting, such as inpatient institutional care rather than home care; type of care, such as nursing care or physical therapy; and frequency of care, such as daily or weekly. Home health services shall not be covered for Custodial Care or primarily for convenience, as determined by the Medical Director.

Subject to any limits on the maximum number of days for which a Copayment is required, You are required to pay a Copayment for each day of Home Health Services as stated in the Schedule of Benefits.

13.7.9 HOME INFUSION THERAPY BENEFIT

As recommended by a physician and subject to any Preauthorization requirements, 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.

13.7.9.1 Copayments for Home Infusion Therapy Benefits

Subject to any limits on the maximum number of days for which a Copayment is required, You are required to pay a Copayment for each day of Home Infusion Therapy as stated in the Schedule of Benefits.

13.7.10 HOSPICE SERVICES

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

13.7.10.1 Copayments for Hospice Benefits

Subject to any limits on the maximum number of days for which a Copayment is required, You are required to pay a Copayment for each day of Hospice Services as stated in the Schedule of Benefits.

13.7.11 MATERNITY SERVICES

13.7.11.1 Maternity Services

Maternity services include physician obstetrical care, labor and delivery services, hospital room and board for the mother, and the care of complicated pregnancies in conjunction with the delivery of a child or children by You or Your Covered Dependent.

Complications of pregnancy shall not be treated differently from any other illness or sickness under this Certificate of Coverage. "Complications of pregnancy" means conditions, requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, 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, but shall not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsis, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

13.7.11.2 Inpatient Maternity Services

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

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

13.7.11.3 Copayments for Maternity Services

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

13.7.12 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,
- tubal ligations, and
- laparoscopies.

13.7.13 DURABLE MEDICAL EQUIPMENT/ORTHOTICS/PROSTHETIC DEVICES

Subject to any preauthorization Requirements, and as prescribed by a physician, Medically Necessary Durable Medical Equipment, Prosthetic Devices, or Orthotic Devices may be covered under this Agreement. The Medical Director 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 Year specified in the Schedule of Benefits.

13.7.13.1 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.

13.7.13.2 Durable Medical Equipment

Durable Medical Equipment shall be covered under this Agreement if determined as Medically Necessary by the Medical Director. Ostomy supplies are considered Durable Medical Equipment for purposes of this Provision. DME may be covered as a purchase 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 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 Network 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 Year specified in the Schedule of Benefits.

13.7.13.3 Prosthetic Devices

Prosthetic Devices may be covered under the conditions determined by the Medical Director and as are Medically Necessary to replace defective parts of the body following injury or illness provided that Limb Prosthetics shall be covered as are Medically Necessary. Health Plan shall cover the initial device, which shall be limited to the most appropriate model that adequately meets the medical needs of the covered person as determined by the treating provider, replacements due solely to growth, other Medically Necessary replacements for medical reasons and normal repairs unless the repair or replacement is necessitated by misuse or loss. Health Plan shall provide coverage for Limb Prosthetics that are Medically Necessary 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 Year, subject to the applicable Copayments, specified in the Schedule of Benefits.

13.7.13.4 Orthotic Devices

Health Plan shall provide coverage for Orthotic Devices that are Medically Necessary. Health Plan shall cover the initial device, which shall be limited to the most appropriate model that adequately meets the medical needs of the covered person as determined by the treating provider.

Medically Necessary replacements for medical reasons and normal repairs unless the repair or replacement is necessitated by misuse or loss. Health Plan shall provide coverage for Orthotic Devices, subject to the applicable Copayments specified in the Schedule of Benefits.

13.7.13.5 Hearing Aids and Cochlear Implants

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

- filing and dispensing services and the provision of ear molds as necessary to maintain optimal fit of hearing aids;
- any treatment related to hearing aids and cochlear implants, including coverage for habilitation and rehabilitation as necessary for educational gains; and
- for a cochlear implant, an external speech processor and controller with necessary component replacements 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 audiologically necessary. Coverage is subject to all of the requirements of the health plan and doesn't include replacement hearing aid batteries. Prior authorization by the health plan is required.

13.7.14 COVERAGE OF PRESCRIPTION DRUGS

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

13.7.14.1 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; which are prescribed by:

a. a Health Professional, or
b. in connection with emergency Treatment, a Health Professional in attendance on You or Your Covered Dependent at an emergency facility.

As medically appropriate, the Medical Director may require the substitution of any drug for another drug or form of Treatment which, in the Medical Director's opinion based upon the recommendations of the Pharmacy and Therapeutics Committee or the Pharmacy and Therapeutics subcommittee, provides equal or better results for less 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.

13.7.14.2 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 a 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 no approved, or prescription drug reference compendia or peer reviewed medical literature has not deemed as a medically-accepted use for the proposed indication.

13.7.14.3 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.

13.7.14.4 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.

13.7.14.5 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 preferred 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 not on the preferred generic or preferred brand tiers on the Health Plan formulary, which are alternate choice drugs or other drugs for some medical conditions not treated by drugs on the preferred tiers, 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 may be 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, the following criteria must be met:

1.1 One of the following:

1.1.1 Failure or contraindication or intolerance to at least three equivalent formulary drugs. If only one or only two equivalents are available, the failure or contraindications or intolerance to all available equivalent formulary drugs.

OR

1.1.2 No formulary drug is appropriate to treat condition

AND

1.2 One of the following:

1.2.1 Both of the following:

1.2.1.1 Requested drug is FDA-approved for the condition being treated

AND

1.2.1.2 Additional requirements listed in the "Indications and Usage" sections of the prescribing information (or package insert) have been met

OR

1.2.2 If requested for an off-label indication, meets coverage criteria

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

1) the use of the formulary alternative(s) is contraindicated;
2) the formulary alternative(s) would cause or has caused adverse effects;
3) the use of the formulary alternative(s) would not be as effective as the non-formulary drug.

The prescribing Health Professional must submit a written request for preauthorization 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 13.4 UTILIZATION REVIEW REQUIREMENTS, of the Certificate of Coverage).

13.7.14.6 Inpatient Prescription Drugs

Prescription Drugs, including Specialty Pharmacy Drugs, administered while admitted to a Network 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.

13.7.14.7 Outpatient Specialty Pharmacy Drugs

Outpatient prescription drugs designated on the drug formulary as Specialty Pharmacy drugs are covered under this Agreement, subject to the Outpatient 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.

Specialty Pharmacy Drugs may require preauthorization by a Medical Director or be subject to medical coverage requirements.

This Agreement excludes Outpatient Specialty Pharmacy drugs that:

1) do not meet the definition of Specialty Pharmacy Drugs, or
2) are not dispensed and administered in the office of a Provider's or other Outpatient setting.

13.7.14.8 Outpatient Non-specialty Pharmacy Drugs Administered In Outpatient Setting

Outpatient Prescription Drugs which do not meet the definition of Specialty Pharmacy Drugs and which are dispensed and administered to 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. Outpatient 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 may require preauthorization by a Medical Director.

Outpatient Prescription Drugs which do not meet the definition of Specialty Pharmacy Drugs and which are dispensed by a pharmacy and administered to You or Your Covered Dependent in the office of a Provider, or in another Outpatient setting, require approval of a Medical Director. Without the prior approval of a Medical Director, coverage for Outpatient Prescription Drugs which do not meet the definition of Specialty Pharmacy Drugs and are dispensed by a pharmacy and administered by a Provider are subject to the Copayments, Coinsurance, and Deductibles described in this Prescription Drug Benefit.

Outpatient 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.

13.7.14.9 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.

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

If coverage for a particular drug or quantity of drug is denied, You and Your Health Professional may appeal the denial (see Section 13.4, 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.

13.7.14.10 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, glucometers, and asthma spacers;
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 effective NOTE: Denials based upon experimental or investigational reasons 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 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, except if drug is listed on Health Plan formulary;
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. biological products; or
l. 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
m. a prescription that has an over the counter alternative;
n. drugs for the treatment of sexual dysfunction, or inadequacy

13.7.14.11 Refill Limitations

Refill prescription will not be covered until either of the following events occurs:

1) You or Your Covered Dependent's existing supply of the prescription will be depleted in less than 10 days; or
2) You or Your Covered Dependent's existing supply is less than 50% of the refill prescription amount.

These limitations will be calculated based upon the prescription being taken at the prescribed dosage and appropriate intervals. However, the Pharmacy Director may make exceptions to these limitations for appropriate reasons.

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;
  - no 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.

13.7.14.12 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 qualify for synchronization refills 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 dispensed in accordance with medication synchronization plans; and
- are not a schedule II or III controlled substance containing hydrocodone.

13.7.14.13 Copayments, Coinsurance, Deductible

You must pay the Copayment or Coinsurance per quantity dispensed per prescription 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. The amount You pay for a prescription medication will not be more than the Copayment, as stated in the Schedule of Benefits, the allowed amount for the prescription medication, or the actual price of the medication.

13.7.14.14 Oral Anticancer Medications

Oral anticancer medications are covered under the Outpatient Specialty Drug benefit, and are subject to the lowest cost-sharing amounts applied to Specialty Drugs in the attached Schedule of Benefits.

Prescriptions for drugs included in the Oral Oncology Dispensing Program will be restricted to a 15-day supply for the first two months of therapy. Note that for members with a flat fee co-payment, drugs included in the Oral Oncology Dispensing Program will be subject to 50% of the applicable copayment amount as listed in the schedule of benefits. Following the first four fills of a drug in the Oral Oncology Dispensing Program, members continuing on therapy may fill their prescription for a maximum day supply allowed per the schedule of benefits.

13.7.15 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.

13.7.15.1 Copayments/Deductibles for Outpatient Radiological or Diagnostic Examinations

Subject to the Radiology Daily Copayment Maximum listed in the Schedule of Benefits, You are required to pay the Copayments listed in the Schedule of Benefits for Outpatient Radiological or Diagnostic Examinations contained in

this Section. In no event will the total Copayments You are required to pay for Covered Radiological or Diagnostic Examinations performed on the same calendar day exceed the Radiology Daily Copayment Maximum listed in the Schedule of Benefits.

An ultrasound or cardiac angiogram shall not be subject to a Radiological or Diagnostic Examination 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 Copayment as listed in the Schedule of Benefits.

13.7.16 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 under the terms of this Agreement as well as surgical reconstruction of an unaffected breast to achieve or restore symmetry with such reconstructed breast. The term also includes prostheses and Treatment of physical complications, including lymphedemas, at all stages of mastectomy. Once symmetry has been attained, the term does not include subsequent breast surgery to affect a cosmetic change, such as cosmetic surgery to change the size and shape of the breasts. However, the term shall include Treatment for functional problems, such as functional problems with a breast implant used in the Breast Reconstruction. Symmetry means the breasts are similar, as opposed to identical, in size and shape.

13.7.17 MINIMUM INPATIENT STAY FOLLOWING MASTECTOMY

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

13.7.18 BENEFITS FOR TREATMENT AND DIAGNOSIS OF CONDITIONS AFFECTING TEMPOROMANDIBULAR JOINT

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

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

13.7.19 TREATMENT FOR CRANIOFACIAL ABNORMALITIES OF A CHILD

Coverage for Covered Dependents younger than 19 years, includes reconstructive surgery for craniofacial abnormalities to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infection or disease. Cosmetic surgery is an excluded service to the extent it is not necessary to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infection or disease for a Covered Dependent younger than 19 years. Dental services are excluded from coverage under this Agreement.

13.7.20 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 care provider, You or Your Eligible Dependent are eligible for coverage for Diabetic Supplies, Diabetic Equipment, and Diabetic Self-Management Training under this Agreement.

Coverage for Diabetic Supplies, Diabetic Equipment and Diabetic Self-Management Training shall be provided on the same basis as other analogous chronic medical conditions are covered, including, but not limited to the applicable Copayments.

Coverage shall also be provided for new or improved Diabetic Supplies or Diabetic Equipment, upon approval of the United States Food and Drug Administration, as Medically Necessary and prescribed by a physician or health care provider.

13.7.20.1 Coverage of Diabetic Supplies under Prescription Drug Benefits (As Appropriate)

Test strips for blood glucose monitors shall be provided according to the copayment levels described in the Schedule of Benefits. Insulin, syringes, oral agents available with a prescription, and Glucagon Emergency Kits shall be provided according to the terms of the Prescription Drug Benefit, if any, except no annual dollar Maximum Benefit limitation shall apply. 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.

13.7.20.2 Copayments/Maximums for Diabetic Equipment and Supplies

All other Diabetic Equipment and Diabetic Supplies shall be provided according to the terms of this Agreement. Diabetic Supplies shall be covered in quantities as stated above. Health Plan will not cover a renewal of a Diabetic Supply until the percentage stated above has been consumed. You are required to pay Copayments for Diabetic Equipment, Diabetic Supplies, and Diabetic Self-Management Trainings as stated in the Schedule of Benefits.

13.7.21 TRANSPLANT SERVICES

Covered transplants, using human tissue only, 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 covered if:

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

If the donor's Health Benefit Plan does not cover donor/procurement costs, such costs will be covered. You are required to pay the same Copayments for transplant services as for other benefits provided under this Agreement.

Transplant services require prior authorization.

13.7.22 ACQUIRED BRAIN INJURY

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

- Cognitive Rehabilitation Therapy,
- Cognitive Communication Therapy,
- Neurocognitive Therapy,
- Neurocognitive Rehabilitation,
- Neurobehavioral Testing,
- Neurobehavioral Treatment,
- Neurophysiological Testing
- Neurophysiological Treatment,
- Neuropsychological 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 will 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; provided that, the Medical Director may determine the reasonableness of a reevaluation based upon one or more of the following factors:

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

13.7.22.1 Copayments for Acquired Brain Injury Services

Copayments for Covered Services for Treatment of Acquired Brain Injury Services shall be the same as the Copayment for Covered Services that are consistent with any other coverage under the Plan.

13.7.23 AUTISM SPECTRUM DISORDER SERVICES

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

Coverage for generally recognized services prescribed to enrollees diagnosed with Autism Spectrum Disorder, is provided, from the date of diagnosis, provided the diagnosis is made before the Covered Person's 10th birthday, in accordance to a Treatment plan recommended by the enrollee's Network Physician.

As used in this provision, "generally recognized services" may include services such as:

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

Autism Spectrum Disorder services must be provided by:

1) a health care practitioner who is:

   (a) licensed, certified of registered by an appropriate agency of Texas;
   (b) a provider whose professional credential is recognized and accepted by an appropriate agency of the United States; or
   (c) a provider 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

13.7.23.1 Copayments for Autism Spectrum Disorder Services

You will pay the same Copayments for the Treatment of Autism Spectrum Disorder that are consistent with any other coverage under the Plan.

13.7.24 TELEMEDICINE

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

13.7.25 AMINO ACID-BASED ELEMENTAL FORMULAS

As ordered by a physician, Medically Necessary Amino Acid-Based Elemental Formulas will be covered only as provided herein. . Health Plan shall provide coverage for these benefits up to the maximum benefit per Year specified in the Schedule of Benefits.

13.7.25.1 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.

13.7.25.2 Copayments and Limitations on Amino Acid-Based Elemental Formulas

You or Your covered Dependents are required to pay the Copayments as stated in the Schedule of Benefits for Amino Acid-Based Elemental Formulas. Benefits for Amino Acid-Based Elemental Formulas shall be limited to the Year maximum as stated in the Schedule of Benefits.

13.7.26 CARDIOVASCULAR DISEASE SCREENING FOR HIGH RISK INDIVIDUALS

Certain cardiovascular disease screening tests for high-risk individuals will be covered only as provided herein. Health Plan shall provide coverage for these benefits up to the maximum benefit per Year specified in the Schedule of Benefits.

13.7.26.1 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.

13.7.26.2 Copayments and Limitations on Cardiovascular Disease Screening

You or Your Covered Dependents are required to pay the 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.

13.7.27 ROUTINE PATIENT CARE COSTS FOR CLINICAL TRIALS

Subject to and only as provided in the terms of this Agreement and the Exclusions and Limitations Provisions herein, You or Your Covered Dependent will 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:

1) the Centers of Disease Control and Prevention of the United State Department of Health and Human Services;
2) the National Institutes of Health;
3) the Agency for Health Care Research and Quality;
4) the Centers for Medicare & Medicaid Services;
5) cooperative group or center of any of the entities described in clauses (1) – (5) or the Department of Defense or the Department of Veteran Affairs;
6) a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
7) 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.

8) 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.

13.7.27.1 Copayments and Limitations on Coverage for Routine Patient Care Costs
We do not provide benefits for routine patient care services provided by Non-Network Providers.

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

13.7.27.2 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.

13.7.28 VISION

13.7.28.1 Annual Eye Exam
The following coverage is provided for a Covered Person:

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

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

- Examinations
- Manipulations
- Conjunctive Physiotherapy

13.6.30 CONTRACEPTIVE METHODS

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

13.6.31 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.

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 due to a medical emergency are excluded.

14.2 BREAST IMPLANTS

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

14.3 CHIROPRACTIC SERVICES

A Doctor of Chiropractic may provide any of the Health Care Services scheduled under this Agreement that are within the scope of the Doctor of Chiropractic's license. Any chiropractic services not scheduled under this Agreement are excluded.

14.4 COMPLICATIONS OF NON-COVERED SERVICES

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

14.5 COSMETIC OR RECONSTRUCTIVE PROCEDURES OR TREATMENTS

Unless otherwise covered under this Agreement, cosmetic or reconstructive procedures or other Treatments which improve or modify a Covered Person's appearance are excluded. Examples of excluded procedures include, but are not limited to, liposuction, abdominoplasty, blepharoplasty, face lifts, osteotomies, and correction of malocclusions, rhinoplasties, and mammoplasties. The only exceptions to this exclusion include certain procedures determined as Medically Necessary, subject to Preauthorization requirements, 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 COURT-ORDERED CARE

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

14.7 CUSTODIAL CARE

Custodial Care as follows is excluded:

- Any service, supply, care or Treatment that the Medical Director determines to be incurred for rest, domiciliary, convalescent or Custodial Care;
- Any assistance with activities of daily living which include activities such as walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking drugs; or
- Any Care that can be performed safely and effectively by a person who does not require a license or certification or the presence of a supervisory nurse. Such services will not be Covered Services no matter who provides, prescribes, recommends or performs those services. The fact that certain Covered Services are provided while You or Your Covered Dependent are receiving Custodial Care does not require the Health Plan to cover Custodial Care.

14.8 DENTAL CARE

All dental care is excluded. This does not include an individual who is unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental, or medical reason as determined by the individual's physician or by the dentist providing the dental care.

14.9 DISASTER OR EPIDEMIC

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

14.10 EXPERIMENTAL OR INVESTIGATIONAL TREATMENT

Any Treatments that are considered to be Experimental or Investigational are excluded, but may be appealed under the Appeal of Adverse Determination provision of this Agreement. This exclusion does not apply to Routine Patient Care Costs for enrollees in clinical trials pursuant to Section 13.7.27 of this Agreement.

14.11 FAMILY COVERED PERSON (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, and 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 health care coverage, are excluded.

14.12 FAMILY PLANNING TREATMENT

The reversal of an elective sterilization procedure and male condoms, are excluded.

14.13 GENETIC TESTING

Subject to Preauthorization requirements, genetic tests are excluded unless approved by the FDA, ordered by a physician, and approved by the Medical Director.

14.14 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.

14.15 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.

14.16 ILLEGAL ACTS

Services received for any condition caused by a Member's commission of, or attempt to commit, an illegal act. This exclusion does not apply to injuries that result from domestic violence or are the result of a medical condition.

14.17 INFERTILITY DIAGNOSIS AND 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.

14.18 MISCELLANEOUS

Artificial aids, corrective appliances, and medical supplies, such as batteries, condoms, dressings, syringes (except for insulin syringes), dentures, hearing aids, eyeglasses and corrective lenses, unless specified in Your Plan, are excluded.

14.19 NON-COVERED BENEFITS/SERVICES

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

14.20 NON-PAYMENT FOR EXCESS CHARGES

No payment will be made for any portion of the charge for a service or supply in excess of the Usual and Customary Rate for such service or supply.

14.21 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.

14.22 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; or
- medical research.

14.23 PREGNANCY INDUCED UNDER A SURROGATE PARENTING AGREEMENT

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

14.24 PRESCRIPTION DRUGS

Over-the-counter drugs are not covered. Unless covered by a Prescription Drug Benefit or Rider, coverage for drugs is limited to:

- those pharmaceutical products prescribed or ordered by a Network Physician or Network Provider, 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, if any.
- Non-Specialty Pharmacy Drugs that are dispensed and administered in the office of a Network Provider, or other Outpatient setting, pursuant to the Coverage of Prescription Drugs provision of this Agreement, if any.
- Non-Specialty Pharmacy Drugs that are dispensed at a pharmacy and administered in the office of a Network 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 REFRACTIVE KERATOTOMY SURGERY

14.26 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.

14.27 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 including diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency, are excluded.

14.28 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.

14.29 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.

14.30 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 a physician or provider and Medical Director.

14.31 WAR, INSURRECTION, RIOT

Treatment for Injuries or sickness as a result of war, participation in a riot, civil insurrection, or act of terrorism are excluded.

14.32 WEIGHT REDUCTION

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

SERVICE AREA

Austin
Bell
Bexar
Blanco
Bosque
Brazos
Burleson
Burnet
Caldwell
Coke
Coleman
Collin
Comal
Concho
Coryell
Crockett
Dallas
Denton
Ellis
El Paso
Erath
Falls
Fayette
Freestone
Grimes
Hamilton
Hays
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: 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 $5,000 / $10,000
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.	$6,600 individual /$13,200 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.	$40
Copayment for each outpatient visit to or by a Network Provider other than a Primary Care Physician.	$60
Copayment per vial of serum for allergy Treatments.	30% of charges
Copayment for outpatient surgery performed in a hospital without admission.	30% of charges
Copayment for Outpatient Diagnostic Procedures.	No charge
Copayment for other Outpatient Services.	30% of charges
Preventive Care Services	None
Hospital Services Copayment for each day of inpatient services.	30% of charges
Copayment for other Inpatient Services	30% of charges
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. Copayment waived if episode results in hospitalization for the same condition within 24 hours.	$250 copay per emergency visit, then 30% of charges.
Copayment for Diagnostic Procedures in conjunction with Emergency Care Services.	30% of charges

Benefit	Network Provider Covered Person Responsibility
Urgent Care Services Copayment for Treatment received at an Urgent Care Facility.	$75 copay per urgent care visit
Emergency Transportation Services Copayment for Emergency Transportation Services.	30% of charges
Emergency Medical Services Copayment for emergency medical services provided by ambulance personnel for which transport is unnecessary or is declined by Member.	30% of charges
Outpatient Mental Health Care	
Copayment for each outpatient mental health care visit to or by a Health Professional.	$40
Inpatient Mental Health Care	
Copayment for each day of inpatient services, Psychiatric Day Treatment Facility services, and alternative mental health Treatment benefits.	30% of charges
Copayments for remaining number of covered days per Year.	30% of charges
Serious Mental Illness Copayment for each day of inpatient services for Serious Mental Illness benefits.	30% of charges
Copayment for each outpatient mental health care visit to or by a Health Professional.	$40
Treatment For Chemical Dependency Copayment for each outpatient chemical dependency visit to or by a Network Provider other than a Primary Care Physician.	$40
Copayment for each day of inpatient chemical dependency services.	30% of charges
Rehabilitative and Habilitative Therapy Copayment for each outpatient therapy visit to or by a Network Provider other than a Primary Care Physician.	$60
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.	30% of charges
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)	30% of charges
Maximum number of days of Home Infusion Therapy services for which Copayment is due.	365 days for 30% of charges
Hospice Services Copayment for each day of Hospice services.	30% of charges
Maternity Services Copayment for each outpatient visit to or by a Network Provider other than a Primary Care Physician.	$60

Benefit	Network Provider Covered Person Responsibility
Copayment for Diagnostic Procedures in conjunction with Maternity Services.	30% of charges
Copayment for each day of inpatient services.	30% of charges
Family Planning Services Copayment for each outpatient visit to or by a Network Provider other than a Primary Care Physician.	$60
Copayment for Outpatient Diagnostic Procedures in conjunction with Family Planning Services.	30% of charges
Copayment for each day of inpatient services.	30% of charges
Durable Medical Equipment/Orthotics/Prosthetic Devices	
Copayment for Durable Medical Equipment, Orthotics and Prosthetic Devices and all other related covered services.	50% of charges
Copayment for Durable Medical Equipment.	50% of charges
Copayment for Orthotic Devices and Prosthetic Devices.	50% of charges
Copayment for each outpatient visit to or by a Network Provider other than a Primary Care Physician.	$60
Inpatient Prescription Drugs Includes Specialty Pharmacy Drugs administered in an inpatient setting	Same as other inpatient services
Office or Clinic Administered Non-Specialty Pharmacy Drugs Non-specialty pharmacy drugs administered in office or another outpatient setting	Same as other outpatient services.
Prescription Drug Program Specialty Pharmacy Drugs and Outpatient Prescription Drugs as listed below	Not Covered unless Prescription Drug Rider is attached
Outpatient Radiological or Diagnostic Examinations Member is required to pay a Copayment for Outpatient radiological/Diagnostic examinations described below**.**	
Angiograms, CT scans, MRIs, Myelography, PET scans, stress tests with radioisotope imaging.	30% of charges
Radiology Daily Copayment Maximum	Not applicable
Breast Reconstruction Benefits Copayment for Breast Reconstruction benefits.	30% of charges
Inpatient Stay following Mastectomy	30% of charges
Treatment and Diagnoses of Conditions affecting Temporomandibular Joint	30% of charges
Treatment for Craniofacial Abnormalities of a Child	30% of charges
Diabetic Supplies, Equipment, and Self-Management Training Copayment for Preferred Level test strips for blood glucose monitors	30% of charges
Copayment for Non-Preferred Level test strips for blood glucose monitors	30% of charges
Copayment for Diabetic Equipment and Diabetic Supplies	30% of charges
Copayment for Diabetes Self-Management Training.	$60
Transplant Services	30% of charges

Benefit	Network Provider Covered Person Responsibility
Acquired Brain Injury	30% of charges
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.	30% of charges
Telemedicine	30% of charges
Amino Acid-Based Elemental Formulas	
Copayment for Amino Acid-Based Elemental Formulas	30% of charges
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 for other CT scans
Copayment for Ultrasonography measuring carotid intima-media thickness and plaque	Same as for other Ultrasound
Routine Patient Care Costs for Clinical Trials Copayments for Routine Patient Care Costs by Enrollee in Clinical Trial	30% of charges
Vision (All Ages)	$60 Maximum of one eye examination per Year.
Hearing Aids and Cochlear Implants Limited to Covered Members age 18 and under. Limited to one hearing aid per hearing impaired ear; or one cochlear implant in each hearing-impaired ear with internal replacement as medically or audiologically necessary	50% of charges

Prescription Drug Program

Copayment/Coinsurance do not apply to Medical Deductible Prescription
Copayment, Coinsurance, and Deductible apply to the Out of Pocket Maximum.

Covered Person electing to purchase a brand name when a generic is available, will be required to pay the non-formulary copayment, but in no case will the Covered Person be required to pay more than the retail price of the drug.

Non-formulary drugs are subject to prior authorization and, if approved via medical necessity review, will be allowed at the non-preferred or non-preferred specialty copay, as appropriate.

Benefit	Network Provider Covered Person Responsibility
Preferred Generic Drugs	$8 copay
Preferred Brand Drugs	$35 copay
Non-Preferred Generic and Non-Preferred Brand Drugs	$70 copay
Specialty drugs tier 1	$200 copay
Specialty drugs tier 2	$300 copay
Specialty drugs tier 3	$400 copay
90 Day Supply Maintenance Prescriptions Available when obtained through a Baylor Scott and White Pharmacy, a participating retail pharmacy, or when using the mail order prescription service	Generic and brand preferred and non-preferred copayment will be 2.5 times the applicable amount indicated above 90-day supply maximum
Mail Order Prescription Service Note: Non-Maintenance drugs obtained through the mail order prescription service will still be limited to a 30-day supply	

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 1-800-321-7947 (رقم

Urdu:
1-800-321-7947 (TTY: 711). خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال 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:
فراهم می باشد. با 1-800-321-7947 (TTY: 711) تماس بگیرید. توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما

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.