



Large Group Consumer Choice Health Maintenance Organization Plan Description

This coverage is provided by Scott & White Care Plans d/b/a Baylor Scott & White Care Plan (herein called "Issuer"). This coverage provides Health Maintenance Organization (HMO) benefits.

This information is intended only as a summary and should not be relied upon to determine coverage. The Evidence of Coverage contains a complete listing of benefits, limitations, exclusions, and a description of all the terms and conditions of coverage. Changes in state or federal law or regulations, or interpretations thereof, may change the terms and conditions of coverage.

You can call customer service at: **844.633.5325**

or

for additional information, write to:
Baylor Scott & White Care Plan
1206 W. Campus Drive
Temple, TX 76502

This Consumer Choice of Benefits Health Maintenance Organization health care plan, either in whole or in part, does not provide state-mandated health benefits normally required in Evidences of Coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. Please consult with your insurance agent to discover which state-mandated health benefits are excluded in the Evidence of Coverage. The following represents the copayment amounts members must pay when receiving the covered benefits listed below. Refer to the Evidence of Coverage for a detailed explanation of covered and non-covered benefits. If you have any questions or would like more information about the Issuer's medical benefits go to **BSWHealthPlan.com** or contact Customer Service, Monday through Friday, 7:00 AM – 7:00 PM CT, at **844.633.5325, TTY Line 711**.

The Issuer does not discriminate based on race, color, national origin, disability, age, sex, gender identity, sexual orientation, political affiliation or expression, or health status in the administration of the plan, including enrollment and benefit determinations.

| | |
|---|---|
| | Calendar Year |
| Medical Deductible | \$0 per Member \$0 per Family |
| Maximum Out-of-Pocket <i>Includes Medical Deductible, Pharmacy Deductible and Copayments.</i> | \$9,000 per Member \$18,000 per Family |
| Annual Maximum | Unlimited |

| Medical Benefits | Participating Provider Member Copayment | Non-Participating Provider Member Copayment |
|--|---|--|
| Adult PCP Office Visit <i>Includes medical services that are not preventive care services. Office visit charge applies when seen by a physician and/or a licensed clinician under the supervision of the physician.</i> | No charge for the first non-preventive sick visit in the calendar year. \$25 copayment per visit for subsequent visits in that calendar year. | Not covered |
| Pediatric PCP Office Visit <i>For a covered dependent through the age of 18. Office visit charge applies when seen by a physician and/or a licensed clinician under the supervision of the physician.</i> | No charge | Not covered |
| Specialist Physician Office Visit <i>Includes medical services that are not preventive care services. Office visit charge applies when seen by a physician and/or a licensed clinician under the supervision of the physician.</i> | \$60 copayment per visit | Not covered |
| Annual Routine Eye Exam | Not covered | Not covered |

| Medical Benefits | Participating Provider Member Copayment | Non-Participating Provider Member Copayment |
|---|--|--|
| Preventive Care Routine Annual Physical Exam, Immunizations, Well-Baby Care, Well-Child Care, Mammography Screening, Osteoporosis Screening, Prostate Cancer Screening, Colorectal Cancer Screening, Ovarian Cancer Screening, Cervical Cancer Screening, Prenatal Visits, Tubal Ligation, any evidence-based items, or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force. | No charge, deductible does not apply | Not covered |
| Allergy Testing, Serum, and Injections | \$125 copayment per visit | Not covered |
| Diagnostic Test Routine lab, EKG, and X-rays. | No charge | Not covered |
| Imaging and Radiology (Including Facility and Physician charges) Angiography, CT Scans, MRIs, Myelography, PET Scans, Stress Tests. | \$350 copayment per visit | Not covered |
| Cardiovascular Disease Screening* | \$350 copayment per visit | Not covered |
| Outpatient Surgery Procedure Facility charges, Covered Prescription Drugs, Specialty Drugs, Medical Supplies, Observation Unit, Surgical Procedures, Pain Management. | \$2,500 copayment per service | Not covered |
| Outpatient Physician Services | No charge | Not covered |
| Emergency Care Copayment waived if episode results in hospitalization for the same condition within 24 hours. | \$700 copayment per visit | \$700 copayment per visit |
| Ambulance Transportation Ground, Sea, or Air. | \$700 copayment per service | \$700 copayment per service |
| Urgent Care | \$50 copayment per visit | \$50 copayment per visit |
| Inpatient Care Facility charges, Physician charges, Pre-admission Testing, Covered Prescription Drugs, Specialty Drugs, Medical Supplies, Blood and Blood Products, Laboratory Tests and X-rays, Pain Management, Maternity Labor and Delivery, Surgical Procedures, Operating and Recovery Room, Neonatal Intensive Care Unit (NICU), Intensive Care Unit (ICU), Coronary Care Unit, Rehabilitation Facility, Mental Health Care, Serious Mental Illness, Chemical Dependency. | \$2,500 copayment per day | Not covered |
| Skilled Nursing Facility* | \$60 copayment per visit | Not covered |
| Adult Outpatient Mental Health Care, Serious Mental Illness and Chemical Dependency | \$25 copayment per visit | Not covered |
| Pediatric Outpatient Mental Health Care, Serious Mental Illness and Chemical Dependency | No charge | Not covered |

| Medical Benefits | Participating Provider Member Copayment | Non-Participating Provider Member Copayment |
|---|--|--|
| Maternity Care and Family Planning Postnatal Care, Family Planning (as medically necessary). | \$25 copayment per visit | Not covered |
| Infertility (Diagnosis Only) | \$60 copayment per visit | Not covered |
| Rehabilitation* Physical Therapy, Occupational Therapy, Speech Therapy, Chiropractic Care. | \$25 copayment per visit | Not covered |
| Habilitation* Physical Therapy, Occupational Therapy, Speech Therapy, Chiropractic Care. | \$25 copayment per visit | Not covered |
| Chiropractic Care* | \$25 copayment per visit | Not covered |
| Home Health Care* | \$60 copayment per visit | Not covered |
| Hospice Care | No charge | Not covered |
| Durable Medical Equipment (DME) Orthotics, Prosthetics. | 50% copayment | Not covered |
| Diabetes Management Diabetes Self-Management Training, Diabetes Education, Diabetes Care Management. | \$25 copayment per visit | Not covered |
| Diabetes Equipment and Supplies | Same as DME or pharmacy, as appropriate | Not covered |
| Nutritional Counseling | \$25 copayment per visit | Not covered |
| Hearing Aids* and Cochlear Implants | 50% copayment | Not covered |
| Telehealth Service and Virtual Visits | No charge | Not covered |
| Other Telehealth Service and Telemedicine Medical Service | The amount of the copayment may not exceed the amount of the copayment required for a comparable medical benefit provided through a face-to-face consultation. | Not covered |
| Amino Acid Based Elemental Formulas | Same as DME or pharmacy as appropriate | Not covered |
| Other Medical Benefits Including, but not limited to Acquired Brain Injury, Autism Spectrum Disorder, Biomarker Testing, Chemotherapy, Craniofacial Abnormalities, Fertility Preservation, Limited Accidental Dental, Organ and Tissue Transplants, Phenylketonuria (PKU) or Heritable Metabolic Disease, Covered Prescription Drugs, Specialty Drugs, Temporomandibular Joint Pain Dysfunction Syndrome (TMJ). | Depending upon location of service, benefits will be the same as those stated under each covered benefit category in this Schedule of Benefits | Not covered |
| All Other Covered Medical Benefits (not specified herein) | \$2500 copayment per visit | Not covered |

Covered Benefit Limitations*

Cardiovascular Disease Screening

Limited to once every 5 years.

Chiropractic Care

Limited to 35 visits per calendar year.

Rehabilitation

Limited to 35 combined PT/OT/SP Outpatient visits per calendar year.

Limits do not apply for therapies for children with developmental delays, autism spectrum disorder, and mental health services.

Habilitation

Limited to 35 combined PT/OT/SP Outpatient visits per calendar year.

Limits do not apply for therapies for children with developmental delays, autism spectrum disorder, and mental health services.

Hearing Aids

Limited to one device per ear every 3 years. Limited to members through the age of 18.

Home Health Care

Limited to 60 visits per calendar year.

Skilled Nursing Facility

Limited to 25 days per calendar year.

The following represents the copayment amounts members must pay when receiving the covered pharmacy benefits listed below. If you have any questions or would like more information about the Issuer's pharmacy benefits go to **BSWHealthPlan.com** or contact Customer Service, Monday through Friday, 7:00 AM – 7:00 PM CT, at **844.633.5325**, TTY Line 711.

The Issuer does not discriminate based on race, color, national origin, disability, age, sex, gender identity, sexual orientation, political affiliation or expression, or health status in the administration of the plan, including enrollment and benefit determinations.

| | |
|---|--|
| | Calendar Year |
| Pharmacy Deductible | \$0 per Member \$0 per Family |
| Maximum Out-of-Pocket <i>Includes Medical Deductible, Pharmacy Deductible and Copayments.</i> | Integrated with Medical per Member Integrated with Medical per Family |
| Annual Maximum | Unlimited |

| Pharmacy Benefits | Participating Provider Member Copayment | | Non-Participating Provider Member Copayment |
|--|--|-------------------------------------|--|
| | <i>30-day Standard</i> | <i>90-day Maintenance*</i> | |
| ACA preventive drugs | No charge | No charge | Not covered |
| Tier 1 Preferred generic drugs | No charge | No charge | Not covered |
| Tier 2 Non-preferred generic drugs | \$8 copayment per prescription | \$20 copayment per prescription | Not covered |
| Tier 3 Preferred brand drugs | \$45 copayment per prescription | \$112.50 copayment per prescription | Not covered |
| Tier 4 Non-preferred brand drugs | \$100 copayment per prescription | \$250 copayment per prescription | Not covered |
| Specialty Tier 1 Specialty preferred generic drugs | \$75 copayment per prescription | Not covered | Not covered |
| Specialty Tier 2 Specialty preferred brand drugs | \$150 copayment per prescription | Not covered | Not covered |
| Specialty Tier 3 Specialty non-preferred brand drugs | \$300 copayment per prescription | Not covered | Not covered |
| Preferred diabetic test strips for blood glucose monitors | No charge | No charge | Not covered |
| Non-preferred diabetic test strips for blood glucose monitors | \$45 copayment per prescription | \$112.50 copayment per prescription | Not covered |

| Pharmacy Benefits | Participating Provider Member Copayment | | Non-Participating Provider Member Copayment |
|--|--|------------------------|--|
| | 30-day Standard | 90-day Maintenance* | |
| <p>*Maintenance drugs are allowed up to a 90-day supply if obtained through a participating pharmacy. Mail Order: Available for a 1- to 90-day supply. Non-maintenance drugs obtained through mail order are limited to a 30-day supply maximum. Specialty pharmacy drugs limited to a 30-day supply. Formulary insulin prescriptions have a maximum copayment of \$25 per prescription per 30-day supply. If a brand name drug is requested when a generic equivalent is available, the member is responsible for the non-preferred copayment plus the difference in cost of the brand name drug and generic equivalent drug.</p> | | | |

The BSW Be Well with Diabetes program (“Program”) is a voluntary wellness program offered by Baylor Scott & White Care Plan (“BSWCP”) that seeks to help improve the health of our members with Type 2 Diabetes. The goal of the Program is to assist eligible members in managing their diabetes and help them reduce diabetes-related complications (such as eye disease, kidney disease, and heart disease) through education and personalized coaching.

The Program will continue for twelve (12) months, as long as participation requirements are met. A new application must be submitted for consideration after that time for subsequent participation and an additional period of the pharmacy benefit cost share reduction.

ELIGIBILITY REQUIREMENTS

A member of Baylor Scott & White Care Plan may be eligible to participate in the Program if:

- the member has Type 2 Diabetes,
- is eighteen (18) years of age or older,
- completes the wellness application,
- provides information about required initial health activities, and
- agrees to comply with Program requirements.

Note: This program is not applicable to members covered under Baylor Scott & White Care Plan HDHP plans.

PROGRAM REQUIREMENTS

The member must complete all of the following health activities to remain in the Program and continue to receive the pharmacy benefit cost share reduction.

- Lab tests: Complete the wellness screening lab tests annually (Hemoglobin A1c, Lipid panel/Cholesterol, and Urine test for protein)
- Annual provider visit: Complete an annual visit to the provider treating the member for the member’s Type 2 Diabetes
- Wellness coaching: Complete eight (8) coaching sessions with a wellness coach (BSW Be Well Coaching) over the course of nine (9) months.

ACTIVE PARTICIPATION REQUIREMENT

Once enrolled in the Program, the member will need to complete eight (8) health coaching sessions provided by BSW Be Well Coaching (“Wellness Coaching”). Active participation (defined as one (1) completed visit) in wellness coaching, BSW Be Well Coaching, is required within the member’s first two (2) months of the Program. Wellness coaching will be provided virtually. If the member is dismissed from BSW Be Well Coaching for three (3) consecutive no call/no shows, the member will be dismissed from BSW Be Well with Diabetes as well.

Failure to meet all requirements of the Program will result in dismissal from the Program for the remainder of the member’s enrollment period. Dismissal from the Program will occur thirty (30) days after written notification is sent from BSWCP, which may be sent to the member’s home address on record with BSWCP, by U.S. mail, or by email. If the member is dismissed from the Program, the member will no longer be eligible to receive the pharmacy benefit cost share reduction for future prescription diabetes drugs and supplies under the pharmacy benefit for the existing 12-month enrollment period. Once a termination notice is sent, reinstatement to the Program is not allowed for any reason for the remainder of the existing 12-month enrollment period.

If the member is unable to participate in activities required to receive the pharmacy benefit cost share reduction, the member may be entitled to reasonable accommodation or an alternative standard. Please contact us as soon as possible. The member may request a reasonable accommodation or an alternative standard by contacting BSWCP Pharmacy Customer Service at 800.728.7947 or email BSWHPDiabetesProgram@BSWHealth.org. Recommendations from the member’s provider will try to be accommodated.

Upon acceptance into the BSW Be Well Diabetes Program, the Pharmacy Schedule of Benefits attached to the Evidence of Coverage is modified with a cost share reduction for covered diabetes medications and supplies as indicated below

provided all of the program participation requirements are met. Refer to the drug formulary located at www.bswcp.org/Pages/Pharmacy.aspx.

| Pharmacy Benefits | Participating Provider Member Copayment | | Non-Participating Provider Member Copayment |
|---|--|-------------------------------------|--|
| | 30-day Standard | 90-day Maintenance* | |
| ACA preventive drugs | No charge | No charge | Not covered |
| Tier 1 Preferred generic drugs | No charge | No charge | Not covered |
| Tier 2 Non-preferred generic drugs | \$8 copayment per prescription | \$20 copayment per prescription | Not covered |
| Tier 3 Preferred brand drugs | \$45 copayment per prescription | \$112.50 copayment per prescription | Not covered |
| Tier 4 Non-preferred brand drugs | \$100 copayment per prescription | \$250 copayment per prescription | Not covered |
| Specialty Tier 1 Specialty preferred generic drugs | \$75 copayment per prescription | Not covered | Not covered |
| Specialty Tier 2 Specialty preferred brand drugs | \$150 copayment per prescription | Not covered | Not covered |
| Specialty Tier 3 Specialty non-preferred brand drugs | \$300 copayment per prescription | Not covered | Not covered |
| Preferred diabetic test strips for blood glucose monitors | No charge | No charge | Not covered |
| Non-preferred diabetic test strips for blood glucose monitors | \$45 copayment per prescription | \$112.50 copayment per prescription | Not covered |
| Drugs for Type 2 Diabetes- oral, injectables, insulin, and supplies (test strips, lancets/lancet devices, injection aids, syringes for administering insulin, continuous glucose monitors and sensors, urine test strips. Note: You will need a prescription for the supplies in order for them to be covered. | \$0 copayment per prescription | \$0 copayment per prescription | Not covered |

| Pharmacy Benefits | Participating Provider Member Copayment | | Non-Participating Provider Member Copayment |
|--|--|------------------------|--|
| | 30-day Standard | 90-day Maintenance* | |
| <p>*Maintenance drugs are allowed up to a 90-day supply if obtained through a participating pharmacy. Mail Order: Available for a 1- to 90-day supply. Non-maintenance drugs obtained through mail order are limited to a 30-day supply maximum. Specialty pharmacy drugs limited to a 30-day supply. Formulary insulin prescriptions have a maximum copayment of \$25 per prescription per 30-day supply. If a brand name drug is requested when a generic equivalent is available, the member is responsible for the non-preferred copayment plus the difference in cost of the brand name drug and generic equivalent drug.</p> | | | |

The member pharmacy benefit cost share reduction shown above is limited to prescription diabetes drugs and supplies that are FDA-approved for the treatment of Type 2 Diabetes and are covered under the member's pharmacy benefit. Specialty drugs are not eligible for the pharmacy benefit cost share reduction. The pharmacy benefit cost share reduction does not apply for other covered services, including non-pharmacy diabetes services.

Requirements for receiving covered prescription medications (such as prior authorization) and limitations and exclusions for the member's benefit plan (such as prescription quantity limits, and step therapy) continue to apply.

The member pharmacy benefit cost share reduction shown above under this Program shall apply to the member's annual out-of-pocket maximum as defined by the member's benefit plan.

The member pharmacy benefit cost share reduction as shown above is not applicable to items or services that are not covered under the member's pharmacy benefit or benefit plan. This means that the member is responsible for any and all copayment, cost share, or other cost associated for items or services obtained outside of the pharmacy benefit, such as visits to the member's provider.

The member will need to complete a new wellness application and required health activities for each year the member wants to participate in the Program and to qualify for another period of the pharmacy benefit cost share reduction.

Participation in the Program and the member pharmacy benefit cost share reduction automatically terminates if the member's current plan coverage ends (for any reason).

Emergency Care

In the case of an emergency, Members may go to a Participating Provider or a Non-Participating Provider. The Plan will provide benefits for the Emergency Care received from a Non-Participating Provider to the same extent as would have been provided if care and Treatment were provided by a Participating Provider. However, follow-up care or Treatment by a Non-Participating Provider will be treated as Network coverage only to the extent it is Medically Necessary and appropriate care or Treatment rendered before the Member can return to Participating Provider in the Service Area. If a Member receives care and Treatment for an emergency from a Non-Participating Provider, the Member should notify Us as soon as reasonably possible to receive assistance transitioning care to a Participating Provider.

Medically Necessary Emergency Care received from a Non-Participating Provider, including diagnostic imaging and laboratory providers, will be reimbursed according to the terms of the Evidence of Coverage at the Usual and Customary Rate or agreed upon rate, except for Copayments, and charges for non-covered benefits. The Member will be held harmless for any amounts beyond the Copayment or other Out-of-Pocket Expenses that the Member would have paid had the Network included Participating Providers from whom the Member could obtain care.

Medically Necessary Emergency Care is provided by the Evidence of Coverage and includes the following benefits:

- An initial 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.
- Treatment and Stabilization of an emergency medical condition; and
- Post-Stabilization care originating in a Hospital emergency room, Freestanding Emergency Medical Care Facility, or comparable emergency Facility, if approved by the Us, provided that We must approve or deny coverage within the time appropriate to the circumstances relating to the delivery of care and the condition of the patient not to exceed one (1) hour of a request for approval by the treating Physician or the Hospital emergency room.

Examples of medical emergencies for which Emergency Care would be covered include but are not limited to:

- Heart attacks.
- Cardiovascular accidents.
- Poisoning.
- Loss of consciousness or breathing.
- Convulsions.
- Severe bleeding; and
- Broken bones.

Once a Member's condition is stabilized and as medically appropriate, We, upon authorization of Our Medical Director, may facilitate transportation to a Participating Facility. Where Stabilization of an emergency medical condition originates in a Hospital emergency Facility or comparable Facility, further Treatment following such Stabilization will require approval by Us.

Provider Network Required Disclosure

A facility-based physician or other healthcare practitioner may not be included in the health benefit plan's physician and provider network. The facility-based physician or other healthcare practitioner may balance bill the Member for amounts not paid by the health benefit plan. If the Member receives a balance bill, the Member should contact the HMO.

Required Payments

You will be responsible for expenses incurred that are limited or not a covered benefit under the Plan. Participating Providers will not look to the Member for payment outside of the Member's Cost Share.

Deductibles

Except where stated otherwise, a Member must pay the Deductible shown in the Schedule of Benefits during each Calendar Year before this Plan provides payments for benefits.

The individual Deductible applies to each Member. Once a Member within a family meets the individual Deductible, no further Deductible is required for the Member that has met the individual Deductible for that Calendar Year. However, after Deductible payments for Members collectively total the family Deductible amount in the Schedule of Benefits in a Calendar Year, no further Deductible will be required for any Member covered for the remainder of that Calendar Year.

Copayments

Some benefits Members receive under the Plan will require that a Copayment amount be paid at the time Members receive the benefits. Refer to the Schedule of Benefits for specific Plan information. The Schedule of Benefits will indicate the basis on which a Copayment amount is calculated. It may be per visit, per day, per service, or any combination thereof.

Maximum Out-of-Pocket

Most of the Member's payment obligations, including Deductibles and Copayment amounts are applied to the Maximum Out-of-Pocket.

The Member's Maximum Out-of-Pocket will not include:

- Cost-sharing for Non-Participating Providers, except for Emergency Care and Medically Necessary covered benefits when those benefits are not available from a Participating Provider.
- Benefits limited or excluded by the Plan.
- Expenses not covered because a benefit maximum has been reached.
- Any expenses paid by the primary plan when the Member's Plan is the secondary plan for purposes of coordination of benefits.
- Penalties applied for failure to Preauthorize.

Individual Maximum Out-of-Pocket

When the Maximum Out-of-Pocket for a Member in a Calendar Year equals the "Individual" "Maximum Out-of-Pocket" shown on the Schedule of Benefits for that level, the Plan will provide coverage for 100% of the Usual and Customary Rate for benefits for the remainder of the Calendar Year.

Family Maximum Out-of-Pocket

When the Maximum Out-of-Pocket for all Members under the Subscriber's coverage in a Calendar Year equals the "Family" "Maximum Out-of-Pocket" shown on the Schedule of Benefits for that level, the Plan will provide coverage for 100% of the Usual and Customary Rate for benefits for the remainder of the Calendar Year. No Member will be required to contribute more than the individual Maximum Out-of-Pocket to the family Maximum Out-of-Pocket.

Premiums

Premiums are due in the office of the Issuer, 1206 W. Campus Drive, Temple, Texas 76502 on or before the date indicated in the monthly billing statement issued to Group by the Issuer. The Contract Holder is responsible for informing the Issuer of any events which render an individual enrollee ineligible for coverage under the 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 the Issuer of that covered individual's ineligibility for coverage. However, if a covered Member loses eligibility for coverage during the last seven (7) calendar days of any month, and the Issuer receives notice from the Contract Holder of that covered individual's ineligibility for coverage during the first three (3) 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 the Issuer as of the date of delivery to the post office. Notice given during the first three (3) 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 does not inform the Issuer 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 Issuer received notice from the Contract Holder of that individual's ineligibility for coverage during the first three (3) 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.

Payment of Premiums for Employer plans are a personal expense to be paid for directly by the Employer on behalf of the employee and the employee's dependents. In compliance with federal guidance, the Issuer will accept third-party payment for Premium from the following entities:

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

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

Contribution Requirements

A Group must contribute to any Subscriber who enrolls in the 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 the 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.

Premium Changes

Pursuant to Texas law, We may change rates only upon sixty (60) days prior written notice. Additionally, We will not change rates more or less frequently than annually unless otherwise allowed by federal law.

Late Payment Fee

A late payment fee may be assessed on any Premium not received by the Issuer at its offices when due. Such late payment fee will be calculated by the Issuer 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 a Required Payment from the Group.

Methods of Payment

In accordance with Title 5, Subtitle C, Chapter 116 of the Business and Commerce Code, Premium payments may be made to the Issuer by electronic funds transfer or paper check with no additional fee.

Grace Period and Cancellation of Coverage

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

Exclusions and Limitations

The benefits under the Evidence of Coverage shall not include or shall be limited by the following:

Abortions

Elective abortions, non-therapeutic termination of pregnancy, including any abortion-inducing medications are excluded except where the life of the mother would be endangered if the fetus were to be carried to term or a medical emergency that places the woman in danger of serious risk of substantial impairment of a major bodily function unless an abortion is performed.

Ambulance Transportation is excluded when another mode of transportation is clinically appropriate; for stable, non-emergency conditions, unless Preauthorized; when provided for the convenience of the Member, the Member's family, Ambulance provider, Hospital, or attending Physician, where no transportation of a Member occurs. Additionally, air or sea Ambulance transportation is excluded when ground Ambulance is clinically appropriate, and to locations other than an acute care Hospital. All forms of Medically Necessary ambulance transportation that are for non-emergency situations must be Preauthorized.

Assistant Surgeons are excluded unless determined to be Medically Necessary.

Breast Implants

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

Circumcision in any male other than a newborn, age 30 days or less, is excluded unless Medically Necessary.

Chiropractic Services other than those described in the Manipulative Therapy and Chiropractic Care provision is excluded.

Complications of non-covered procedures

Treatment related to complication of non-covered procedures are excluded.

Cosmetic or Reconstructive Procedures or Treatment

Cosmetic, plastic, medical or surgical procedures, and cosmetic therapy and related supplies, including, but not limited to Hospital confinement, Prescription Drugs, diagnostic laboratory tests and x-rays or surgery and other reconstructive procedures, including any related prostheses, except breast prostheses after

mastectomy, are excluded, unless specifically covered in the **Medical Benefits** section of the Evidence of Coverage. Among the procedures that are excluded are:

- Excision or reformation of any skin on any part of the body, removal of port wine stains, removal of superficial veins, tattoos or tattoo removal, the enlargement, reduction implantation or change in the appearance of any portion of the body unless determined to be Medically Necessary.
- Removing or altering sagging skin.
- Changing the appearance of any part of the Member's body, such as enlargement, reduction, or implantation, except for breast construction following a mastectomy.
- Hair transplants or removal.
- Peeling or abrasion of the skin.
- Any procedure that does not repair a functional disorder; and
- Rhinoplasty is associated surgery except when Medically Necessary to treat craniofacial abnormalities as described in the **Medical Benefits** section of the Evidence of Coverage.

Court Ordered Care

Benefits provided solely because of the order of a court or administrative body, which benefits would otherwise not be covered under the Evidence of Coverage are excluded.

Cryotherapy devices such as PolarCare™ are excluded.

Custodial Care as follows is excluded:

- Any services, 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 Prescription Drugs; and
- 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 benefits no matter who provides, prescribes, recommends, or performs those services. The fact that certain benefits are provided while a Member is receiving Custodial Care does not require Us to cover Custodial Care.

Dental Care

All dental care or oral surgery is excluded, except for corrective Treatment of craniofacial abnormalities or an Accidental Injury to natural teeth, or any Treatment relating to the teeth, jaw, or adjacent structures, including but not limited to:

- Cleaning of teeth.
- Any services related to crowns, bridges, fillings, or periodontics.
- Rapid palatal expanders.
- X-rays or exams.
- Dentures or dental implants.
- Dental prostheses or shortening or lengthening of the mandible or maxillae for Members over the age of 18, correction of malocclusion, and any non-surgical dental care involved in the Treatment of temporomandibular joint pain dysfunction syndrome (TMJ), such as oral appliance and devices.
- Treatment of dental abscess or granuloma.
- Treatment of gingival tissues, other than for tumors.
- Surgery or Treatment for overbite or under bite and any malocclusion associated thereto, including those deemed congenital or development abnormalities; and
- Orthodontics, such as splints, positioners, extracting teeth, or repairing teeth.

The only dental related coverage We provide is described in the **Medical Benefits** section of the Evidence of Coverage.

Disaster or Epidemic

In the event of a major disaster or epidemic, benefits shall be provided to the extent that is practical, according to the best judgment of Participating Providers and within the limitations of facilities and personnel available; but neither the Issuer, nor any Participating Providers shall have any liability for delay or failure to provide or to arrange for services due to a lack of available facilities or personnel.

Exceeding Medical Benefit Limits

Any services provided to a Member who has exceeded a Medical Benefit maximum are excluded from coverage, regardless of authorization status, as permitted by law.

Experimental or Investigational Treatment

A Prescription Drug, device, Treatment, or procedure that is Experimental or Investigational is excluded. We consider a Prescription Drug, device, Treatment, or procedure to be Experimental or Investigational if:

- It cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time it is provided.
- It was reviewed, and approved by the treating Facility's Institutional Review Board, or similar committee, or if federal law required it is be reviewed and approved by that committee. This exclusion also applies if the informed consent form used with the Prescription Drug, device, Treatment, or procedure was or was requested by federal law to be reviewed and approved by that committee.
- Reliable evidence shows that the Prescription Drug, device, Treatment, or procedure is the subject of ongoing Phase I or Phase II clinical trials, is the research, Experimental study, or Investigational arm of ongoing Phase I or Phase II clinical trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness, or its effectiveness compared to a standard method of Treatment or diagnosis.
- The safety and/or efficacy has not been established by reliable, accepted medical evidence, or
- Reliable evidence shows that the prevailing opinion among experts is that further studies or clinical trials of the Prescription Drug, device, Treatment, or procedure are needed to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness, or its effectiveness compared to a standard method of Treatment or diagnosis.

"Reliable evidence" includes only published reports and articles in authoritative medical and scientific literature, and written protocols and informed consent forms used by the treating Facility or by another Facility studying substantially the same Prescription Drug, device, Treatment, or procedure.

Additionally, any Prescription Drug, device, Treatment, or procedure that would not be used in the absence of an Experimental or Investigational drug, device, Treatment, or procedure is excluded.

Family Member (Service 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 dwells in the Member's household, or any services or supplies for which the Member would have no legal obligation to pay in the absence of the Evidence of Coverage or any similar coverage; or for which no charge or different charge is usually made in the absence of healthcare coverage, are excluded.

Family Planning Treatment

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

Foot Care (Routine)

Treatment of weak, strained, or flat feet, corns, calluses, or medications for the Treatment of uncomplicated nail fungus are excluded. Corrective orthopedic shoes, arch supports, splints, or other foot care items are excluded, except as noted in the **Medical Benefits** section of the Evidence of Coverage. This will not apply to the removal of nail roots.

Genetic Testing

Genetic testing relating to pre-implantation of embryos for in-vitro fertilization is excluded, except for those required under applicable state or federal law and Medically Necessary prenatal genetic counseling.

Genetic testing results or the refusal to submit to genetic testing will not be used to reject, deny, limit, cancel, refuse to renew, increase Premiums for, or otherwise adversely affect eligibility for or coverage under this plan.

Hearing Devices

The following exclusions include hearing aid batteries or cords, temporary or disposable hearing aids, repair, or replacement of hearing aids due to normal wear, loss, or damage, a hearing aid that does not meet the specifications prescribed for correction of hearing loss.

Household Equipment

The following devices, equipment, and supplies are excluded:

- Corrective shoes, shoe inserts, arch supports, and Orthotic inserts, except as provided for in the **Medical Benefits** section of the Evidence of Coverage and for the Treatment of diabetes.
- Equipment and appliances considered disposable or convenient for use in the home, such as over-the-counter bandages and dressings.
- Comfort or convenience items, such as bathtub chairs, whirlpool tubs, safety grab bars, stair gliders or elevators, over-the-bed tables, bed boards, saunas, and exercise equipment.
- Environmental control equipment, such as air conditioners, purifiers, humidifiers, dehumidifiers, electrostatic machines, and heat lamps.
- Consumable medical supplies, such as over-the-counter bandages, dressings, and other disposable supplies, skin preparations, surgical leggings, elastic stockings, TED stockings, stump socks and compression garments.
- Foam cervical collars.
- Stethoscopes, sphygmomanometers, and recording or hand-held pulse oximeters.
- Hygienic or self-help items or equipment; and
- Electric, deluxe, and custom wheelchairs or auto tilt chairs.

Illegal Acts

Charges for services received as a result of injury or sickness caused by or contributed to by the Member engaging in an illegal act or occupation or by committing or attempting to commit a crime, criminal act, assault, or other felonious behavior, regardless of whether charged, are excluded. For purposes of this exclusion, an act is "illegal" if it is contrary to or in violation of law, and includes, but is not limited to, operating a motor vehicle, recreational vehicle, or watercraft while intoxicated. Intoxication includes situations in which the Member has a blood alcohol content or concentration (BAC) which exceeds the applicable legal limit. This exclusion does not apply if the injury resulted from an act of domestic violence or medical condition (including both physical and mental health), or in case of emergency, the initial medical screening examination, Treatment and Stabilization of an emergency condition.

Infertility Treatment

The following Infertility services are excluded:

- in vitro fertilization unless covered by a Rider.
- artificial insemination.
- gamete intrafallopian transfer, and similar procedures.
- 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.
- any costs related to surrogate parenting, sperm banking for future use, or any assisted reproductive technology or related Treatment that is not specified in the **Medical Benefits** section of the Evidence of Coverage.

Mental Health

Services for mental illness or disorders are limited to those services described in the “Mental Health Care” provision of the Evidence of Coverage including counseling and related services. Coverage for services for or in connection with a Court Order or condition of parole or probation are subject to the same limitation.

Miscellaneous

Artificial aids, corrective appliances, other than those provided as Orthotic Devices. Non-prescribed medical supplies, such as take home and over the counter drugs, batteries, condoms, syringes (other than insulin syringes), dentures, eyeglasses, and corrective lenses, unless specified in the Plan, are excluded.

Non-Emergency Care when traveling outside the U.S.

Non-Payment for Excess Charges

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

Organ Transplants and Post-Transplant Care is not covered if:

- the transplant operation is performed in China, or another country known to have participated in Forced Organ Harvesting,
- the human organ to be transplanted was procured by a sale or donation originating from China or another country known to have participated in Forced Organ Harvesting,

Orthotripsy and related procedures are excluded.

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 the Evidence of Coverage, are excluded.

Pharmacy Benefit excludes the following:

- Covered drugs, devices, or other pharmacy services which a Member may properly obtain at no cost through a local, state, or federal government program, except if provided through Medicaid or this exclusion is specifically prohibited by law.
- “Over-the-counter” drugs which do not require a Participating Provider or Participating Health Professional's Prescription Order for dispensing. The exception is insulin and if the drug is listed on Our Formulary.
- Anything which is not specified as covered or not defined as a drug, such as therapeutic devices, appliances, support garments, glucometers, asthma spacers and machines, including syringes (except disposable syringes for insulin dependent Members) unless listed on Our Formulary.
- Experimental or Investigational drugs or other drugs which, in the opinion of the Pharmacy and Therapeutics Committee or Medical Director, have not been proven to be effective. NOTE: Denials based upon Experimental or Investigational use are considered Adverse Determinations and are subject to the Appeal of Adverse Determination and Independent Review provisions of the Evidence of Coverage.
- Drugs not approved by the Food and Drug Administration for use in humans.
- Drugs not recognized by the Food and Drug Administration, standard drug reference compendium, or substantially accepted peer-reviewed medical literature for the condition, dose, route, duration, or frequency prescribed.
- Drugs used for cosmetic purposes.
- Drugs used for Treatments or medical conditions not covered by the Evidence of Coverage.
- Drugs used primarily for the Treatment of Infertility.
- Vitamins except if drug is listed on Our Formulary.
- Any initial or refill prescription dispensed more than one (1) year after the date of the Participating Provider or Participating Health Professional's Prescription Order.

- Except for medical emergencies, drugs not obtained at a Participating Pharmacy.
- Drugs given or administered to a Member while at a Hospital, Skilled Nursing Facility, or other Facility.
- A prescription that has an over-the-counter alternative.
- Initial or refill prescriptions the supply of which would extend past the termination of the Evidence of Coverage, even if the Participating Provider or Participating Health Professional's Prescription Order was issued prior to termination.
- Drugs for the Treatment of sexual dysfunction, impotence, or inadequacy; or,
- High-cost drugs that are chemically similar drugs and share the same mechanism of action to an existing, approved chemical entity and offer no significant clinical benefit.
- Drugs used for the treatment of obesity or weight reduction.

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 license 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; and
- qualifying for participation in athletic activities, such as school sports.

Surgery for Refractive Keratotomy is excluded.

Reimbursement

We shall not pay any provider or reimburse Member for any Medical Benefit or Pharmacy Benefit for which a Member would have no obligation to pay in the absence of coverage under the Evidence of Coverage.

Speech and Hearing Loss

Services for the loss or impairment of speech or hearing are limited to those rehabilitation services described in the Rehabilitation Therapy provision unless covered by a Rider.

Sports Rehabilitation refers to continued Treatment for sports related injuries to improve above and beyond normal ability to perform activities of daily living (ADLs). Sports-related rehabilitation or other similar avocational activities is excluded because it is not considered Treatment of disease. This includes, but is not limited to baseball, pitching/throwing, cheerleading, golfing, martial arts of all types, organized football, baseball, basketball, soccer, lacrosse, swimming, track, and field, etc. at a college, high school, or other school or community setting, professional and amateur tennis, professional and amateur/hobby/academic dance, and competitive weightlifting and similar activities.

Therapies and Treatments

The following therapies and Treatments are excluded: Equine therapy; cranial sacral therapy; recreational therapy; exercise programs; hypnotherapy, music therapy; reading therapy; sensory integration therapy; vision therapy; vision training; orthoptic therapy; orthoptic training; behavioral vision therapy; visual integration; vision therapy; orthotripsy; oral allergy therapy; acupuncture; naturopathy; hypnotherapy or hypnotic anesthesia; Christian Science Practitioner Services; Biofeedback services, except for the Treatment of Acquired Brain Injury and for rehabilitation of Acquired Brain Injury; massage therapy, unless associated with a physical therapy modality provided by a licensed physical therapist.

Transplants

Organ and bone marrow transplants and associated donor/procurement costs for a Member are excluded except to the extent specifically listed as covered in the Evidence of Coverage.

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 Participating Provider and Preauthorized, if required, by Our Medical Director.

Unauthorized Services

Non-emergency Medical Benefits or Pharmacy Benefits which are not provided, ordered, prescribed, or authorized by a Participating Provider or Participating Health Professional are excluded.

Vision Care – Adult

Eye exercises, training, orthoptics, multiphase testing, eyeglasses, including eyeglasses and contact lenses prescribed following vision surgery, contact lenses for Members over the age of 18, except for Treatment of Keratoconus, and any other items or services for the correction of the Member's eyesight, including but not limited to orthoptics, vision training, vision therapy, radial keratotomy (RK), automated lamellar keratoplasty (ALK or LK), astigmatic keratotomy (AK), laser vision corrective surgery and photo refractive keratectomy (PRK-laser) are excluded unless specifically provided in the **Medical Benefits** section of the Evidence of Coverage, or provided by a Rider.

Vision Care – Pediatric

- Routine eye exams do not include professional services for contact lenses.
- Laser eye surgery (LASIK) is excluded.
- Any vision service, Treatment or materials not specifically listed as a covered Medical Benefit is excluded.
- Services and materials not meeting accepted standards of optometric practice are excluded.
- Telephone consultations are excluded.

War, Insurrection or Riot

Medical Benefits or Pharmacy Benefits provided as a result of any injury or illness caused by any act of declared or undeclared war, or Member's participation in a riot or insurrection are excluded.

If the rendition of a Medical Benefit or Pharmacy Benefit is delayed or rendered impractical due to circumstances beyond the reasonable control of the Issuer, such as complete or partial destruction of facilities due to war, riot, or civil insurrection; an act of terrorism; labor dispute; government order; national, state or local state of emergency; pandemic; or the like, neither We, nor any Participating Provider, Participating Health Professional, nor any Facility shall have any liability to Members or Contract Holder.

Weight Reduction

Weight reduction programs, supplements, services, supplies, surgeries including but not limited to Gastric Bypass, gastric stapling, Vertical Banding, and gym memberships are excluded, even if the Member has medical condition or is prescribed by a Physician or Healthcare Professional.

Utilization Review

The Plan includes a Utilization Review program to evaluate inpatient and outpatient Hospital and Ambulatory Surgical Center admissions and specified non-emergency outpatient surgeries, diagnostic procedures, and other services. This program ensures that Hospital and Ambulatory Surgical Center care

is received in the most appropriate setting, and that any other specified surgery or services are Medically Necessary. Utilization Review includes all review activities and may be undertaken by:

- Preauthorization review which takes place before a service is provided that requires Preauthorization.
- Admission review which takes place before a Hospital admission or after an emergency admission.
- Continued stay review which takes place during a Hospital stay.
- Retrospective review which takes place following discharge from a Hospital or after any services are performed.

Certain benefits require Preauthorization in order to be covered. For a complete list of benefits that require Preauthorization, visit Our website at **BSWHealthPlan.com**.

We will accept requests for renewal of an existing Preauthorization beginning sixty (60) days from the date that the existing Preauthorization is set to expire. Upon receipt of a request for renewal of an existing Preauthorization, We will, to the extent possible, review the request and issue a determination indicating whether the benefit is Preauthorized before the existing authorization expires.

Preauthorization Review

To satisfy Preauthorization review requirements, the Member or Participating Provider should contact Us at the authorization phone number listed on the Member ID Card on business days 6:00 AM – 6:00 PM CT and on Saturdays, Sundays, and Holidays 9:00 AM – 12:00 PM CT at least three (3) calendar days prior to any admission or scheduled date of a proposed benefit that requires Preauthorization. Participating Providers may Preauthorize benefits for Members, when required, but it is the Member's responsibility to ensure Preauthorization requirements are satisfied.

The Preauthorization process for health care services may not require a Physician or Participating Provider to obtain Preauthorization for a particular health care service if the Physician or Participating Provider meets exemption criteria for certain health care services.

Subject to the notice requirements and prior to the issuance of an Adverse Determination, if We question the Medical Necessity or appropriateness of a service, We will give the Participating Provider who ordered it a reasonable opportunity to discuss with Our Medical Director the Member's Treatment plan and the clinical basis of Our determination. If We determine the proposed benefit is not Medically Necessary, the Member or Participating Provider will be notified in writing within three (3) days. The written notice will include:

- the principal reason(s) for the Adverse Determination.
- the clinical basis for the Adverse Determination.
- a description of the source of the screening criteria used as guidelines in making the Adverse Determination; and
- description of the procedure for the Complaint and Appeal process, including the Member's rights and the procedure to Appeal to an Independent Review Organization.

For an Emergency admission or procedure, We must be notified within forty-eight (48) hours of the admission or procedure or as soon as reasonably possible. We may consider whether the Member's condition was severe enough to prevent the Member from notifying Us, or whether a family member was available to notify Us for the Member.

If the Member has a Life-Threatening Disease or Condition, including emergency Treatment or continued hospitalization, or in circumstances involving Prescription Drugs or intravenous infusions, the Member has the right to an immediate review by an Independent Review Organization and the Member is not required to first request an internal review by Us.

Admission Review

If Preauthorization review is not performed, We will determine at the time of admission if the Hospital admission or specified non-emergency outpatient surgery or diagnostic procedure is Medically Necessary.

Continued Stay Review

We also will determine if a continued Hospital or Skilled Nursing Facility stay is Medically Necessary. We will provide notice of Our determination within twenty-four (24) hours by either telephone or electronic transmission to the provider of record followed by written notice within three (3) working days to the Member or provider of record. If We are approving or denying Post Stabilization care subsequent to Emergency Care related to a Life-Threatening Disease or Condition, We will notify the treating Physician or other provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the Member, but in no case to exceed one (1) hour after the request for approval is made.

Retrospective Review

In the event services are determined to be Medically Necessary, benefits will be provided as described in the Plan. If it is determined that a Hospital stay or any other service was not Medically Necessary, You are responsible for payment of the charges for those services. We will provide notice of Our Adverse Determination in writing to the Member and the provider of record within a reasonable period, but not later than thirty (30) days after the date on which the Claim is received, provided We may extend the 30-day period for up to fifteen (15) days if:

- We determine that an extension is necessary due to matters beyond Our control; and
- We notify You and the provider of record within the initial 30-day period of circumstances requiring the extension and the date by which We expect to provide a determination.

If the period is extended because of Your failure or the failure of the provider of record to submit the information necessary to make the determination, the period for making the determination is tolled from the date We send Our notice of the extension to You or the provider until the earlier of the date You or the provider responds to Our request, or the date by which the specified information was to have been submitted.

Failure to Preauthorize

If any benefit requiring Preauthorization is not Preauthorized and it is determined that the benefit was not Medically Necessary, the benefit may be reduced or denied. The Member may also be charged additional amounts which will not count toward the Member's Deductible or Maximum Out-of-Pocket.

Prescription Drugs and Intravenous Infusions

We will determine if the use of Prescription Drugs or intravenous infusions is Medically Necessary.

Appeal of an Adverse Determination

Internal Appeal

Our determination that the care the Member requested or received was not Medically Necessary or appropriate or was Experimental or Investigational based on Our Utilization Review standards is an Adverse Determination, which means the Member's request for coverage of the care is denied. Once We have all the information to provide a determination, Our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an Adverse Determination subject to an internal Appeal.

The Member, a person acting on the Member's behalf, or the Member's Physician may request an internal Appeal of an Adverse Determination to Us orally or in writing in accordance with Our internal Appeal procedures. Members will have one hundred eighty (180) days following receipt of a notification of an

Adverse Determination within which to Appeal the determination. We will acknowledge the Member's request for an internal Appeal within five (5) working days of receipt. This acknowledgment will, if necessary, inform the Member of any additional information needed before a decision can be made. A clinical peer reviewer who is a Physician or a Health Professional in the same or similar specialty as the provider, who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial Adverse Determination will perform the Appeal.

If the Member's Appeal is denied, Our notice will include a clean and concise statement of the clinical basis for the denial and the Member's right to seek review of the denial from an Independent Review Organization and the procedures for obtaining that review.

If the Member has a Life-Threatening Disease or Condition or in circumstances involving Prescription Drugs or intravenous infusions, the Member has the right to an immediate review by an Independent Review Organization and the Member is not required to first request an internal review by Us.

If the Member's Appeal relates to an Adverse Determination, We will decide the Appeal within thirty (30) calendar days of receipt of the Appeal request. Written notice of the determination will be provided to the Member, or the Member's designee, and where appropriate, the Member's Provider, within two (2) business days after the determination is made, but no later than thirty (30) calendar days after receipt of the Appeal request.

An Appeal regarding continued or extended benefits, additional benefits provided in the course of continued Treatment, Home Health Care benefits following discharge from an inpatient Hospital admission, benefits in which a provider requests an immediate review, or any other urgent matter will be handled on an expedited basis.

The Member can additionally request an expedited Appeal for the denial of Emergency Care, continued hospitalization, Prescription Drugs for which the Member is receiving benefits through the Plan and a step therapy exception request. For an expedited Appeal, the Member's provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. The Member's provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or one (1) business day of receipt of the information necessary to conduct the Appeal.

If a Member has any questions about the Appeals procedures or the review procedure, contact Us at **844.633.5325**.

Independent Review Organization

An Adverse Determination means a determination by Us or Our designated Utilization Review organization that the benefits provided or proposed to be provided are not Medically Necessary or are Experimental or Investigational.

A Final Internal Adverse Determination means an Adverse Determination that has been upheld by Us at the completion of Our internal review and Appeal process. This procedure pertains only to Appeals of Adverse Determinations.

The Member or an individual acting on the Member's behalf or the Member's provider has the right to request an immediate review of Our Appeal decision by an IRO by submitting a request to Our HHS administered external review contractor, MAXIMUS, within four (4) months after receipt of the notice of the determination of the Member's Appeal. There is no cost to the Member for the independent review.

The Member will not be required to exhaust Our Appeal process before requesting an IRO if:

- the Appeal process timelines are not met; or
- in an Urgent Care situation.

Under non-urgent circumstances, the Member may request a standard external review. For Urgent Care, the Member may request an expedited external review.

The IRO examiner will contact Us upon receipt of the request for external review. For a standard external review, We will provide the examiner all documents and information used to make the final internal Adverse Determination within three (3) business days. For an expedited external review, We will provide the examiner all documents and information used to make the final internal Adverse Determination as soon as possible.

The IRO examiner will give the Member and Us written notice of the final external review decision as soon as possible, but no later than twenty (20) days after the examiner receives the request for a standard external review. For an expedited external review, the examiner will give the Member and Us the external review decision as quickly as medical circumstances require, but no later than within seventy-two (72) hours of receiving the request.

The Member may request an external review for an Adverse Determination for Prescription Drug exception requests. The IRO will issue a response to the Member or the Member's legal representative no later than seventy-two (72) hours from receipt of the Member's request. For an expedited Appeal for Prescription Drug exception requests, the IRO will issue a response to the Member or the Member's legal representative no later than twenty-four (24) hours from receipt.

Continuity of Care

During the course of medical care, a Member qualifies as a continuing care patient if he or she is receiving care from a Participating Provider under the following special circumstances:

- a Serious and Complex Condition,
- a course of institutional or inpatient care from a Participating Provider or Facility,
- a nonelective surgery from a Participating Provider or Facility, including receipt of post-operative care with respect to a surgery,
- pregnancy and is undergoing a course of treatment for the pregnancy, or
- if past the 24th week of pregnancy at the time of termination, we will reimburse the terminated provider, and the Member is covered through delivery and postpartum care within the six-week period after delivery.
- a determined terminal illness and is receiving treatment for such illness from a Participating Provider or Facility, and such Participating Provider or Facility's contract to be a network provider terminates or expires for any reason other than fraud by such Participating Provider or Facility, then the Issuer is required to meet all of the following requirements:
 - We will notify each Member under the Plan who is a continuing care patient that he or she is protected for continuing care at the time the Participating Provider or Facility's contract terminates and tell such Member of his or her right to elect continued transitional care from such Participating Provider or Facility.
 - We will provide the Member with an opportunity to notify Us of the Member's need for transitional care.
 - We will permit the Member to elect to continue to have the benefits provided under the Plan or such coverage under the same terms and conditions as would have applied and with respect to such items and services as would have been covered under the Plan had the Participating Provider or Facility's contract not terminated.

The transitional coverage shall continue beginning on the date the Provider's contract is terminated and shall continue until the earlier of ninety (90) days after the Provider's contract is terminated, or the date the Member is no longer qualified as a continuing care patient with respect to that Participating Provider or Facility. If a Member has been diagnosed with a terminal illness at the time of the Provider's termination,

the expiration of the continuity of care is nine (9) months after the effective date of the Provider's termination. The Participating Provider caring for the continuing care patient agrees to accept payment from the Issuer for services and items furnished to the continuing care patient as payment in full for such items and services and to maintain compliance with all policies, procedures, and quality standards imposed by the Issuer.

Complaint Procedure

We recognize that a Member, Physician, provider, or other person designated to act on behalf of a Member may encounter an event in which performance under the Agreement does not meet expectations. It is important that such an event be brought to the attention of Issuer. We are dedicated to addressing problems quickly, managing the delivery of benefits effectively, and preventing future Complaints and Appeals. We will not retaliate against a Member because the Member, the Member's provider, or a person acting on the Member's behalf files a Complaint or appeals a decision made by Us.

We offer Members the opportunity to file a Complaint within one hundred eighty (180) days to dispute the benefit/Claim processing. Members are required to file a Complaint in writing and can call Customer Service to begin the process. If Our resolution of the Complaint is unsatisfactory Member, the Member will be afforded the opportunity to Appeal that Complaint.

In some cases, We may ask for additional time to process a Member's Complaint. If a Member does not wish to allow additional time, We will decide a Member's Complaint based on the information We have. This may result in a denial of a Member's Complaint.

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

We 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.

The Complaint resolution letter will include the specific reason(s) for Our determination. The response letter will also 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.

Complaints concerning an emergency, or a denial of continued hospitalization are resolved no later than one (1) business day after We receive the Complaint.

Appeal of Complaints

If the Complainant is not satisfied with Our resolution of the Complaint, the Complainant will be given the opportunity to appear in person before an Appeal panel at the site of which the Member normally receives benefits or at another site agreed to by the Complainant or address a written Appeal to an Appeal panel.

We 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 Our Appeal procedures and time frames. If the Appeal is received orally, We will also enclose a one-page Appeal form, which must be returned for prompt resolution of the Appeal.

We will appoint members to the Complaint Appeal panel, which shall advise Us on the resolution of the Complaint. The Complaint Appeal panel shall be composed of one Issuer staff member, one Participating Provider, and one Member. No member of the Complaint Appeal panel may have been previously involved

in the disputed decision. The Participating Provider must have experience in the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the Treatment in the area of care that is in dispute and must be independent of any Physician or provider who made any prior determination. If specialty care is in dispute, the Participating Provider serving on the Appeal panel must be a specialist in the field of care to which the Appeal relates. The Member may not be an employee of Issuer.

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

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

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

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

Notice of the final decision of the Issuer on the Appeal will include a statement of:

- The specific medical determination.
- The clinical basis for the Appeal’s denial.
- The 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.

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

Physicians and Providers

A current list of physicians and providers, including behavioral health providers and substance abuse treatment providers can be accessed through **BSWHealthPlan.com**.

Service Area

The following counties are included in the Service Area:

| | | | | | | |
|-----------|---------------|-----------|------------|-----------|-----------|--------------|
| Andrews | Cochran | Eastland | Hansford | Lee | Navarro | Stephens |
| Armstrong | Coke | Ector | Hartley | Leon | Nolan | Sterling |
| Austin | Coleman | El Paso | Haskell | Limestone | Ochiltree | Stonewall |
| Bailey | Collin | Ellis | Hays | Lipscomb | Oldham | Sutton |
| Bastrop | Collingsworth | Erath | Hemphill | Llano | Parmer | Swisher |
| Bell | Comal | Falls | Hill | Loving | Pecos | Tarrant |
| Bexar | Comanche | Fayette | Hockley | Lubbock | Potter | Taylor |
| Blanco | Concho | Fisher | Hood | Lynn | Randall | Terry |
| Borden | Coryell | Floyd | Houston | Madison | Reagan | Throckmorton |
| Bosque | Cottle | Freestone | Howard | Martin | Reeves | Tom Green |
| Brazos | Crane | Gaines | Hutchinson | Mason | Roberts | Travis |
| Brewster | Crockett | Garza | Irion | McCulloch | Robertson | Upton |
| Briscoe | Crosby | Glasscock | Johnson | McLennan | Rockwall | Walker |

| | | | | | | |
|-----------|------------|-----------|----------|----------|-------------|------------|
| Burleson | Dallam | Gray | Jones | Menard | Runnels | Waller |
| Burnet | Dallas | Grayson | Kent | Midland | San Saba | Ward |
| Caldwell | Dawson | Grimes | Kimble | Milam | Schleicher | Washington |
| Callahan | Deaf Smith | Guadalupe | King | Mills | Scurry | Wheeler |
| Carson | Denton | Hale | Knox | Mitchell | Shackelford | Williamson |
| Castro | Dickens | Hall | Lamb | Moore | Sherman | Winkler |
| Childress | Donley | Hamilton | Lampasas | Motley | Somervell | Yoakum |

Access to Obstetrical or Gynecological Care

ATTENTION FEMALE ENROLLEES: You have the right to select and visit an obstetrician-gynecologist (OB-GYN) without first obtaining a referral from your PCP. Scott & White Care Plans d/b/a Baylor Scott & White Care Plan has opted not to limit your selection of an OB-GYN to your PCP's network. You are not required to select an OB-GYN. You may elect to receive your OB-GYN services from your PCP.

Balance Billing Notification

Some Facility-based providers such as anesthesiologist, pathologist, radiologists, diagnostic imaging, and laboratory service providers may not be included in the Plan's Network. In certain circumstances We may authorize the Member to receive Treatment from a Non-Participating Provider. For non-emergency Treatment by a Non-Participating Provider at a Participating Facility the Member will not be responsible for an amount greater than the applicable Copayment and Deductible under the Plan on the initial amount determined to be payable by the Plan had the Treatment and services been furnished by a Participating Provider.

In all cases, Medically Necessary Emergency Care (including Air Ambulance Transportation) received from a Non-Participating Provider will be reimbursed according to the terms of the Agreement at the Usual and Customary Rate or agreed upon rate, except for Copayments, and charges for non-covered care. The Member will be held harmless for any amounts beyond the Copayment or other Out-of-Pocket Expenses that the Subscriber would have paid had the Network included Participating Providers from whom the Member could obtain the care.

A Member should contact the Issuer if the Member receives a balance bill from a Facility-based provider, Non-Participating Facility-based provider, EMS provider, or other Health Professional that may balance bill the Member. In order to determine the contract status of providers, Members may consult the provider directory on Our website at **BSWHealthPlan.com** or contact Us at **844.633.5325**.

Hospital Services

Members are entitled to Medically Necessary benefits of any Participating Hospital to which Members may be admitted by a Participating Provider. If a Member is admitted to a Non-Participating Hospital by a Participating Provider to whom the Member was referred in accordance with Our procedures, the services of the Non-Participating Hospital will be covered on the same bases as admission to a Participating Hospital, provided admission to the Non-Participating Hospital was approved in accordance with the Evidence of Coverage.

For a service provided in a Hospital to be a covered benefit, the Hospital should be the medically appropriate setting for that service.

If a Member is hospitalized at a Non-Participating Hospital, the Member must notify Us within forty-eight (48) hours of admission or as soon as is reasonably possible, and We shall review the admission and the

stay for Medical Necessity under the Evidence of Coverage. Failure to provide notification may result in denial of payment unless it is shown not to have been reasonably possible to give such notice.

Examples of Hospital benefits may include, but are not limited to the following:

- Semiprivate room, or the equivalent, for routine acute care.
- Inpatient meals and special diets, when Medically Necessary.
- Inpatient medications and biologicals.
- Intensive care units.
- Nursing care, including private duty nursing, when Medically Necessary.
- Short term rehabilitation therapy services in the acute Hospital setting.
- Inpatient lab, x-ray, and other diagnostic tests.
- Inpatient medical supplies and dressings.
- Anesthesia.
- Oxygen.
- Operating room and recovery room.
- Inpatient physical therapy.
- Inpatient radiation therapy.
- Inpatient inhalation therapy.
- Cost of and administration of whole blood, blood plasma, and blood plasma expanders.

Prescription Drugs administered while admitted to a Participating Hospital will be covered as part of the Member's inpatient benefit, and no additional Deductible or Copayments are required for the administered Prescription Drugs.

Texas Department of Insurance Notice of Rights

Scott & White Care Plans d/b/a Baylor Scott & White Care Plan provides no benefits for services you receive from out-of-network physicians or providers, with specific exceptions as described in your evidence of coverage and below.

- You have the right to an adequate network of in-network physicians and providers (known as network providers).
- If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance at: www.tdi.texas.gov/consumer/complfrm.html.
- If your HMO approves a referral for out-of-network services because no network physician or provider is available, or if you have received out-of-network emergency care, the HMO must, in most cases, resolve the out-of-network physician's or provider's bill so that you only have to pay any applicable copayment, coinsurance, and deductible amounts.
- You may obtain a current directory of network physician and providers at the following website: **BSWHealthPlan.com** or by calling **844.633.5325** for assistance in finding available network physicians and providers. If you relied on materially inaccurate directory information, you may be entitled to have a claim by an out-of-network physician or provider paid as if it were from a network physician or provider, if you present a copy of the inaccurate directory information to the HMO, dated not more than 30 days before you received the service.