



**SCOTT & WHITE
HEALTH PLAN**

LARGE EMPLOYER

HEALTH CARE

EVIDENCE OF COVERAGE

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

Corporate Office
2401 South 31st Street
Temple, Texas 76508
(254) 298-3000
(800) 321-7947

CERTIFICATE OF COVERAGE

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

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

Important Notices:

1. The initial rates agreed upon by Group and Scott and White Health Plan are effective during the initial year from and after the effective date of this Agreement. Thereafter, Health Plan reserves the right to change rates upon 60 days notice prior to renewal.
2. The coverage provided under this Agreement is health maintenance organization (HMO) coverage and not indemnity insurance. As an HMO, the Health Plan contracts with only certain providers; therefore, with certain exceptions as explained herein, You and Your Covered Dependents are required to use those providers in order to receive the coverage described. Those providers shall determine the methods used and the form of Treatment to be provided. The Health Plan does not intend that all alternative forms and methods of Treatment will be eligible for coverage. If You or Your Covered Dependents elect to receive Treatment from a non-Health Plan provider, or receive a form of Treatment not authorized by the Health Plan, You may be required to pay for the services provided out of your own pocket.
3. Scott and White Health Plan is a named fiduciary to review claims under this Agreement. Group delegates to Health Plan the discretion to determine whether You and Your Covered Dependents are entitled to the benefits of this Agreement. In making these determinations, Health Plan has the authority to review claims in accord with the procedures contained herein and to construe this Agreement to determine if You and Your Covered Dependents are entitled to its benefits. If Group is subject to the Employee Retirement Income Security Act, a federal law, this Agreement may be governed by the provisions of that law.

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



Chief Executive Officer
Scott and White Health Plan
2401 South 31st Street
Temple, Texas 76508

TEACHER RETIREMENT SYSTEM (TRS) AMENDMENTS

The Health Care Evidence of Coverage of Scott and White Health Plan is hereby amended.

A. The following sections of the Health Care Evidence of Coverage shall be excluded as follows:

The Certificate of Coverage introduction page reference to changing rates upon 60 days notice prior to renewal (under item 1) shall be deleted.

Section 1, Definitions, 1.3 “Affiliation Period” and 1.947 “Waiting Period” shall be deleted.

Section 4.1 (2) under Termination of Coverage for Members shall be deleted.

Section 6.1.1-6.1.3, Payment of Premiums, Premium Changes, and Contribution Requirements, and 6.4, Late Payment Fee, shall be deleted.

Section 6.5, Grace Period and Cancellation of Coverage, shall be deleted.

Section 12.3, Changes in Coverage, shall be deleted.

B. Section 1, Definitions, 1.16 “Contract Holder” is amended by replacing the term “Group” in the last sentence with “TRS”. 1.33 “Employer” is amended by replacing the entire definition with “means the school district with whom You are employed.” 1.36 “Group” is amended by replacing “Your Employer” in the first sentence with “TRS”. A new definition 1.94 is added as follows: 1.94 “TRS” means the Teacher Retirement System of Texas. All definitions thereafter shall be appropriately renumbered.

C. Section 1, Definitions, 1.62 “Open Enrollment Period” shall be amended to read “Plan Enrollment Period” and the phrase “each calendar year” shall be deleted from the definition.

D. Section 1, Definitions, 1.29 “Eligible Dependent” and 1.30 “Eligible Employee” and Section 2, Eligibility Provisions, are deleted and replaced with the following:

Eligibility

To be eligible for TRS-ActiveCare, an individual must be employed by a participating entity. Then, answer the following questions:

- (1) Is the individual an active, contributing TRS member?
- (2) Is the individual employed for 10 or more hours each week?

If the answer is yes to *either* question, then the employee is eligible for TRS-ActiveCare coverage *unless* the individual is also:

- Receiving health care coverage as an employee or retiree under the State University Employees Uniform Insurance Benefits Act, for example, a school employee that has UT Select coverage as an employee with The University of Texas.
- Receiving health care coverage as an employee or retiree under the Texas Employees Group Benefits Act, for example, a school employee that has HealthSelect coverage as a state employee through ERS.
- A TRS retiree receiving, or who waived coverage, under TRS-Care, including a retiree who has returned to work.

Note: Although a retiree, a higher education employee or a state employee may not be covered as an **employee** of a participating entity, he or she can be covered as a **dependent** of an eligible employee.

You may also cover your eligible dependents at the same time you enroll for coverage. Eligible dependents of a covered employee include a spouse (including a common law spouse) and an unmarried child under the age of 25 described by any of the following:

- A natural or adopted child
- A stepchild
- A foster child
- A child under the legal guardianship of the employee

- A child in a regular parent-child relationship with the employee. This means the child may be covered if:
 - The child's primary residence is the household of the employee;
 - The employee provides at least 50% of the child's support;
 - Neither of the child's natural parents resides in that household; and
 - The employee has the legal right to make decisions regarding the child's medical care.
 - A grandchild whose primary residence is the household of the employee and who is a dependent of the employee for federal income tax purposes.

A child of a covered employee, regardless of age, may be eligible for dependent coverage provided the child is either mentally retarded or physically incapacitated to such an extent to be dependent on the employee on a regular basis and meets other requirements as determined by TRS.

If an employee and spouse both work for a participating district/entity, the spouse may be covered as an employee or as a dependent of an eligible employee. Only one parent may enroll dependent children for coverage.

An unmarried child (under age 25) who is employed by a participating entity and is a contributing TRS member cannot be covered as a dependent on his or her parent's TRS-ActiveCare coverage. This child must be covered as an **employee** of the participating entity. If the child is not a contributing TRS member, the child may be covered as a dependent.

Special Enrollment Event: Your TRS-ActiveCare plan choice will remain in effect through August 2005 unless you have a qualified status change, such as a marriage, divorce, birth or adoption of a child, or a loss or gain of coverage from another group plan. Any TRS-ActiveCare change must be made within 31 days of the special enrollment event, except in the case of a newborn, the change must be made within 60 days after the date of birth (unless the newborn's date of birth is on or after September 1, 2004, and the employee has employee and family or employee and children coverage with TRS ActiveCare at the time of newborn's birth, then the employee has up to one year after birth of newborn to add the newborn to coverage.)

- E. Section 4.2, Termination or Non-Renewal for Coverage of Group, shall be deleted and replaced with the contractual agreement between Scott and White Health Plan and Teacher Retirement System of Texas (TRS).
- F. Sections 5.2 and 5.3 shall be amended to state that members should contact the COBRA Administrator, not TRS, if they have a qualifying COBRA event. In addition, the COBRA Administrator will provide the notice referenced in Section 5.3.
- G. Section 12.1, Confidentiality, shall be revised to exclude (4) and (5).
- H. Section 12.4, Entire Agreement, shall be revised to exclude the reference to "Group's application" and include the following statement: Any policies, procedures, and rules adopted by Scott & White Health Plan will not modify in any way the terms of this Agreement or the contract between Scott and White Health Plan and the Teacher Retirement System of Texas (TRS).
- I. Section 12.6, Modification of Terms, shall be amended to delete the words "in accordance with any provision hereof" in the first sentence.
- J. Section 12.8, Venue, shall be revised as follows:
Bell County, Texas shall be replaced with Austin, Travis County, Texas.
- K. Section 12.9, Recovery, shall be amended to delete any reference to Contract Holder or the reference to group coverage in its entirety in the last sentence since in this instance Contract Holder refers to TRS and recovery efforts shall be addressed to Subscribers or Members.

SCHEDULE OF BENEFITS

Paragraph Reference	Benefit	Copayment/ Deductible
13.2	<p><u>Out-of-Pocket Maximum (Contract Year)</u> No carryover will be allowed. The maximum amount of Out-of-Pocket Expenses to be incurred by you and Your Covered Dependents.</p> <p>NOTE: the following shall not be considered Out-of-Pocket Expenses for purposes of meeting Out-of-Pocket Maximum:</p> <ul style="list-style-type: none"> • Copayments for Out-of-Network benefits authorized out of contract. • Deductibles for Out-of-Network benefits authorized out of contract. • Copayments and Deductibles (if any) for any Riders attached to this Agreement. • Copayments for Non-Preferred Specialty Pharmacy Drugs 	\$3,000 ind./\$6,000 family Once the Out-of-Pocket Maximum above is reached, then Covered Services will be covered at 100%.
13.5.1	<p><u>Medical Services that are not Preventive Care Services</u> Copayment for each outpatient visit to or by a Primary Care Physician.</p>	\$25.00
	<p>Copayment for each outpatient visit to or by a Participating Provider other than a Primary Care Physician.</p>	\$25.00
	<p>Copayment per vial of serum for allergy Treatments.</p>	\$25.00
	<p>Copayment for outpatient surgery performed in a hospital without admission.</p>	20% of charges
	<p>Copayment for Outpatient Diagnostic Procedures.</p>	20% of charges
13.5.2	<p><u>Preventive Care Services</u></p>	No Charge
13.5.3	<p><u>Hospital Services</u> Copayment for each day of inpatient services.</p>	\$100.00, 20% of charges
	<p>Maximum number of days per admission for which Copayment is due.</p>	5 days for \$100.00 copayment, 365 days for 20% of charges
13.5.4	<p><u>Emergency Care Services</u> Copayment for each episode of Emergency Care.</p>	\$100 per emergency visit, 20% of charges
	<p>Copayment for Diagnostic Procedures in conjunction with Emergency Care Services.</p>	20% of charges
13.5.4.2	<p><u>Urgent Care Services</u> Copayment for Treatment received at an Urgent Care Facility.</p>	\$40.00, 20% of charges
	<p>Copayment for Diagnostic Procedures in conjunction with Urgent Care Services.</p>	20% of charges
13.5.4.3	<p><u>Emergency Transportation Services</u> Copayment for Emergency Transportation Services.</p>	\$40.00, 20% of charges
13.5.4.4	<p><u>Emergency Medical Services</u> Copayment for emergency medical services provided by ambulance personnel for which transport is unnecessary or is declined by Member.</p>	\$40.00, 20% of charges
13.5.5.3	<p><u>Outpatient Mental Health Care</u> Maximum number of outpatient mental health care visits per Contract Year covered by Health Plan.</p>	20
	<p>Copayment for each outpatient mental health care visit to or by a Health Professional.</p>	50% of charges
	<p><u>Inpatient Mental Health Care</u> Maximum number of days of inpatient mental health care per Contract Year covered by Health Plan.</p>	20
	<p>Copayment for each day of inpatient services, Psychiatric Day Treatment Facility services, and alternative mental health Treatment benefits.</p>	50% of charges

Paragraph Reference	Benefit	Copayment/ Deductible
13.5.5.7	<u>Serious Mental Illness</u> Copayment for each day of inpatient services for Serious Mental Illness benefits.	Same as other inpatient services
	Maximum number of days inpatient Treatment for Serious Mental Illness per Calendar Year per Member.	45 days
	Copayment for each outpatient mental health care visit to or by a Health Professional.	Same as other outpatient medical services
	Maximum number of outpatient visits for Serious Mental Illness per Calendar Year per Member.	60
13.5.6.2	<u>Treatment For Chemical Dependency</u> Copayment for each outpatient chemical dependency visit to or by a Participating Provider other than a Primary Care Physician.	\$25.00
	Copayment for each day of inpatient chemical dependency services.	\$100.00, 20% of charges
	Maximum number of days per inpatient chemical dependency admission for which Copayment is due.	5 days for \$100.00 copayment, 365 days for 20% of charges
	Lifetime Maximum for Chemical Dependency Treatment. This Lifetime Maximum shall apply to inpatient and outpatient treatment combined, and is not considered to be one maximum for inpatient treatment and a separate maximum for outpatient treatment.	3 series of treatments during Member's Lifetime
13.5.7	<u>Rehabilitative Therapy</u> Copayment for each outpatient therapy visit to or by a Participating Provider other than a Primary Care Physician.	\$25.00
13.5.8	<u>Home Health Services</u> Copayment for each home health visit to or by a Participating Provider other than a Primary Care Physician.	\$25.00
13.5.9.1	<u>Home Infusion Therapy Benefit</u> 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)	\$50.00, 20% of charges
	Maximum number of days of Home Infusion Therapy services for which Copayment is due.	5 days for \$50.00 copayment, 365 days for 20% of charges
13.5.10	<u>Hospice Services</u> Copayment for each day of Hospice services.	\$0.00
	Maximum number of days per Hospice admission for which Copayment is due.	365
13.5.11.3	<u>Maternity Services</u> Copayment for each outpatient visit to or by a Participating Provider other than a Primary Care Physician.	\$25.00
	Copayment for Diagnostic Procedures in conjunction with Maternity Services.	20% of charges
	Copayment for each day of inpatient services.	\$100.00, 20% of charges
	Maximum number of days per admission for which a Copayment is due.	5 days for \$100.00 copayment, 365 days for 20% of charges
13.5.12	<u>Family Planning Services</u> Copayment for each outpatient visit to or by a Participating Provider other than a Primary Care Physician.	\$25.00
	Copayment for Outpatient Diagnostic Procedures in conjunction with Family Planning Services.	20% of charges
	Copayment for each day of inpatient services.	\$100.00, 20% of charges
	Maximum number of days per admission for which a Copayment is due.	5 days for \$100.00 copayment, 365 days for 20% of charges

Paragraph Reference	Benefit	Copayment/ Deductible
13.5.13	<u>DME/Orthotics/Prosthetic Medical Appliances</u>	
	Copayment for durable medical equipment, orthotics and prosthetic medical appliances and all other related covered services.	50% of charges
	Copayment for each outpatient visit to or by a Participating Provider other than a Primary Care Physician.	\$25.00
	Maximum benefit per Member per Contract Year for durable medical equipment and prosthetic appliances combined.	\$1,000.00
13.5.14.1	<u>Immunizations</u>	None
	Copayment for age appropriate Immunization agent.	
	Copayment for each outpatient visit to or by a Primary Care Physician.	\$25.00
	Copayment for each outpatient visit to or by a Participating Provider other than a Primary Care Physician.	\$25.00
13.5.15	<u>Prescription Drugs</u>	
13.5.15.1	<u>Inpatient Prescription Drugs</u> Includes Specialty Pharmacy Drugs administered in an inpatient setting	Same as other inpatient services
13.5.15.2	<u>Outpatient Specialty Pharmacy Drugs</u>	
	<u>Copayments</u> Specialty Pharmacy Drugs on the formulary at Level 1	10% of charges
	Specialty Pharmacy Drugs on the formulary at Level 2 (Preferred Specialty Pharmacy drugs)	20% of charges
	Specialty Pharmacy Drugs on the formulary at Level 3 (Premium Preferred Specialty Pharmacy drugs)	30% of charges
	Specialty Pharmacy Drugs on the formulary at Level 4 (Non-Preferred Specialty Pharmacy drugs) NOTE: Copayments for Non-Preferred Specialty Pharmacy drugs will not be considered Out-of-Pocket Expenses for purposes of meeting Out-of-Pocket Maximums.	50% of charges
13.5.15.3	<u>Prescription Drugs Administered in Outpatient Setting</u> Non-Specialty Pharmacy Drugs Administered in Provider's Office or other Outpatient setting	Same as other outpatient services
13.5.15.4	<u>Outpatient Prescription Drugs</u> Non-Specialty Pharmacy Drugs and Outpatient Prescription Drugs not administered in Provider's office	Not Covered unless Prescription Drug Rider is attached
13.5.16.1	<u>Outpatient Radiological or Diagnostic Examinations</u> Member is required to pay a Copayment for Outpatient radiological/Diagnostic examinations described below.	
	Angiograms, CT scans, MRIs, Myelography, PET scans, stress tests with radioisotope imaging.	20% of charges
	Radiology Daily Copayment Maximum	Not Applicable
13.5.17	<u>Benefits for Screening Exams</u>	\$25.00
	Copayment for each outpatient visit to or by a Primary Care Physician.	
	Copayment for each outpatient visit to or by a Participating Provider other than a Primary Care Physician.	\$25.00
13.5.18	<u>Breast Reconstruction Benefits</u> Copayment for Breast Reconstruction benefits.	Same as for other benefits
13.5.19	<u>Inpatient Stay following Mastectomy</u>	Same as other inpatient health care services
13.5.20	<u>Treatment and Diagnoses of Conditions affecting Temporomandibular Joint</u>	Same as for other benefits
13.5.21	<u>Treatment for Craniofacial Abnormalities of a Child</u>	Same as for other benefits

Paragraph Reference	Benefit	Copayment/ Deductible
13.5.22.2	<u>Diabetic Supplies, Equipment, and Self-Management Training</u>	\$5.00
	Copayment for Preferred Level test strips for blood glucose monitors	
	Copayment for Non-Preferred Level test strips for blood glucose monitors	\$25.00
	Copayment for Diabetic Equipment and Diabetic Supplies	Same as prescription drugs or durable medical equipment and supplies, as appropriate
	Copayment for Diabetes Self-Management Training.	Same as other outpatient services
13.5.23	<u>Transplant Services</u>	Same as for other benefits
13.5.24	<u>Acquired Brain Injury</u>	Same as for other benefits
13.5.25	<u>Autism Spectrum Disorder</u> Copayment for each visit to or by a Health Professional for generally recognized service prescribed by enrollee's Primary Care Provider.	Same as for other benefits
13.6.1	<u>Out-of-Network Referrals</u> You are required to pay the same Copayments and Deductibles, as applicable, for referral Treatments as for other benefits provided under this Agreement.	Same as other benefits
13.7	<u>Out-of-Network Benefits</u> For "out-of-network" benefits authorized out of contract, You are required to pay a Copayment. NOTE: Copayments for Out-of-Network benefits authorized out of contract will not be considered Out-of-Pocket Expenses for purposes of meeting Out-of-Pocket Maximum.	50% of charges
	You are required to pay a Deductible for "out-of-network" benefits authorized out of contract, excluding Emergency Care Services and approved Referrals. NOTE: Deductibles for Out-of-Network benefits authorized out of contract will not be considered Out-of-Pocket Expenses for purposes of meeting Out-of-Pocket Maximum.	\$1,000.00

Paragraph Reference	Benefit	Copayment/ Deductible
	Prescription Drug Benefit Rider	
	<u>Authorization Requirements</u> A one-time prescription which costs the amount specified or more and refillable prescriptions whose total cost is the amount specified to the right will require preauthorization by the SWHP Medical Director.	A one-time prescription of \$175 Total cost of \$1,200
	<u>Quantity Limitations</u> Covered drugs are provided in quantities per prescription or refill up to the limits listed at right.	Initial or refill prescription: up to a 34 day supply or 100 units Maintenance: up to a 90 day supply or 360 units
	<u>Maximum Benefit</u> This prescription drug benefit is subject to a maximum benefit payment per Member per Contract Year.	\$4,000.00
	<u>Deductible</u> You are required to pay a deductible prior to receiving coverage for covered prescription drugs.	\$50.00
	<u>Copayments</u> Drugs appearing on List A (Formulary generic drugs)	\$5.00
	Drugs appearing on List B (Formulary preferred brand drugs)	30% of charges after deductible
	Drugs appearing on List C (Formulary non-preferred and alternate choice drugs)	50% of charges after deductible
	Drugs not appearing on Health Plan Formularies	The greater of \$50.00 or 50% of charges after deductible
	<u>Maintenance Drug Copayments</u> Drugs appearing on List A (Formulary generic drugs)	\$10.00
	Drugs appearing on List B (Formulary preferred brand drugs)	30% of charges after deductible
	Drugs appearing on List C (Formulary non-preferred and alternate choice drugs)	50% of charges after deductible
	Drugs not appearing on Health Plan Formularies	Not available

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Scott and White Health Plan's toll-free telephone numbers for information or to make a complaint at

LOCAL/LONG DISTANCE NUMBERS

Temple	Bryan/College Station
(254) 298-3000	(979) 268-7947
(800) 321-7947	(800) 791-8777
Georgetown	Waco
(512) 930-6040	(254) 756-8000
(800) 758-3012	(800) 684-7947

You may also write to Scott and White Health Plan at:

**2401 South 31st Street
Temple, TX 76508**

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

1-800-252-3439

You may write the Texas Department of Insurance

**P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 475-1771**

**E-Mail: [Consumer Protection @tdi.state.tx.us](mailto:ConsumerProtection@tdi.state.tx.us)
Web: <http://www.tdi.state.tx.us>**

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

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

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numeros de teléfono gratis de la Scott and White Health Plan's para informacion o para someter una queja al

NUMEROS LOCALES/DE LARGA DISTANCIA

Temple	Bryan/College Station
(254) 298-3000	(979) 268-7947
(800) 321-7947	(800) 791-8777
Georgetown	Waco
(512) 930-6040	(254) 756-8000
(800) 758-3012	(800) 684-7947

Usted tambien puede escribir a la Scott and White Health Plan

**2401 South 31st Street
Temple, TX 76508**

Puede comunicarse con el Departamento de seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas

**P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 475-1771**

**E-Mail: [Consumer Protection@tdi.state.tx.us](mailto:ConsumerProtection@tdi.state.tx.us)
Web:<http://www.tdi.state.tx.us>**

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

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

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1. DEFINITIONS

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

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 Evidence of Coverage.

1.3 “**Affiliation Period**” means the ninety (90) day period of time which must expire before coverage of a late enrollee under this Agreement becomes effective.

1.4 “**Age of Ineligibility**” means the age at which dependents are no longer eligible for coverage, subject to the definition of Eligible Dependent. Unless amended by Your Group, Age of Ineligibility will be 25.

1.5 “**Agreement**” means this Scott and White Health Plan evidence of coverage and all attachments and riders herein.

1.6 “**Appeal**” is an oral or written request for Health Plan to reverse a previous decision.

1.7 “**Autism spectrum disorder**” means a neurobiological disorder that includes autism, Asperger’s syndrome, or Pervasive Developmental Disorder--Not Otherwise Specified.

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

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

1) affiliated with a hospital under a contractual agreement with an established system for patient referral; or

2) accredited as a chemical dependency treatment center by the Joint Commission on Accreditation of Health Care Organizations; or

3) licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or

4) licensed, certified, or approved as a chemical dependency treatment program or center by any other agency of the State of Texas having legal authority to so license, certify, or approve.

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

1.11 “**Cognitive rehabilitation therapy**” means services designed to address therapeutic cognitive activities, based on an assessment and understanding of a Member’s brain-behavioral deficits.

1.12 “**Community reintegration services**” means services that facilitate the continuum of care as an affected Member transitions into the community.

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

1.14 “**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.

1.15 “**Contract Date**” means the date on which coverage for Your Employer’s Health Benefit Plan commences.

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

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

1.18 “**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).

1.19 “**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 Member to a Participating Hospital, Participating Physician, or Participating Provider, when Health Care Services are obtained from that Participating Hospital, Participating Physician, or Participating Provider.

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

1.21 “**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.

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

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

1.24 “**Deductible**” means the dollar amount, if any, shown in the Schedule of Benefits payable by the Member for Health Care Services before benefits under the Health Care Plan will be payable.

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

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

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

1.28 “**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.

1.29 “**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. Unmarried; and
 - b. Under the Age of Ineligibility; or
 - i. if the Age of Ineligibility or older
 1. at the time of reaching the Age of Ineligibility, incapable of self-sustaining employment by reason of physical disability or mental incapacity; and
 2. chiefly dependent upon You for support and maintenance.
- 3) Your grandson or granddaughter who is:
 - a. Unmarried; and
 - b. Under the Age of Ineligibility; or
 - i. if the Age of Ineligibility or older
 1. at the time of reaching the Age of Ineligibility, incapable of self-sustaining employment 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.

1.30 “**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 CHAMPUS 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.

1.31 “**Eligibility Date**” means the date the Member satisfies the definition of either Eligible Employee or Dependent and is in a class eligible for coverage under the Health Plan.

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

- 1) placing his or her health in serious jeopardy;
- 2) serious impairment 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.

1.33 “**Employer**” means Group.

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

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

- 1) Well-designed and well conducted investigations published in recognized peer reviewed medical literature, such as the New England Journal of Medicine or the Journal of Clinical Oncology, when such papers report conclusive findings of controlled or randomized trials. The Medical Director shall consider the quality of the body of studies and the consistency of the results in evaluating the evidence;

- 2) Communications about the Treatment that have been provided to patients as part of an informed consent;
- 3) Communications about the procedure or Treatment that have been provided from the physician undertaking a study of the Treatment to the institution or government sponsoring the study;
- 4) Documents or records from the institutional review board of the hospital or institution undertaking a study of the Treatment;
- 5) Regulations and other communications and publications issued by the Food and Drug Administration and the Department of Health and Human Services; and
- 6) the Member’s medical records.

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

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

1.36 “**Group**” means Your Employer which is the party contracting with Health Plan to purchase coverage for its employees who become Subscribers 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. No less than the applicable Participating Percentage of the Eligible Employees must 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.

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

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

1.39 “**Health Plan**” means Scott and White Health Plan.

1.40 “**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 or Referral Physicians 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.

1.41 “**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.

1.42 “**Independent Review Organization**” means an organization selected as provided under Texas Insurance Code Chapter 4202.

[1.43] “**Individual Treatment Plan**” means a Treatment plan prepared or approved by the Member's Primary Care Physician with specific attainable goals and objectives appropriate to both the Members and the Treatment modality of the program.

[1.44] “**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.

[1.45] “**Life-Threatening Condition**” means a disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

1.46 “**Lifetime Maximum**” means the maximum benefits for Chemical Dependency Treatment available under this Agreement during a Member's lifetime. Lifetime Maximum does not apply to all Health Care Services.

1.47 “**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.

1.48 “**Medically Necessary**” means those Health Care Services which, in the opinion of Member's Primary Care Physician or Referral Physician, 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) essential to preserve the health of Member; and
- 2) consistent with the symptoms or diagnosis and Treatment of the Member's condition, disease, ailment or injury; and
- 3) appropriate with regard to standards of good medical practice within the surrounding community; and
- 4) not solely for the convenience of the Member, Member's Physician, Hospital, or other health care provider; and
- 5) the most appropriate supply or level of service which can be safely provided to the Member.

1.49 “**Medicare**” means Title XVIII of the Social Security Act, and amendments thereto.

1.50 “**Member**” means You or Your Covered Dependent.

1.51 “**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 two Eligible Employees.

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

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

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

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

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

1.57 “**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.

1.58 “**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.

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

1.60 “**Neurophysiological testing**” means an evaluation of the functions of the nervous system.

1.61 “**Neurophysiological treatment**” means interventions that focus on the functions of the nervous system.

1.62 “**Open Enrollment Period**” means the period each calendar 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 Enrollment Application form must be received by Health Plan within the open Enrollment Period and all other requirements of this Agreement must be met.

1.63 “**Out-of-Pocket Expenses**” means the portion of Covered Services for which a Member is required to pay at the time services and treatments are received after the Deductible has been met. 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.

1.64 “**Out-of-Pocket Maximum**” means the total dollar amount of Out-of-Pocket Expenses which a Member will be required to pay for Covered Services during a Contract Year after the Deductible has been met. 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.

1.65 “**Out-of-Pocket Maximum, Family**” means the total amount of Out-of-Pocket Expenses which one family

will be required to pay in any one Contract Year after the Deductible has been met.

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

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

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

1.69 “**Participation Percentage**” means the minimum percentage of total Eligible Employees of Your Employer who must participate in the Health Plan.

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

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

1.72 “**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.

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

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

1.75 “**Primary Care Physician**” means a Participating Physician specializing in family medicine, community internal medicine, general medicine, or pediatrics selected by You or Your Covered Dependent to manage the Health

Care Services which will be made available to You or Your Covered Dependent by Health Plan.

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

1.77 “**Psychophysiological testing**” means an evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

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

1.79 “**Qualified Medical Support Order**” means an order issued by a Texas Court or enforceable by a Texas Court which sets forth the responsibility for providing health care coverage for Eligible Dependents.

1.80 “**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.

1.81 “**Referral Physician**” means a professional person who is licensed to practice medicine in the State where his or her medical services are required to be performed, and to whom in the opinion of the Medical Director and Member's Primary Care Physician it is necessary to refer a Member for a Health Care Service.

1.82 “**Remediation**” means the process(es) of restoring or improving a specific function.

1.83 “**Required Payments**” means any payment or payments required of the Group, an applicant for coverage hereunder, or a Member in order to obtain or maintain coverage under this health care Agreement, including application fees, Copayments, Deductibles, subrogation, Premiums, late fees and any other amounts specifically

identified as Required Payments under the terms of this Agreement.

1.84 “**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.

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

1.86 “**Series of Treatments**” is a planned, structured, and organized program to promote chemical free status which may include different facilities or modalities. Such a program is considered complete when the covered Member

- 1) is discharged on medical advice from inpatient detoxification, inpatient rehabilitation/Treatment, partial hospitalization or intensive outpatient care or a series of these levels of Treatment without a lapse in Treatment, or
- 2) fails to materially comply with the Treatment program for a period of thirty (30) days.

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

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

1.89 “**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.

1.90 “**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; or
- 4) FDA mandated or evidence-based medical-guideline determined comprehensive patient and/or physician education.

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

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

1.93 “**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.

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

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

1.96 “**Usual, Customary and Reasonable Charges**” means the fee which a physician or other provider of a particular service usually charges his/her patients for the same service and which is within the range of fees usually charged by other physicians or other providers located within the immediate geographic area where the service is received under similar or comparable circumstances. When applied to a Participating Provider, it means the amount allowed under a Participating Provider’s agreement with the Health Plan.

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

1.98 “**You**” means the Subscriber.

1.99 “**Your**” means relating or pertaining to the Subscriber.

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, and
- 2) the Permanent Legal Residence of any Eligible Dependents must be the same as Yours, except in the case of an Eligible Dependent for whom You have been ordered to provide health coverage under a Qualified Medical Support Order, the Eligible Dependent may reside anywhere in the United States. If a Covered Dependent being covered under a Qualified Medical Support Order resides outside of the Service Area, Health Plan shall not enforce any otherwise applicable provisions which deny, limit, or reduce medical benefits because the child resides outside the Services Area, 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.

2.2.2 Dependent coverage requirement of Subscriber enrollment

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

2.2.3 Service Area requirement

Except for continuation coverage, coverage for a Subscriber, including his/her Dependents, who ceases to work or reside in the Service Area will be terminated. Exceptions may be

made for dependents of deceased Subscribers or retired Subscribers if Group has elected retiree coverage.

2.3 Enrollment and Effective Dates of Coverage

The Effective Date is the date the coverage for a Member 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 Applicability of Affiliation Period

During the Affiliation Period, no benefits or Health Care Services are covered and no Premium is due.

2.3.2 Timely Applications

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

- 1) a completed Enrollment Application which must be received by Health Plan 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 DISENROLLED FROM THE HEALTH PLAN, IN ACCORDANCE WITH THE PROCEDURES SET FORTH IN THIS AGREEMENT.

IF A GROUP FAILS TO PAY A REQUIRED PAYMENT WHEN DUE, THE GROUP (AND ITS ENROLLEES) MAY BE DISENROLLED FROM THE HEALTH PLAN, IN ACCORDANCE WITH THE PROCEDURES SET FORTH IN THIS AGREEMENT.

2.3.3 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.

2.3.4 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 eligible to apply for coverage immediately, but You or Your Dependent may be subject to a 90-day Affiliation Period. Such Affiliation Period will begin the date your written application is received by Health Plan.

2.3.5 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 Health 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. Continuation coverage has been exhausted; or
 - b. Was terminated as a result of legal separation, 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 enroll 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.

2.3.6 Dependent Special Enrollment Period

2.3.6.1 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 60 days of birth, complete proper application to add the newborn child and pay any required Premium within that 60-day period or a period consistent with the next billing cycle. With such notice, the Effective Date for Your newborn Child will be the date of birth. If You notify the Health Plan after that 60-day period, Your newborn child will be considered a Late Enrollee.

2.3.6.2 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 60 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 60-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 60-day period, Your adopted child will be considered a Late Enrollee.

2.3.6.3 Court Ordered Dependent Children

If a court has ordered You to provide coverage for a child, written application and the required Premium must be received within 31 days after Your Group receives notice of the court order. The Effective Date will be the day application for coverage is received by the employer or Health Plan and the required premium is received. If You notify the Health Plan after the 31-day period, the Dependent Child will be considered a Late Enrollee.

2.3.6.4 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.

2.3.6.5 Loss of Child's Coverage under a Governmental Program

If Your Dependent Child loses coverage 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 31 days after the date on which coverage was lost. If application is not made within the initial 31 days, the Dependent Child will be considered a Late Enrollee.

2.3.7 **Other Dependents**

2.3.7.1 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.

2.3.7.2 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.

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

2.3.8 **Employee Special Enrollment Period**

2.3.8.1 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.

2.3.8.2 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.

2.3.8.3 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.

2.4 **Additional Requirements**

2.4.1 The composition of Group and the requirements determining eligibility for membership in Group's health benefit 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.

2.4.2 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, 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.

2.4.3 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.

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

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

3. PROVIDERS OTHER THAN HEALTH PLAN PROVIDERS

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

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

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

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

3.2 Contract Status of Providers

You should be aware of the contract status of the providers from whom you receive treatment, especially participating hospitals, as some facility-based physicians or other health care practitioners such as anesthesiologists, pathologists, and radiologists may not be included in Health Plan's network and may balance bill for amounts not 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.

4. TERMINATION OF COVERAGE

4.1 Termination of Coverage for Members

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

- 1) except for continuation privileges, on the date on which You and/or Your Covered Dependents cease to be eligible for coverage in accordance with this Agreement; or
- 2) thirty-one (31) days after written notice from Health Plan that You have failed to pay any Required Payment when due; or
- 3) thirty-one (31) days after written notice from Health Plan that a Participating Provider, after reasonable efforts, including the opportunity to select another Primary Care Physician, Referral Physician or Health Professional, has been unable to establish a satisfactory patient relationship with You or Your Covered Dependent. Prior to providing written notice of termination, Health Plan shall specify in writing the changes that are necessary in order to avoid termination; or
- 4) in the event of fraud or intentional misrepresentation by You or Your Covered Dependent, except as described under Incontestability, or fraud in the use of services or facilities, sixteen (16) days after written notice from Health Plan; or
- 5) on the date You or Your Covered Dependent commits any act detrimental to safe Health Plan operations and the delivery of services; or
- 6) 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) Group fails to meet Minimum Group Size for at least six (6) consecutive months;
- 5) No Eligible Employees of the Group work, live or reside in the Service Area;
- 6) Health Plan elects to cease providing coverage to all small employers or large employers in its Service Area;
- 7) Health Plan elects to discontinue a particular type of coverage; or
- 8) Group elects to terminate this agreement.

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, except, if termination is due to Group's failure to meet the required Participation Percentage, termination shall be upon the first renewal date which occurs after Group has failed to maintain the required Participation Percentage for at least six (6) consecutive months. 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 (5) above, Health Plan shall give Group at least sixty (60) days advance notice. If termination is due to reason (4) above, 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 (6), Health Plan shall give all affected Groups at least 180 days advance written notice. If termination is due to reason (7), Health Plan shall give Group at least ninety (90) days advance written notice and offer Group the option to purchase other coverage. If termination is due to reason (8), Group shall give Health Plan at least sixty (60) days advance written notice; however, if termination is due to a material change by Health Plan to any provisions required to be disclosed to Group or Members pursuant to State law or regulation which adversely affects benefits or services provided, Group shall give Health Plan at least thirty (30) days advance written notice.

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

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

5.2 COBRA Continuation of Coverage

The Group will provide written notice to each Member enrolled through the Group of the continuation coverage available to Members under the Consolidated Omnibus Budget Reconciliation Act (COBRA). If any Member is granted the right to continue coverage beyond the date when Member's coverage would otherwise terminate, this Health Plan will be deemed to allow continuation of coverage to the extent necessary to comply with COBRA requirements. Member should contact the employer or Group 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 Member whose coverage under this Agreement has been terminated for any reason except involuntary termination for cause, and who has been continuously covered under this Agreement or any similar group contract providing similar services and benefits which it replaces for at least three (3) consecutive months

immediately prior to termination shall be eligible to continue coverage as follows:

- 1) Continuation of group coverage must be requested in writing within 31 days following the later of:
 - a. the date the group coverage will terminate; or
 - b. the date the Member is given notice of the right of continuation by either the employer or the Contract Holder.
- 2) A Member electing continuation coverage must pay to the employer or Contract Holder on a monthly basis, in advance, the Premiums, plus 2% of the total health premium when due.
- 3) Continuation coverage will continue until the earliest of:
 - a. 6 months after the date the election for continuation coverage is made;
 - b. the date on which failure to make payments would terminate coverage;
 - c. the date on which the Member is covered for similar services and benefits by another health plan; or
 - d. the date on which this Agreement terminates as to all Members.
- 4) If the Subscriber dies, retires or the Subscriber's family relationship with Covered Dependents is otherwise terminated due to "divorce," which term shall include annulment and legal separation for purposes of this Section, and a Covered Dependent loses coverage, the Subscriber's Covered Dependent may continue group coverage pursuant to this Agreement. Continuation coverage will not be conditioned in any way on the Covered Dependent's health status or condition. However, this continuation coverage does not include Covered Dependents who have been covered pursuant to this Agreement for less than one year, except for covered dependent children less than one year of age. The premiums charged for this continuation coverage shall be no more than the premiums charged for all other individuals covered by this Agreement. To elect this continuation coverage, the subscriber, his or her personal representative or the Covered Dependent must notify Group within fifteen (15) days of the Subscriber's death, retirement or divorce. Upon receipt of such notice, the Group will immediately give written notice to each affected Covered Dependent. The Covered Dependent must give written notice to the Group of its desire to continue coverage under this Agreement within sixty (60) days of the Subscriber's death, retirement or divorce. Coverage under this Agreement will remain in effect during the sixty (60) day period, provided that written notice is given, and the required premium paid, within the sixty (60) day period. This continuation coverage shall be concurrent with any other continuation coverage provided for under this Agreement. This continuation coverage will terminate upon the earlier of the following:
 - a. the day a premium is due and unpaid; or

- b. the day the Covered Dependent becomes eligible for similar coverage; or
- c. three (3) years from the date of the Subscriber's death, retirement or divorce.

5.4 **Texas High Risk Pool Coverage Notification**

Health Plan will notify Member that Member may be eligible for coverage under the Texas Health Insurance Risk Pool and provide Member with the address and toll-free telephone number to make application to the Texas Health Insurance Risk Pool not less than 30 days before termination of continuation of coverage under this Agreement.

6. REQUIRED PAYMENTS

6.1 Premiums

6.1.1 Payment of Premiums

Premiums are due in the office of the Health Plan, 2401 South 31st Street, Temple, Texas 76508 on or before the date indicated in the monthly billing statement issued to Group by Health Plan. The Contract Holder is responsible for informing Health Plan of any events which render an individual enrollee ineligible for coverage under this Agreement. Generally the Contact Holder is liable for premiums for a covered individual from the time that individual is no longer eligible for coverage until the end of the month in which the Contract Holder notifies Health Plan of that covered individual's ineligibility for coverage. However, in a covered member loses eligibility for coverage during the last seven (7) calendar days of any Month, and Health Plan receives notice from the Contract Holder of that covered individual's ineligibility for coverage during the first three business days of the immediately succeeding month, the Contract Holder is not liable for that individual's premium for that succeeding month.

Notice of an individual's loss of eligibility of coverage may be provided prior to the end of a month by United States Mail, postage prepaid or by other means. Mailed notice shall be deemed to have been received by Health Plan as of the date of delivery to the post office. Notice given during the first three business days of a succeeding month must be by a method that provides immediate notification, including hand delivered, internet portal, e-mail or facsimile.

For example, if a covered member loses eligibility by ceasing employment with the Contract Holder on June 2, and the Contract Holder doesn't inform Health Plan of this loss of eligibility until July 2, the employee, as well as that employee's covered dependents, would be entitled to coverage until through July 31, and the Contract Holder would be liable for those individual's premiums. If, however, the same employer lost eligibility on June 25, and the Health Plan received notice from the contract holder of that individual's ineligibility for coverage during the first three business days of July, the Contract Holder is not liable for that individual's premium for the month of July. It is the Contract Holder's responsibility to collect any premium contribution due from its covered employees. Premiums are Required Payments.

6.1.2 Premium Changes

Health Plan may change premium rates annually. Not less than sixty (60) days prior to expiration of the Contract Year, the Contract Holder shall be advised of the premium rates applicable for the upcoming year.

6.1.3 Contribution Requirements

A Group must contribute for any Subscriber who enrolls in Health Plan at least the same dollar amount as it contributes for any Subscriber who enrolls in other health coverage provided by the Group. A Group which pays a proportion of an employee's premium based on some percentage or other formula must contribute for a Subscriber who enrolls in Health Plan the same proportion of the Subscriber's total health premium as it contributes for any Subscriber who enrolls in other health coverage provided by the Group.

6.2 Copayments and Deductibles

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

6.3 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 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.

6.4 Late Payment Fee

A late payment fee may be assessed on any Premium not received by Health Plan at its offices when due. Such late payment fee will be calculated by Health Plan at the rate of 10% per annum. In no event will any such charge for late payments exceed the maximum rate allowed by law. Any late payment fee is considered to be a Required Payment from the Group.

6.5 Grace Period and Cancellation of Coverage

If any Premium is not received by the Health Plan within thirty (30) days of the due date, Health Plan may terminate coverage under this Agreement after the 30th day. During the 30-day grace period, coverage shall remain in force. However, if payment is not received, Health Plan shall have no obligation to pay for any services provided to You or Your Covered Dependents during the 30-day grace period or thereafter, and You shall be liable to the Provider for the cost of those services.

7. HEALTH CARE SERVICES

7.1 Health Care Services Within the Service Area

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

7.2 Health Care Services Outside of the Service Area

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

7.3 Limitations and Exclusions

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

7.4 Health Care Services that are not Medically Necessary

In the event that the Medical Director determines that a Health Care Service proposed or provided, to You or Your Covered Dependent is not medically necessary, You 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. 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.

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

7.5.1 Health Care Services and Your Beliefs

You understand that the Health Plan is a health maintenance organization and not an indemnity insurance company and that Health Plan arranges for the provision of Health Care Services through contractual arrangements with certain providers. Health Plan reserves the right to contract with such providers of Health Care Services as it shall determine can reasonably provide them. Health Plan's Participating Providers shall determine the manner of provision of those Health Care Services and such services are subject to their discretion. Not every form of Treatment may be provided, and even though certain of Your personal beliefs or preferences may be in conflict with the care as offered by Participating Providers, You shall not be entitled to any specific class of licensed provider, school of approach to such services or otherwise be able to determine the providers who will care for You or Your Covered Dependents other than as provided in this Agreement. This provision does not restrict Your right to consent or agree to any procedure or Treatment. However, this provision defines the coverage provided under this Agreement. Your decision to follow medical advice or to seek any particular Treatment is solely yours and you agree to bear all legal and ethical consequences of the decision without regard to the coverages provided hereunder.

7.5.2 Provision of Health Services

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

7.6 Refusal to Accept Treatment

Should You or Your Covered Dependent refuse to cooperate with or accept the recommendations of Participating Providers with regard to health care for You or Your Covered Dependent, Participating Providers may regard such refusal as a failure of the patient relationship and as

obstructing the delivery of proper medical care. In such cases, Participating Providers shall make reasonable efforts to accommodate You or Your Covered Dependent. However, if the Participating Provider determines that no alternative acceptable to the Participating Provider exists, You shall be so advised. If You or Your Covered Dependent continues to refuse to follow the recommendations, then neither Health Plan or its Participating Providers shall have any further responsibility under this Agreement to provide care for the condition under Treatment, and may terminate You or Your Covered Dependent's coverage in accordance with this Agreement.

7.7 **Coordination of Health Care Services**

7.7.1 **Designation of Primary Care Physician**

At the time of enrollment under this Agreement, You or Your Covered Dependents should designate a Primary Care Physician to coordinate the delivery of Health Care Services. Should You or Your Covered Dependent fail to designate a Primary Care Physician, Health Plan will assign one.

7.7.2 **Selection of Primary Care Physician**

Primary Care Physicians must be selected from the list of Primary Care Physicians published by the Health Plan and supplied to each new Member. The right to select a particular Participating Physician as a Primary Care Physician is subject to that physician's availability. A current, updated list of Primary Care Physicians may be found on Health Plan's website, www.swhp.org.

7.7.3 **Changing Your Primary Care Physician**

You or Your Covered Dependents may change Your Primary Care Physician designation as reasonable to reflect changes in Your medical needs (for example, a Covered Dependent changing from a pediatrician to an internist) or preferences. A Primary Care Physician may also require You to change to another Primary Care Physician.

7.7.4 **Role of Primary Care Physician**

The Primary Care Physician is responsible for coordinating medical care and the delivery of Health Care Services under this Agreement. Except for Emergency Care Services, weekend/evening clinics, OB/GYN services, and eye refractions through participating optometrists, You and Your Covered Dependents must contact Your Primary Care Physician for all Health Care Services, including, but not limited to, referral to a Referral Physician or to a physician or facility not under contract with Health Plan.

7.7.5 **Access to Specialist without Referral**

Effective only after approval by Health Plan, if You or Your Covered Dependent has a chronic, life-threatening, or disabling condition, You may apply to the Medical Director to be allowed to access a physician specialist without having to have a referral from a Primary Care Physician. The following conditions must be met:

- the condition must, in the opinion of the Medical Director, qualify;
- the specialist must agree to provide the necessary specialty care and coordinate the other health care needs of the patient; and
- the specialist must be qualified, in the opinion of the Medical Director, to perform these dual roles.

The Medical Director's decision to deny the request may be appealed as described in the Complaint and Appeal Procedure.

7.7.6 **Open Access to OB/GYN**

In addition to a Primary Care Physician, a female Member may select an OB/GYN Physician to provide obstetrical and gynecological specialty medical services under the terms of the Health Care Agreement. As used herein, OB/GYN Physician means a Participating Physician approved by the Health Plan to provide obstetrical or gynecological services.

The terms of this Agreement and Health Plan's rules pertaining to the Member's selection and deselection of a Primary Care Physician shall apply to the selection and deselection of an OB/GYN Physician. A female Member may have only one OB/GYN Physician at a time. The selected OB/GYN Physician shall have the right to accept, reject or terminate that Member as his or her patient. Once the Member has selected and been accepted by an OB/GYN Physician, the Member may receive Medically Necessary obstetrical and gynecological specialty medical services from that OB/GYN Physician without having to have approval or authorization from the Member's Primary Care Physician or Health Plan. However, the selected OB/GYN Physician may limit the range of obstetrical and gynecological services he or she provides under the terms of this Agreement.

7.8 **Continuity of Treatment**

7.8.1 **Notice of Termination of Treating Physician or Provider**

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

7.8.2 **Continued Treatment by Terminated Physician or Provider**

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

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

7.9 **Health Care Services Not Available From Contracting Providers**

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

8. CLAIM PROCEDURE

8.1 Necessity of Filing Claims

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

8.2 Effect of Failure to File Claim Within 60 Days

Failure to submit written proof of and claim for payment within the 60 day period shall not invalidate or reduce Your entitlement to reimbursement provided it was not reasonably possible for You to submit such proof and claim within the time allowed and written proof of and claim for payment were filed as soon as reasonably possible. Written proof and claim for payment submission should consist of itemized receipts containing: name and address where services were received, date service was provided, amount paid for service, and diagnosis for visit. Claims for reimbursement should be sent to Scott & White Health Plan, Attn: Claims Dept., 2401 South 31st St., Temple, TX 76508. In no event will Health Plan have any obligation under this paragraph if such proof of and claim for payment is not received by Health Plan within one (1) year of the date the services were provided to You or Your Covered Dependent.

8.3 Acknowledgement of Claim

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

8.4 Acceptance or Rejection of Claim

Not later than the fifteenth (15th) business day after receipt of all requested items and information, Health Plan will notify You in writing of the acceptance or rejection of the claim and the reason if rejected; or notify You that additional time is needed to process the claim and state the reason Health Plan needs additional time. If additional time

is needed to make a decision, Health Plan shall accept or reject the claim no later than the forty-fifth (45th) day after you have been notified of the need for additional time.

8.5 Payment of Claims

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

8.6 Payment to Physician or Provider

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

8.7 Limitations on Actions

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

9. EFFECT OF MEDICARE, SUBROGATION AND COORDINATION OF BENEFITS

9.1 Effect of Medicare

Regardless of any other provisions of this Agreement to the contrary, on and after the first day You or Covered Dependent become entitled to coverage under Medicare and Medicare would be the primary payor of benefits, You or Your Covered Dependent shall not be eligible for, nor entitled to receive, any further benefits under this Agreement 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 Parts A and B of 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 Participating Providers for the services provided.

9.2 Subrogation

9.2.1 **Health Plan's Right to Reimbursement**

If another person or entity is, or may be, responsible to pay for or provide health care services to You or Your Covered Dependent and if Health Plan paid for or provided those health care services, then Health Plan is entitled to subrogation rights against such person or entity. Health Plan is also entitled to recover from You the value of services provided, arranged, or paid for, when You were reimbursed for the cost of care by another party, including Your auto insurance for Uninsured Motorist and Underinsured Motorist coverage. Health Plan is also entitled to recover its costs and expenses related to recovery activities, including, but not limited to, attorney's fees and court costs.

9.2.2 **Action Against Party Liable**

By receiving service from Health Plan, You assign to Health Plan the right to proceed in Your name to secure right of recovery of its costs, expenses, or the value of services rendered. The value of services rendered which Health Plan is entitled to recover shall be limited to the cost of providing such services. Health Plan is entitled to discharge of its subrogation rights on a prorata basis with any other contractual or statutory subrogation holder. Furthermore, Health Plan is entitled to deem the first amounts received by You as recoupment of the value of health care services or damages to which Health Plan is entitled to subrogate up to the value of Health Plan's claim.

9.2.3 **Cooperation with Health Plan**

You shall cooperate fully in the exercise of these rights of subrogation and shall take no action or refuse to take any action which would prejudice the rights of Health Plan. You may not settle, compromise or release a claim against a third party unless (1) the rights of Health Plan are expressly reserved in the settlement, compromise or release and You advise the Health Plan in writing within such period of time as is reasonably necessary to protect Health Plan's rights, (2) Health Plan is paid in full, or (3) Health Plan has given a written waiver of claim after notice. Health Plan reserves the right to select its own representation, including legal representation, in pursuit of its subrogation rights herein, You shall distribute to Health Plan any subrogation without offset for attorney's fees or other costs of representation.

9.3 Coordination of Benefits

9.3.1 If this Coordination of Benefits (COB) provision applies, the order of benefit determination rules will be looked at first. Those rules determine whether the benefits of This Plan (defined below) are determined before or after those of another plan. The benefits of This Plan:

- 1) Shall not be reduced when This Plan determines its benefits before another plan; but
- 2) May be reduced when another plan determines its benefits first.

9.3.2 **Definitions Relating to Coordination of Benefits**

The following definitions apply only to the COB provisions of this Agreement.

9.3.2.1 "Plan" is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

- 1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
- 2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title IX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).
- 3) Auto no fault or medical payments coverage.

Each contract or other arrangement for coverage under 1, 2 or 3 is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

9.3.2.2 "This Plan" is the part of the policy that provides benefits for health care expenses.

9.3.2.3 "Primary Plan/Secondary Plan" means the order of benefit determination rules state whether This Plan is a

Primary Plan or Secondary Plan covering You or Your Covered Dependent.

When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering You or Your Covered Dependent, This Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

9.3.2.4 "Allowable Expense" means a necessary, reasonable and customary item of expense for health care; when the item of expense is covered at least in part by one or more plans covering You.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in the plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

When benefits are reduced under a Primary Plan because You do not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions or Recertification of admissions or services.

9.3.2.5 "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which You have no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

9.3.3 Order of Benefit Determination and Priority Between Plans

When there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan which has its benefits determined after those of the other plan, unless:

The other plan has rules coordinating its benefits with those of This Plan; and

Both those rules and This Plan's rules require that This Plan's benefits be determined before those of the other plan.

The following rules apply in determining priority:

9.3.3.1 Non-Dependent/Dependents

This Plan determines its order of benefits using the first of the following rules which applies:

The benefits of the plan which covers You as an employee or Subscriber are determined before those of the plan which covers You or Your Covered Dependent as a dependent, except that: You or Your Covered Dependent is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

- 1) secondary to the Plan covering You or Your Covered Dependent as a dependent; and
 - 2) primary to the Plan covering You or Your Covered Dependent as other than a dependent;
- then the benefits of the Plan covering You or Your Covered Dependent as a dependent are determined before those of the Plan covering You or Your Covered Dependent as other than a dependent.

9.3.3.2 Dependent Child of Parents Not Separated or Divorced

Except as stated in paragraph 9.3.3.3 below, when This Plan and another Plan cover the same child as a dependent of different parents:

- 1) the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but
- 2) if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in paragraph 9.3.3.2(1), but instead has a rule based on gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

9.3.3.3 Dependent Child of Separated or Divorced Parents

If two or more Plans cover a Member who is a dependent child of divorced or separated parents, benefits for the child are determined in this order:

- 1) first, the Plan of the parent with custody of the child;
- 2) then, the Plan of the spouse of the parent with custody of the child; and
- 3) finally, the Plan of the parent not having custody of the child.

However, if a Qualified Medical Support Order states that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first.

The plan of the other parent shall be the Secondary Plan. This paragraph does not apply when any benefits are actually paid or provided before the entity has that actual knowledge.

9.3.3.4 **Joint Custody**

If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, benefits for the child are determined in accordance with paragraph 9.3.3.2.

9.3.3.5 **Active/Inactive Employee**

The benefits of a Plan which covers You as an employee who is neither laid off nor retired, or as that employee's dependent, are determined before those of a plan which covers that person as a laid off or retired employee or as that employee's dependent. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this paragraph 9.3.3.5 is ignored.

9.3.3.6 **Continuation of Coverage**

If You or Your Covered Dependent's coverage is provided under a right of continuation pursuant to federal or state law and You and Your Covered Dependent is also covered under another plan, benefits for You or Your Covered Dependent are determined in this order:

- 1) first, the benefits of the plan covering You as an employee, or as that person's dependent;
- 2) second, the benefits under the continuation coverage.

If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

9.3.3.7 **Longer/Shorter Length of Coverage**

If none of the above rules determine the order of benefits, the benefits of the Plan which covered You or Your Covered Dependent longer are determined before those of the Plan which covered You or Your Covered Dependent for the shorter time.

9.3.4 **Effect on the Benefits of This Plan**

This section applies when This Plan is the Secondary Plan in accordance with the order of benefits determination outlined above. In this event, the benefits of This Plan may be reduced under this section. In addition, the benefits of This Plan will be refused when the sum of:

9.3.4.1 The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and the benefits that would be payable for the Allowable Expense under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the

benefits payable under the other plans do not total more than those Allowable Expenses.

9.3.4.2 When these rules reduce This Plan's benefits, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

9.4 **Facility of Payment**

Whenever payments which should have been made under This Plan in accordance with this provision have been made under any other plans, This Plan will have the right, exercisable alone and in as sole discretion, to pay directly to any organizations making such other payments any amounts it will determine to be warranted in order to satisfy the intent of this provision. Amounts so paid will be deemed to be benefits paid under This Plan. To the extent of such payments, This Plan will be fully discharged from liability under This Plan.

9.4.1 **Right of Recovery**

Whenever payments have been made by This Plan with respect to Health Care Services in a total amount in excess of the maximum amount of payment necessary to satisfy the intent of this provision. This Plan will have the right to recover such excess payments from any party to whom or on behalf of whom such payments were made, including:

- 1) the persons to or for whom it has provided such benefits (but only to the extent that person has received payment from another Plan for a service or supply provided under This Plan);
- 2) insurance companies;
- 3) other organizations.

The "amount of the payments made" includes the reasonable cash value of the benefits provided in the form of services.

9.5 **Right to Release and Receive Needed Confidential Information**

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

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

10. RECORDS

- eligibility for recovery from a third party of benefits which may be subject to subrogation.

10.1 Records Maintained by Health Plan

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

10.2 Necessity of Requested Information

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

10.2.1 Authorization for Health Care Information from Physicians and Providers

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

10.3 Notification of Changes in Status

You shall notify Health Plan immediately in writing of any fact which may affect 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

11. COMPLAINT AND APPEAL PROCEDURE

11.1 Purpose

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

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

11.2 Complaints

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

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

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

11.3 Appeals

11.3.1 If the Complainant is not satisfied with Health Plan's resolution of the Complaint, the Complainant will be

given the opportunity to appear before an appeal panel or address a written Appeal to an appeal panel.

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

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

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

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

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

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

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

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

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

11.4 **Appeal of Adverse Determinations**

11.4.1 A member, a person acting on behalf of the member, or the member's physician or health care provider may appeal an Adverse Determination orally or in writing to a Member Relations Coordinator. Health Plan will send an acknowledgment letter of the receipt of oral or written Appeal of Adverse Determination from Complainants no later than five (5) business days after the date of the receipt of the Appeal. The acknowledgment letter will include a description of the Health Plan's Appeal procedures and time frames, as well as a reasonable list of documents needed to be submitted by the Complainant for the Appeal. If the Appeal is received orally, the Health Plan will also enclose a one-page Appeal form, which must be returned for prompt resolution of the Appeal.

11.4.2 Health Plan will issue a response letter to the patient or a person acting on behalf of the patient, and the patient's physician or health care provider, explaining the resolution of the appeal; and provide written notification to the appealing party of the determination of the Appeal, as soon as practical, but in no case later than thirty (30) calendar days after the date the Health Plan receives the 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 clinical basis for the Appeal denial;

- 2) the specialty of the physician or other health care provider making the denial; and
- 3) notice of the appealing party's right to seek review of the denial by an Independent Review Organization as provided in this Evidence of Coverage.

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

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

11.4.5 Notwithstanding any provisions to the contrary, in a circumstance involving an enrollee's life-threatening condition, 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 Evidence of Coverage.

11.4.6 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 Evidence of Coverage.

11.5 **Independent Review of Adverse Determinations**

11.5.1 Health Plan will permit any party whose Appeal of an Adverse Determination is denied to seek review of that determination by an Independent Review Organization assigned to the appeal in accordance with Texas Insurance Code Chapter 4202.

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

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

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

12. MISCELLANEOUS PROVISIONS

12.1 Confidentiality

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

12.2 Independent Agents

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

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

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

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

12.3 Changes in Coverage

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

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

12.4 Entire Agreement

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

12.5 Severability

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

12.6 Modification of Terms

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

12.7 Not a Waiver

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

12.8 Venue

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

12.9 Recovery

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

12.10 Notice

With the exception of electronic notices sent pursuant to subparagraph 6.1.1 of this Agreement, any notice under this Agreement shall be given by United States Mail, postage prepaid, addressed as follows:

If to Health Plan:

Scott and White Health Plan
2401 South 31st Street
Temple, Texas 76508

If to You:

To the latest address provided by You

If to a Contract Holder:

To the latest address provided by the Contract Holder.

12.11 Incontestability

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

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

This Agreement may only be contested because of fraud or intentional misrepresentation of material fact on the Enrollment Application. If the Group has less than 50 employees, the misrepresentation shall be other than a misrepresentation related to health status. 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.

12.12 Proof of Coverage

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

12.13 Identification Card

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

DESCRIPTION OF BENEFITS

13. WHAT'S COVERED?

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

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

You and Your Covered Dependent's entitlement to Health Care Services is contingent upon such services being determined as Medically Necessary and prescribed or ordered by a designated Primary Care Physician, Participating OB/GYN Physician or, upon an approved referral, a Participating Physician, Participating Provider or Referral Physician. Health Care Services are also contingent upon all definitions, terms, conditions, and limitations on Health Care Services set forth in all parts of this Agreement being met. In order to receive these Health Care Services, You must pay the Copayments and Deductibles specified in the Schedule of Benefits and any amendments and riders to this Agreement. Except for Emergency Care Services, Referrals and Health Care Services provided to a Covered Dependent child under a Qualified Medical Support Order who is outside the Service Area, all of the benefits are to be provided by Participating Physician and Participating Providers. You must select a Primary Care Physician for You and Your Eligible Dependents who will coordinate the delivery of Health Care Services.

13.1 COPAYMENTS AND DEDUCTIBLES

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

13.2 OUT-OF-POCKET MAXIMUM

If the amount of qualifying Out-of-Pocket Expenses You pay during a Contract 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. Copayments paid under any rider attached to this Agreement, including a Prescription Drug Rider, are not considered Out-of-Pocket Expenses for purposes of meeting Your Out-of-Pocket Maximum. Copayments for a Specialty Pharmacy Drug appearing on Level 4 of the formulary under Section 13.5 of this Agreement are not considered Out-of-Pocket Expenses for purposes of meeting Your Out-of-Pocket Maximum. Out-of-Contract Copayments and Out-of-Contract Deductibles paid under Section 13.7 of this Agreement are not considered Out-of-Pocket Expenses for purposes of meeting Your Out-of-Pocket Maximum.

OOP 1/2009

13.3 BENEFIT LIMITATIONS

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

LIMITS 1/2009

13.4 CASE MANAGEMENT PROGRAM

Health Plan has in place Case Management Programs for Members 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 Management program, You may be contacted by Health Plan or Health Plan's designated case management vendor and offered the opportunity to participate in case management.

Participation in Case Management is strictly voluntary.

CM 1/2009

13.5 BENEFITS

13.5.1 MEDICAL SERVICES

You and Your Covered Dependents are entitled to the Medically Necessary professional services of Participating Physicians and Participating Providers on an inpatient and outpatient basis. Medical Necessity is determined by the designated Primary Care Physician or Participating OB/GYN Physician, subject to the review of the Health Plan Medical Director.

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

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

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

MED 1/2009

13.5.2 PREVENTIVE CARE SERVICES

You and Your Covered Dependents are entitled to the Medically Necessary Preventive Services of Participating Physicians and Participating Providers. Medical Necessity is determined by the designated Primary Care Physician or Participating OB/GYN Physician, subject to the review of the Health Plan Medical Director.

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

Examples of covered Preventive Care Services may include, but are not limited to, the following:

- one annual physical exam by Your Primary Care Physician or one annual well-woman exam by your Primary Care Physician or OB/GYN
- well child care,
- age-appropriate pediatric and adult immunizations and boosters as described in the Immunization Provision of this Agreement
- newborn hearing screenings,
- lab and x-ray for screening purposes only as described in the Benefits for Screening Exam is Provision of this Agreement.

13.5.3 HOSPITAL SERVICES

You and Your Covered Dependents are entitled to the Medically Necessary services of any Participating Hospital to which You or Your Covered Dependent may be admitted by a Primary Care Physician or Referral Physician. In the event You or a Covered Dependent are admitted to a non-Participating Hospital by a Referral Physician to whom You or Your Covered Dependent were referred in accordance with Health Plan procedures, the services of the non-Participating Hospital will be covered on the same basis as admission to a Health Plan Hospital, provided admission to the non-Participating Hospital was approved in accordance with this Agreement. Health Plan will cover the cost of a semi-private room, or the equivalent thereof, for covered hospital admissions for routine acute care. For more intense levels of care, that level of care which is Medically Necessary will be covered. Medically necessary services for an inpatient stay following a mastectomy shall be covered under this provision.

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

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

13.5.4 EMERGENCY CARE SERVICES

13.5.4.1 QUALIFICATION OF EMERGENCY SERVICES

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

13.5.4.2 URGENT CARE SERVICES

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

13.5.4.3 EMERGENCY TRANSPORTATION SERVICES

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

13.5.4.4 EMERGENCY MEDICAL SERVICES

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

13.5.4.5 TRANSPORTATION TO PARTICIPATING FACILITY AFTER STABILIZATION

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

13.5.4.6 EMERGENCY CARE COVERAGE EXCEPTIONS/LIMITATIONS

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

13.5.4.7 HOSPITALIZATION AT OTHER THAN PARTICIPATING HOSPITAL

If You or Your Covered Dependent is hospitalized at other than a Participating Hospital, You must notify Health Plan within forty-eight (48) hours of admission or as soon thereafter as it is reasonably possible, and Health Plan shall provide information about its obligations under this Agreement. Failure to provide notification may result in denial of payment unless it is shown not to have been reasonably possible to give such notice.

13.5.5 MENTAL HEALTH CARE

Medically Necessary Inpatient and Outpatient Treatment of Your or Your Covered Dependent's mental illness, emotional disorders and Serious Mental Illness are determined by the designated Primary Care Physician. Services provided for Outpatient Mental Health Care and Inpatient Mental Health Care listed below are limited to those services which, in the judgment of a Participating Physician, meet or exceed Treatment goals as set forth in the Individual Treatment Plan within the benefits described below. Covered services include the following:

13.5.5.1 OUTPATIENT MENTAL HEALTH CARE

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

13.5.5.2 INPATIENT MENTAL HEALTH CARE

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

13.5.5.3 COPAYMENTS AND DAY LIMITS ON MENTAL HEALTH CARE

For outpatient mental health care, You or Your Covered Dependents are entitled to the number of outpatient mental health care visits per Contract Year stated in the Schedule of Benefits. You are required to pay the Copayment for each outpatient mental health care visit to or by a Health Professional during normal working hours on a Participating Provider's premises and on weekends, after normal working hours, or away from Participating Provider's premises as stated in the Schedule of Benefits.

For inpatient mental health care, You or Your Covered Dependents are entitled to the number of days for inpatient services per Contract year stated in the Schedule of Benefits.

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

13.5.5.4 PSYCHIATRIC DAY TREATMENT FACILITY

Psychiatric Day Treatment Facility services are available for Medically Necessary mental health evaluations, diagnostic and therapeutic services, as shall be recommended by a Participating Physician in lieu of hospitalization upon a referral to such facility, if any, with which Health Plan may maintain an agreement for the provision of such services. In order to be considered for coverage, the Participating Physician attending a member must certify that treatment at such facility is in lieu of hospitalization. Two (2) days of Treatment at a Psychiatric Day Treatment Facility shall be counted as one (1) day of inpatient care for purposes of applying the stay in such a facility against the inpatient mental health care limits stated in the Schedule of Benefits.

13.5.5.5 RESIDENTIAL AND STABILIZATION MENTAL HEALTH TREATMENT

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

13.5.5.6 QUALIFICATION OF RESIDENTIAL AND STABILIZATION MENTAL HEALTH TREATMENT

The above alternative mental health Treatment benefits may be covered by Health Plan under the following conditions:

- 1) as determined by a Participating Physician specializing in psychiatry, You or Your Covered Dependents have a serious mental illness which substantially impairs thought, perception of reality, emotional process, or judgment or grossly impairs behavior as manifested by recent disturbed behavior and which would otherwise necessitate confinement in a hospital if such care and Treatment were not available through a Crisis Stabilization Unit or Residential Treatment Center for Children and Adolescents;
- 2) the services rendered for which benefits are to be paid must be based on an Individual Treatment Plan; and
- 3) providers of services for which benefits are to be paid must be licensed or operated by the appropriate state agency or board to provide those services, be located within the Service Area, and be designated by Health Plan as an approved provider with which Health Plan has entered into an agreement for the provision of such services.

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

13.5.5.7 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, paranoid and other psychotic disorders; bipolar disorders (hypomanic, manic, depressive, and mixed), major depressive disorders (single episode or recurrent), schizo-affective disorders (bipolar or depressive), obsessive-compulsive disorders, and depression in childhood and adolescence.

13.5.5.8 COPAYMENTS AND DAY LIMITS ON TREATMENT FOR SERIOUS MENTAL ILLNESS

You will pay the same Copayments for the Treatment of Serious Mental Illness as for any other physical illness. Treatment for Serious Mental Illness is limited to the number of inpatient and outpatient days stated in the Schedule of Benefits. If there is a limit on the number of days for which You or Your Covered Dependent would pay for an inpatient Hospital stay, that same limit would apply to an inpatient Serious Mental Illness stay. A Serious Mental Illness outpatient visit solely for the purpose of medication management shall not be applied against the maximum number of outpatient visits as stated above and shall be covered on the same basis as an outpatient visit for physical illness.

13.5.6 TREATMENT FOR CHEMICAL DEPENDENCY

13.5.6.1 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 applicable limitations, and exclusions provisions of this Agreement, and the Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers, adopted by the Texas Department of Insurance.

13.5.6.2 COPAYMENT/LIFETIME MAXIMUM FOR CHEMICAL DEPENDENCY

You or Your Covered Dependents are required to pay the same Copayments for Outpatient Treatment for Chemical Dependency as for other outpatient benefits provided under this Agreement. You or Your Covered Dependents are required to pay the same Copayments for Inpatient Treatment for Chemical Dependency as for other inpatient benefits provided under this Agreement. Benefits for the Treatment of Chemical Dependency shall be limited to the Lifetime Maximum benefit for each covered Member of three (3) separate series of Treatments. This Lifetime Maximum shall apply to inpatient and outpatient treatment combined, and is not considered to be one maximum for inpatient treatment and a separate maximum for outpatient treatment.

13.5.7 REHABILITATIVE THERAPY

13.5.7.1 REHABILITATIVE THERAPY

As recommended by a Participating Physician or Referral Physician as Medically Necessary, outpatient rehabilitative therapy services are available for services for physical, inhalation, speech, hearing, and occupational therapies. Rehabilitation and services that, in the opinion of the Participating Physician or Referral 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.

13.5.7.2 EARLY CHILDHOOD INTERVENTION SERVICES

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

13.5.8 HOME HEALTH SERVICES

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

13.5.9 HOME INFUSION THERAPY BENEFIT

As recommended by a Participating Physician or Referral Physician and approved by the Medical Director as Medically Necessary, Home Infusion Therapy services are available for high technology services, including line care, chemotherapy, pain management infusion and antibiotic, antiviral or antifungal therapy. Included within the Home Infusion Therapy benefit are administrative and professional pharmacy services and all necessary supplies and equipment to perform the home infusion. Not included in the Home Infusion Therapy benefit are medical professional services (physician, nursing, etc), enteral formula, and covered durable medical equipment not related to the home infusion therapy some of which may be covered under other provision of this Agreement, and subject to additional copayments. Specialty Pharmacy Drugs administered through Home Infusion Therapy will be covered under Your Specialty Pharmacy Drug benefit, if applicable, and will be subject to the appropriate copayment under that benefit. Prescription drugs administered through Home Infusion Therapy may be covered under your Prescription Drug Benefit, if any, and may be subject to additional copayments under that benefit.

13.5.9.1 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.

13.5.10 HOSPICE SERVICES

Hospice services consist of Medically Necessary Hospice care that is recommended by a designated Participating Physician, approved in advance by the Medical Director, and provided by a licensed Hospice agency with which Health Plan has arranged for You or Your Covered Dependent's care and Treatment.

13.5.11 MATERNITY SERVICES

13.5.11.1 MATERNITY SERVICES

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

13.5.11.2 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 Participating Physician or is requested by the mother.

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

13.6.11.3 COPAYMENTS FOR MATERNITY SERVICES

You are required to pay a Copayment for each outpatient visit to or by a Health Professional during normal working hours on provider's premises, on weekends, after normal working hours or away from provider's premises as stated in the schedule of benefits. A Copayment is also required for each day of inpatient services for the amount and days as stated in the Schedule of Benefits.

13.5.12 FAMILY PLANNING SERVICES

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

- counseling,
- sex education instruction in accordance with medically acceptable standards,
- contraceptive devices,
- placement of contraceptive devices,
- 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.

**13.5.13 DURABLE MEDICAL
EQUIPMENT/ORTHOTICS/
PROSTHETIC MEDICAL
APPLIANCES**

As approved by the Medical Director and prescribed by a Participating Physician, Medically Necessary durable medical equipment or prosthetic medical appliances 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 Contract Year specified in the Schedule of Benefits.

13.5.13.1 CONSUMABLE SUPPLIES

Consumable supplies associated with the use of covered durable medical equipment and prosthetic medical appliances are covered under this Agreement only to the extent that such supplies are required in order to use the specific piece of durable medical equipment or prosthetic medical appliance. Repair, maintenance, and cleaning due to abnormal wear and tear or abuse is Your responsibility. Benefits for consumable supplies will be applied to the maximum benefit for the device with which the consumable supply is associated.

**13.5.13.2 DURABLE MEDICAL EQUIPMENT/
ORTHOTICS**

Durable Medical Equipment/Orthotics may be covered under this Agreement if determined as Medically Necessary by the Medical Director. Durable Medical Equipment/Orthotics is equipment intended for repeated use, primarily and customarily used to treat a medical condition covered under this Agreement, and not customarily useful in the absence of a covered illness or injury. Ostomy supplies are considered Durable Medical Equipment for purposes of this Provision. Rented or loaned equipment must be returned in satisfactory condition and You are responsible for cleaning and repair required due to abnormal wear and tear or abuse. Coverage for rented or loaned equipment is limited to the amount such equipment would have cost if purchased by Health Plan from a Participating DME provider. Health Plan shall have no liability for installation, maintenance or operation of such equipment for home-based use. Health Plan shall provide coverage for durable medical equipment and orthotics up to the maximum benefit per Contract Year specified in the Schedule of Benefits.

**13.5.13.3 PROSTHETIC MEDICAL
APPLIANCES**

Prosthetic Medical Appliances 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. Prosthetic Medical Appliances are artificial substitutes for missing body parts, such as an arm or leg, used for functional purposes. Health Plan shall cover the initial device, replacements due solely to growth, other Medically Necessary replacements for medical reasons and normal repairs. Health Plan shall provide coverage for prosthetic medical appliances up to the maximum benefit per Contract Year specified in the Schedule of Benefits.

13.5.14 IMMUNIZATIONS

This Agreement covers Immunizations for You and Your Covered Dependents. Immunizations mean immunizations against:

- diphtheria,
- haemophilus influenzae type b,
- hepatitis B,
- measles,
- mumps,
- pertussis,
- polio,
- rubella,
- tetanus,
- varicella, and
- other immunizations required by the laws of the State of Texas or the United States.

13.5.14.1 COPAYMENT FOR IMMUNIZATIONS

No Copayment is charged for age appropriate Immunization agents. However, Copayments for other Health Care Services rendered at the same time Immunizations are administered shall be payable at the applicable level for that Health Care Service as indicated in the Schedule of Benefits.

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13.5.15 COVERAGE OF PRESCRIPTION DRUGS

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

13.5.15.1 INPATIENT PRESCRIPTION DRUGS

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

13.5.15.2 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 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.

Copayments for Non-Preferred Specialty Pharmacy drugs will not be considered Out-of-Pocket Expenses for purposes of meeting Out-of-Pocket Maximum.

13.5.15.3 OUTPATIENT NON-SPECIALTY PHARMACY DRUGS ADMINISTERED IN OUTPATIENT SETTING

Outpatient Prescription Drugs which do not meet the definition of Specialty Pharmacy Drugs and which are dispensed and administered to You or Your Covered Dependent in the office of a Participating Provider or in another Outpatient setting, will be covered as a part of Your

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Medical Services benefit, and no additional Copayments 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 Participating Provider or in another Outpatient setting which cost \$300 or more for a single dose, and refillable prescriptions whose total cost during a twelve (12) month period could equal or exceed \$1,000, 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 Participating Provider, or in another Outpatient setting, require approval of a Medical Director in order to be covered as a part of Your Medical Services benefit. Without the prior approval of a Medical Director, coverage for Outpatient Prescription Drugs which do not meet the definition of Specialty Pharmacy Drugs and are dispensed by a pharmacy and administered by a Participating Provider will be excluded under this Agreement, unless covered by a Prescription Drug Benefit rider.

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

13.5.15.4 OUTPATIENT PRESCRIPTION DRUGS

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

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

13.5.15.5 DETERMINATION OF COVERAGE LEVEL FOR PRESCRIPTION DRUG BENEFITS

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

- 1) Prescription Drug administered while admitted in an inpatient setting;
- 2) Outpatient Specialty Pharmacy Drug;
- 3) Outpatient Prescription Drug that is not a Specialty Pharmacy Drug, administered in the office of a Participating Provider or other Outpatient setting; or
- 4) Outpatient Prescription Drug that is not a Specialty Pharmacy Drug and is not administered in the office of a Participating Provider, or other Outpatient setting, if Prescription Drug Benefit Rider is attached to this Agreement.

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

13.5.16 OUTPATIENT RADIOLOGICAL OR DIAGNOSTIC EXAMINATIONS

Outpatient Radiological and Diagnostic exams shall be covered as Medically Necessary and as prescribed and authorized by a Participating Physician or Provider. Examples of such services include:

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

13.5.16.1 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.

13.5.17 BENEFITS FOR SCREENING EXAMS

13.5.17.1 Prostate Cancer Screening Exam

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

13.5.17.2 Colorectal Cancer Screening Exam

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.

13.5.17.3 Exam for Detection and Prevention of Osteoporosis

You or Your Covered Dependent are eligible for medically accepted bone mass measurement for the detection of low bone mass and to determine the risk of osteoporosis and fractures associated with osteoporosis.

13.5.17.4 Low Dose Mammography

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

13.5.17.5 Cervical Cancer Screening

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

13.5.17.6 Phenylketonuria (PKU) or a Heritable Disease

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

13.5.18 BREAST RECONSTRUCTION BENEFITS

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

13.5.19 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.

13.5.20 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.

13.5.21 TREATMENT FOR CRANIOFACIAL ABNORMALITIES OF A CHILD

Coverage for Covered Dependents younger than 18 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 18 years. Dental services are excluded from coverage under this Agreement

**13.5.22 DIABETIC SUPPLIES,
EQUIPMENT AND SELF-
MANAGEMENT TRAINING**

If You or a Covered Dependent has been diagnosed with insulin dependent diabetes, non-insulin dependent diabetes, or abnormal elevated blood glucose levels induced by pregnancy or another medical condition, as Medically Necessary and prescribed by a Participating Physician or Health Professional, You or Your Eligible Dependent are eligible for coverage for Diabetic Supplies, Diabetic Equipment, and Diabetic Self-Management Training under this Agreement.

Coverage for 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 Participating Physician or Health Professional.

**13.5.22.1 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, 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.

**13.5.22.2 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.

13.5.23 TRANSPLANT SERVICES

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

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

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

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

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

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

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

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

13.5.24.1 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 similar to the treatment for the Acquired Brain Injury service.

13.5.25 AUTISM SPECTRUM DISORDER SERVICES

Coverage for generally recognized services prescribed to enrollees older than two years of age and younger than six years of age diagnosed with Autism Spectrum Disorder, is provided in accordance to a treatment plan recommended by the enrollee's Primary Care Physician.

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

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

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

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

13.5.25.1 COPAYMENTS FOR AUTISM SPECTRUM DISORDER SERVICES

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

13.6 OUT-OF-NETWORK REFERRALS

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

13.6.1 OUT-OF-POCKET EXPENSES FOR REFERRALS

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

OON REF 1/2009

13.7 OUT-OF-NETWORK BENEFITS

Except for Health Care Services described in this Agreement under the headings Emergency Care Services and Out-of-Network Referrals, Health Plan's obligation to pay for any health care service or Treatment received by You or Your Covered Dependent from any provider that does not contract with Health Plan, herein called out-of-network benefits, shall be limited to the Usual, Customary, and Reasonable charge for such services or the amount Health Plan would normally pay for such service or Treatment to providers that contract with Health Plan, whichever is less. You are required to pay any applicable Copayments, Deductible, and the provider's charges not paid by Health Plan for services which are not covered under the Health Plan and submitted as a Claim for reimbursement under this Agreement. Except as expressly authorized in this Agreement or as authorized out of contract by the Medical Director, this paragraph shall not be interpreted to authorize You to receive or obligate Health Plan to pay for coverage for health care services or Treatments by providers that do not contract with Health Plan.

13.7.1 AUTHORIZED OUT OF CONTRACT COPAYMENT

For out-of-network benefits authorized out of contract by the Medical Director, You are obligated to pay the Out-of-Contract Copayments stated in the Schedule of Benefits. Out-of-Contract Copayments shall not be considered Out-of-Pocket Expenses for purposes of meeting Out-of-Pocket Maximum.

13.7.2 AUTHORIZED OUT OF CONTRACT DEDUCTIBLE

Except for Emergency Care Services and approved out-of-network Referrals, for out-of-network benefits authorized out of contract by the Medical Director, and in addition to the Contract Year Deductible stated in the Schedule of Benefits, You are obligated to pay the Out-of-Contract Deductible stated in the Schedule of Benefits. The Out-of-Contract Deductible shall not be considered as Out-of-Pocket Expenses for purposes of meeting Out-of-Pocket Maximum.

OOC 1/2009

14. EXCLUSIONS AND LIMITATIONS

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

14.1 Abortions

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

14.2 Altered Sexual Characteristics

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

14.3 Blood and Blood Products

Blood, blood plasma, and other blood products are excluded.

14.4 Breast Implants

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

14.5 Chiropractic Services

Chiropractic Services are excluded.

14.6 Cosmetic or Reconstructive Procedures or Treatments

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

14.7 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.

14.8 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.

14.9 Dental Care

All dental care is excluded.

14.10 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.

14.11 Elective Treatment or Elective Surgery

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

14.12 Exceeding Benefit Limits

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

14.13 Experimental or Investigational Treatment

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

14.14 Family Member (Services Provided by)

Treatments or services furnished by a Physician or Provider who is related to You, or Your Covered Dependent, by blood or marriage, 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.

14.15 Family Planning Treatment

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

14.16 Genetic Testing

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

14.17 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.

14.18 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.

14.19 Infertility Diagnosis and Treatment

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

- in vitro fertilization unless covered by a rider;
- 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;
- abortions unless determined to be Medically Necessary or required to preserve the life of the mother.

14.20 Mental Health

Services for mental illness or disorders are limited to those services described in Mental Health Care and Treatment for Chemical Dependency provisions of this Agreement.

14.21 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 covered by Rider, are excluded.

14.22 Non-Covered Benefits/Services

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

14.23 Non-Emergent Treatment for Non-Plan Providers

In cases involving non-emergent Treatments performed or prescribed by non-Participating Providers, either inside or outside of the Service Area, and for which Health Plan has not authorized a referral, Health Plan will not cover any expenses associated with such Treatments. Complications of those Treatments will not be covered prior to the date Health Plan arranges for Member's transfer to Participating Providers.

14.24 Non-Payment for Excess Charges

No payment will be made for any portion of the charge for a service or supply in excess of the Usual, Customary, and Reasonable charges for such service or supply prevailing in the area in which the service or supply was received.

14.25 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.

14.26 Physical and Mental Exams

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

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

14.27 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.

14.28 Prescription Drugs

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

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

14.29 Refractive Keratotomy

Radial Keratotomy and other refractive eye surgery is excluded.

14.30 Reimbursement

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

14.31 Routine Foot Care

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

14.32 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.

14.33 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.

14.34 Transplants

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

14.35 Treatment Received in State or Federal Facilities or Institutions

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

14.36 Unauthorized Services

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

14.37 Vision Corrective Surgery, including Laser Application

Traditional or laser surgery for the purposes of correcting visual acuity is excluded.

14.38 War, Insurrection or Riot

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

14.39 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

PRESCRIPTION DRUG BENEFIT RIDER

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

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 physician with appropriate law enforcement agency registrations; which are prescribed by:

- (a) a Participating Physician, or
- (b) in connection with emergency Treatment, a physician in attendance on You or Your Covered Dependent at an emergency facility, or
- (c) by a Referral Physician to whom You or Your Covered Dependent has been referred by a Participating Physician; which are used for the Treatment of an illness or injury covered under this Agreement;
- (d) filled through a Health Plan Participating Pharmacy in accordance with this Agreement.

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 expedited review 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.

COVERAGE FOR OFF-LABEL USE OF DRUGS

Drugs prescribed to treat Your, or Your Covered Dependent's, covered chronic, disabling or life-

threatening illness are covered 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. 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 determined to be contraindicated for treatment of the current indication.

EVIDENCE BASED FORMULARY DEVELOPMENT

Health Plan provides coverage for prescription drugs in accordance with an evidence based formulary developed by Medical Group physicians and pharmacists comprising the Pharmacy and Therapeutics Committee. A formulary is a list of drugs for which Health Plan provides coverage at a reduced Copayment. To select drugs to be covered and placed on the formulary, the Pharmacy and Therapeutics Committee reviews at least quarterly the scientific evidence, economic data, and a wide range of other information about available drugs. Based upon that review, the committee selects the drugs it believes to be the most safe and effective 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 contract with the manufacturer of the drugs for discounts for Members. 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 effectiveness. 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. When necessary, a subcommittee may conduct an expedited review of a particular drug and make formulary determinations.

REQUEST FOR FORMULARY INFORMATION

You or Your Covered Dependent may contact Health Plan to find out if a specific drug is on the formulary. 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 physician will prescribe the drug for a particular medical condition or mental illness.

FORMULARY LISTS

Copayments vary based upon the list a particular drug has been placed on by Health Plan. Drugs on the Health Plan formulary List A, which are generic drugs, require the smallest Copayment; drugs on the Health Plan formulary List B, which are name brand drugs selected by the Pharmacy and Therapeutics Committee as the preferred drugs in each category on which the manufacturer has given Health Plan favorable value for Members, require an increased Copayment, and drugs on the Health Plan formulary List C, which are alternate choice drugs or other drugs for some medical conditions not treated by drugs on List A or B and usually of less favorable value from the manufacturer for Members, require the largest Copayment. 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.

CONTRACTED PHARMACIES

You must use the Scott and White Health Plan (SWHP) Pharmacy or a Participating Pharmacy for the following prescriptions:

- (1) initial and one-time prescriptions;
- (2) medical emergencies; and
- (3) drugs which cannot be mailed safely and legally.

If You have a bona fide medical condition or other legitimate circumstance which makes the refill procedure unreasonable, You may make a request for an exception to the SWHP Pharmacy Director. Requests based solely on preference will not be considered as a bona fide or legitimate circumstance or condition.

AUTHORIZATION REQUIREMENTS

One-time prescriptions which cost \$300 or more and refillable prescriptions whose total cost during a twelve (12) month period could equal or exceed \$1,000 may require preauthorization by the SWHP Medical Director.

EXCLUSIONS

This Prescription Drug Benefit excludes the following:

- (a) drugs which do not require a physician's order for dispensing (sometimes commonly referred to as "over-the-counter" drugs), except insulin;
- (b) anything which is not specified as covered or not defined as a drug, such as therapeutic devices, appliances, machines including syringes, except disposable syringes for insulin dependent Members, support garments, etc.;
- (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;
- (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;
- (i) any initial or refill prescription dispensed more than one (1) year after the date of the physician's order;
- (j) except for medical emergencies, drugs not obtained at a Participating Pharmacy;
- (k) drugs given or administered to You or a Covered Dependent while at a hospital, skilled nursing facility, or other facility;
- (l) biological products;
- (m) initial or refill prescriptions the supply of which would extend past the termination of this Agreement, even if the physician order was issued prior to termination; or
- (n) initial or refill prescriptions the supply of which would extend past the termination of this agreement even if the physician order was issued prior to termination.

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.

MAINTENANCE DRUGS

In order for a drug to be considered a Maintenance Drug, You or Your Covered Dependent must actually have taken the prescription drug for at least six (6) months, the prescribing physician must prescribe it for at least twelve (12) months, and the drug must appear on Health Plan's maintenance drug list. If these conditions are met, those prescription drugs qualify as "Maintenance Drugs" beginning with the 7th month, and coverage is provided at the Maintenance Drug Quantity appearing on the Schedule of Benefits.

MAXIMUM BENEFIT

This prescription drug benefit is subject to a maximum benefit payment per Member per Contract Year stated in the Schedule of Benefits. Once You or one of Your Covered Dependents have obtained covered prescriptions for which the Health Plan's obligation to pay equals this maximum benefit payment, You or that particular Covered Dependent are entitled to no further benefits under this benefit for the remainder of the Contract Year.

COPAYMENTS

You must pay the Copayment per quantity dispensed per prescription stated in the Schedule of Benefits. The Deductible and Copayments for prescription drugs shall not be considered Out-of-Pocket Expenses for purposes of meeting Your Out-of-Pocket Maximum.

ATTACHMENT 2 SCOTT AND WHITE HEALTH PLAN SERVICE AREAS

1. SERVICE AREAS

Figure 1 shows the approved Service Area of the Health Plan. Subscribers must work or reside inside of this Service Area in order to be covered by the Health Plan.

Service Area Description:

All of the following counties in central Texas: Bastrop, Bell, Blanco, Bosque, Brazos, Burleson, Burnet, Caldwell, Coke, Coleman, Concho, Coryell, Crockett, Falls, Grimes, Hamilton, Hays, Hill, Hood, Irion, Johnson, Kimble, Lampasas, Lee, Limestone, Llano, Madison, Mason, McCulloch, McLennan, Menard, Milam, Mills, Reagan, Robertson, Runnels, San Saba, Schleicher, Somervell, Sterling, Sutton, Tom Green, Travis, Walker, Washington, and Williamson; and, the portion described of each of the following counties in central Texas:

Austin--the northern one-third of the county above Texas Highway 159 east from the Fayette County line to Bellville and from Bellville east on Farm to Market Road 529 to the Waller County line but including the towns of Industry, Nelsonville, Bellville, and Burleigh;

Erath--the southeastern one-half of the county below U.S. Highway 377 southwest from the Hood County line to the Comanche County line but including the towns of Bluff Dale, Stephenville, and Dublin;

Leon--the southwestern one-fourth of the county bounded on the north by Texas Highway 7 east from the Robertson County line to Texas Highway 75 and bounded on the east by Texas Highway 75 south from Texas Highway 7 to the Madison County line but including the towns of Marquez, Robbins, Centerville, and Leona; and

Waller--the northern two-thirds of the county bounded on the south by Farm to Market Road 529 east from the Austin County line to Farm to Market Road 362 and bounded on the southeast by Farm to Market Road 362 from Farm to Market Road 529 north to the Harris County line but including the town of Waller.

2. ADMITTING HOSPITALS

Following Figure 1 is a listing of the names and addresses of the admitting hospitals in the service area.

ADMINISTRATIVE OFFICES

SCOTT AND WHITE
HEALTH PLAN
TEMPLE OFFICE
2401 South 31st Street
Temple, Texas 76508

SCOTT AND WHITE
HEALTH PLAN
WACO OFFICE
American Plaza
200 W. State Hwy 6, Ste. 300
Waco, Texas 76712

SCOTT AND WHITE
HEALTH PLAN BRYAN/
COLLEGE STATION OFFICE
3000 Briarcrest, Suite 422
Bryan, Texas 77802

SCOTT AND WHITE
HEALTH PLAN
GEORGETOWN OFFICE
204 S. IH-35, Suite 100
Georgetown, Texas 78628

ADMITTING HOSPITALS

SCOTT AND WHITE MEMORIAL
HOSPITAL
2401 South 31st Street
Temple, Texas 76508

PROVIDENCE HOSPITAL
6901 Medical Parkway
Waco, Texas 76712

METROPLEX HOSPITAL
2201 South Clear Creek Road
Killeen, Texas 76542

CORYELL MEMORIAL HOSPITAL
1507 West Main Street
Gatesville, Texas 76528

JOHNS COMMUNITY HOSPITAL
403 Mallard Lane
Taylor, Texas 76574

HAMILTON GENERAL HOSPITAL
400 N. Brown
Hamilton, Texas 76531

BALLINGER MEMORAL HOSPITAL
608 Avenue B
Ballinger, Texas 76821

COLEMAN COUNTY MEDICAL CENTER
310 South Pecos Street
Coleman, Texas 76834

CONCHO COUNTY HOSPITAL
Eaker and Burleson Streets
Eden, Texas 76837

HEART OF TEXAS HOSPITAL
2008 Nine Road
Brady, Texas 76825

ST. JOSEPH REGIONAL HEALTH CENTER
2801 Franciscan Drive
Bryan, Texas 77802

ROLLINS-BROOK HOSPITAL
608 North Key Avenue
Lampasas, Texas 76550

GOODALL-WITCHER HEALTHCARE
101 South Avenue T
Clifton, Texas 76634

GLEN ROSE MEDICAL CENTER
1021 Holden Street
Glen Rose, Texas 76043

LLANO MEMORIAL HOSPITAL
200 West Ollie Street
Llano, Texas 78643

RICHARDS MEMORIAL HOSPITAL
1700 Brazos Street
Rockdale, Texas 76567

KIMBLE HOSPITAL
2101 Main Street
Junction, Texas 76849

LILLIAN M HUDSPETH MEMORIAL
HOSPITAL
308 Hudspeth Avenue
Sonora, Texas 76950

LIMESTONE MEDICAL CENTER
701 McClintic
Groesbeck, Texas 76642

NORTH RUNNELS HOSPITAL
Hwy 153 E
Winters, Texas 79567

PARKVIEW REGIONAL HOSPITAL
600 South Bonham
Mexia, Texas 76667

MADISON ST. JOSEPH HEALTH CENTER
100 West Cross Street
Madisonville, Texas 77864

BURLESON ST. JOSEPH HOSPITAL
1101 Woodson Dr.
Caldwell, Texas 77836

TRINITY MEDICAL CENTER
700 Medical Parkway
Brenham, Texas 77833

LAKESIDE HOSPITAL
3201 Hwy. 71 East
Bastrop, Texas 78602

THE HOSPITAL AT WESTLAKE
5656 Bee Cave Road
Austin, Texas 78746

SCOTT AND WHITE HOSPITAL
UMC
300 University Blvd.
Round Rock, Texas 78665

HILLCREST BAPTIST MEDICAL CENTER
3000 Herring Avenue
Waco, Texas 76708

REAGAN MEMORIAL HOSPITAL
805 North Main Street
Big Lake, Texas 76932

SCHLEICHER COUNTY MEDICAL
CENTER
400 W Murchison Avenue
Eldorado, Texas 76936

SHANNON MEDICAL CENTER
120 E Harris Avenue
San Angelo, Texas 76903