BaylorScott&White Insurance Company

LARGE GROUP
PREFERRED PROVIDER ORGANIZATION
HEALTHCARE
CERTIFICATE OF COVERAGE

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

Corporate Office
1206 W. Campus Drive
Temple, TX 76502
254.298.3000
844.633.5325
BSWHealthPlan.com

Certificate of Coverage

Baylor Scott & White Insurance Company (herein called “Issuer”)

This Certificate of Coverage, Group’s application, Your completed and accepted Enrollment Application, Schedule of Benefits, any Riders, along with any attachments and amendments to those documents constitute the entire Agreement between the parties. No agent or other person, except the President and Chief Executive Officer of the Issuer, has the authority to waive any conditions or restrictions of the Agreement, to extend the time for making a payment, or to bind the Issuer by making any promise or representation, or by giving or receiving any information.

In consideration of the Group’s application, completed and accepted Enrollment Application and timely payment of the Required Payments, the Issuer agrees to provide or arrange to provide the covered benefits as described in this Certificate of Coverage.

In consideration of the Issuer providing or arranging to provide the covered benefits specified in this Certificate of Coverage and subject to the terms, the Subscriber and the Contract Holder promise to pay all Required Payments when due and abide by all the terms of the Agreement and comply with all applicable local, state, and federal laws.

The initial rates agreed upon by the Group and the Issuer are effective during the initial year from and after the Effective Date of the Agreement. Thereafter, the Issuer reserves the right to change rates upon sixty (60) days’ notice prior to renewal.

The coverage provided under this Certificate of Coverage is Preferred Provider Organization (PPO) coverage and not indemnity insurance.

The Issuer hereby certifies that it has issued a healthcare benefit plan (herein called the “Plan”) for the Subscriber and any Covered Dependent(s). The Effective Date of coverage under the Agreement shall be as indicated on the Member’s Identification Card and as confirmed by the Issuer. The Agreement shall continue in effect for one (1) year from the Effective Date until terminated in accordance with the terms of the **Termination of Coverage** section of this Certificate of Coverage.

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.

Jeffrey C. Ingrum
President and Chief Executive Officer
Baylor Scott & White Insurance Company
1206 W. Campus Drive
Temple, Texas 76502

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Baylor Scott & White Insurance Company
To get information or file a complaint with your insurance company or HMO:

Call: Customer Service at 254.298.3000
Toll-free: 844.633.5325
Online: **BSWHealthPlan.com**
Email: **hpappealsandgrievances@BSWHealth.org**
Mail: 1206 W. Campus Drive, Temple, TX 76502

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:

Call with a question: **800.252.3439**
File a complaint: **www.tdi.texas.gov**
Email: **ConsumerProtection@tdi.texas.gov**
Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance, PO Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Baylor Scott & White Insurance Company
Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Customer Service at 254.298.3000
Teléfono gratuito: 844.633.5325
En línea: **BSWHealthPlan.com**
Correo electrónico: **hpappealsandgrievances@BSWHealth.org**
Dirección postal: 1206 W. Campus Drive, Temple, TX 76502

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: **800-252-3439**
Presente una queja en: **www.tdi.texas.gov**
Correo electrónico: **ConsumerProtection@tdi.texas.gov**
Dirección postal: Consumer Protection, MC: CO-CP, Texas Department of Insurance, PO Box 12030, Austin, TX 78711-2030

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Introduction

In this Certificate of Coverage, “We”, “Us” and “Our” means the Issuer. “You” are the Subscriber whose Enrollment Application has been accepted by Us. The word “Member” means You and any Covered Dependents under the Plan.

This Certificate of Coverage will explain:

- Member rights and responsibilities, and Our rights and responsibilities.
- Covered benefits and how to receive them; and
- Costs the Subscriber will be responsible for paying.

The defined terms in this Certificate of Coverage are capitalized and shown in the appropriate provision, or in the **Definitions** section of this Certificate of Coverage.

Please read this Certificate of Coverage completely and carefully, particularly any sections relevant to Member special healthcare needs.

Important Contact Information

Resource	Contact Information	Accessible Hours
Website	**BSWHealthPlan.com**	24 hours a day 7 days a week
Mailing Address	1206 W. Campus Drive Temple, Texas 76502	24 hours a day 7 days a week
Customer Service	**844.633.5325** **TTY Line 711**	Monday – Friday 7:00 AM – 7:00 PM CT

Customer Service can:

- Identify the Member Service Area.
- Provide Members with information about Participating Providers.
- Assist Members with concerns about Participating Providers.
- Provide Claim forms.
- Answer Member questions on Claims.
- Provide information on the Plan’s features.
- Assist Members with questions regarding covered benefits.

We have a free service to help Members who speak languages other than English. This service allows the Member and the Member’s Physician to talk about the Member’s medical or behavioral health concerns.

We have representatives that speak Spanish and have medical interpreters to assist with other languages.

Members who are blind, visually impaired, deaf, hard of hearing or speech impaired may also contact Us at **844.633.5325 (TTY 711)** to arrange for oral interpretation services.

Definitions

The following defined terms shall have the specific meaning stated below and will be capitalized when used in this Certificate of Coverage.

Accidental Injury means accidental bodily injury resulting, directly and independently of all other causes, in initial necessary Treatment provided by a Physician or Health Professional.

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.

Administer means to directly apply a drug to the body of a patient by injection, inhalation, ingestion, or any other means.

Adverse Determination means a determination by a Utilization Review agent made on behalf of the Issuer that the healthcare provided or proposed to be provided to a Member is not Medically Necessary or appropriate; or that the service is Experimental or Investigational. The term does not include a denial of healthcare due to the failure to request prospective or concurrent Utilization Review. The term includes rescissions of coverage as described in Your coverage document.

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

Agreement is the legal contract between the Issuer, Subscriber, and Contract Holder and includes this Certificate of Coverage, Group's application, Enrollment Application, Schedule of Benefits, and Riders along with any attachments and amendments to those documents.

Allowable Expense means a necessary reasonable and customary item of expense for healthcare when the item of expense is covered at least in part by Medicare.

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 Member's stay in a private room is Medically Necessary either in terms of generally accepted medical practices or as specifically defined by the Issuer.

When benefits are reduced under Medicare because a Member does not comply with Medicare's provisions, the amount of such reduction will be considered an allowable expense. Examples of such provisions are those related to second surgical opinion or precertification of admission or healthcare.

Ambulance means a vehicle superficially designed, equipped, and licensed for transporting the sick and/or injured.

Ambulatory Surgical Center means a Facility not located on the premises of a Hospital which provides specialty Outpatient Surgical Treatment. It does not include individual or group practice offices of private Physicians or Health Professionals, unless the offices have a distinct part used solely for Outpatient Surgical Treatment on a regular and organized basis.

Amino Acid-Based Elemental Formulas means complete nutrition formulas designed for Members who have an immune response to allergens found in whole foods or formulas composed of whole proteins, fats, and/or carbohydrates. Amino Acid-Based Elemental Formulas are made from individual (single)

nonallergenic amino acids (building blocks of proteins) broken down to their “elemental level” so that they can be easily absorbed and digested.

Appeal is an oral or written request for the Issuer to reverse a previous denial determination.

Autism Spectrum Disorder means a Neurobiological Disorder that is characterized by social and communication difficulties and included the previously used diagnoses such as Autism Disorder, Asperger’s Syndrome, or Pervasive Development Disorder – Not Otherwise Specified.

Behavioral Health Provider means a Physician or Health Professional who provides benefits for Mental Health Care, Serious Mental Illness or Chemical Dependency.

Biomarker means a characteristic that is objectively measured and evaluated as an indicator or normal biological processes, pathogenic processes, or pharmacological responses to a specific therapeutic intervention. The term includes gene mutations, and protein expression.

Biomarker Testing means the analysis of a patient's tissue, blood, or other bio spectrum for the presence of a biomarker. The term includes single-analyte tests, multiplex panel tests, and whole genome sequencing.

Breast Tomosynthesis means a radiologic Mammography procedure that involves the acquisition of projection images over a stationary breast to produce cross-sectional digital three-dimensional images of the breast from which applicable breast cancer screening diagnoses may be determined.

Calendar Year means the twelve (12) month period from January 1 through December 31.

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

Chemical Dependency means the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance.

Chemical Dependency Treatment Center means a facility which provides a program for the treatment of Chemical Dependency under the care of a behavior health practitioner and is also:

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

Chemotherapy means any medication used to directly treat cancer. Medications used as supportive therapy (i.e., anti-nausea, etc.) are not included in this definition.

Claim means a request for payment that the Member or the Member’s Participating Provider submits to the Issuer when benefits are provided by the Participating Provider. Claims typically include proof of loss or evidence of a claim, which includes the form on which the claim is made, bills and statements reflecting benefits and their respective charges provided to a Member, and correct diagnosis codes and procedure codes for the benefits.

Clinician-Administered Drug means an outpatient prescription drug other than a vaccine that:

- cannot reasonably be:
    - self-administered by the member to whom the drug is prescribed, or

    - administered by an individual assisting the member with the self-administration, and
- is typically administered:
    - by a physician or other health care provider authorized under the laws of this state to administer the drug, including when acting under a physician's delegation and supervision, and
    - in a physician's office.

Cognitive Communication Therapy is therapy designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.

Cognitive Rehabilitation Therapy means therapy designed to address therapeutic cognitive abilities, based on an assessment, and understanding of the Member's brain behavior deficits.

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

Community Reintegration Services means services that facilitate the continuum of care as an affected Member transitions into the community.

Complainant means a Member, Physician, Health Professional, or other person designated to act on behalf of a Member, who files a Complaint.

Complaint is an oral or written expression of dissatisfaction with any aspect of the Issuer'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 benefit for reasons not related to Medical Necessity.
- The way a benefit 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.
- Dissatisfaction or disagreement with an Adverse Determination.

Complications of Pregnancy means conditions, requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as:

- acute nephritis.
- nephrosis.
- cardiac decompensation.
- missed abortion; and
- similar medical and surgical conditions of comparable severity.

Complications of Pregnancy does not include:

- false labor.
- occasional spotting.
- physician prescribed rest during the period of pregnancy.
- morning sickness.
- hyperemesis gravidarum.
- pre-eclampsia; and
- similar conditions associated with the management of a difficult pregnancy do not constitute a nosologically distinct complication of pregnancy.

Contract Date means the date on which the Agreement is executed. The Contract Date may not be the date coverage for the Plan commences.

Contract Holder means the person or entity with whom the Issuer has entered into an Agreement to provide healthcare. Under the Agreement, the Group is the Contract Holder.

Contract Year means that period of time which begins at 12:00 midnight on the Contract Date and ends at 12:00 midnight one (1) year later.

Copayment means the dollar amount of the cost of covered benefits, if any, shown in the Schedule of Benefits payable by the Member to a Participating Provider, when those benefits are obtained from that Participating Provider.

Cost Sharing means the Copayment, Coinsurance, Deductible, and any amounts exceeding benefit limits that a Member will incur as an expense for covered benefits. Specific cost sharing amounts for covered benefits can be found on the Schedule of Benefits.

Cosmetic, Reconstructive, or Plastic Surgery means surgery that:

- Can be expected or is intended to improve the physical appearance of a Member.
- Is performed for psychological purposes; or
- Restores form but does not correct or materially restore a bodily function.

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

Covered Employee is the Eligible Employee whose Application has been accepted by the Issuer for coverage under the Plan.

Covered Expenses are the expenses incurred for covered benefits. Covered Expenses for covered benefits received from Participating Providers will not exceed the contracted rate. Covered Expenses for covered benefits received from Non-Participating Providers will not exceed Usual and Customary Rates. In addition, Covered Expenses may be limited by other specific maximums described in this Plan. Covered Expenses are subject to applicable Deductibles and other benefit limits. An expense is incurred on the date the Member receives the covered benefit. In some cases, Covered Expenses may be less than the amount that You are billed.

Covered Prescription Drugs means those medications prescribed by a Physician that, under state or federal law, may be dispensed only by a Prescription Order for a Medically Necessary condition, and active ingredient(s) is/are FDA approved Legend Drug(s) or insulin.

Creditable Coverage means any group health coverage or individual health coverage, including insurance or a health maintenance organization, which 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.

Crisis Stabilization Unit or Facility means an institution which is appropriately licensed and accredited as a Crisis Stabilization Unit or Facility for the provision of Mental Health Care and Serious Mental Illness Treatment to Members who are demonstrating an acute psychiatric crisis of moderate to severe proportions.

Cryotherapy also known as cold therapy, is the Treatment of pain and/or inflammation by lowering the temperature of the skin over the affected area.

Custodial Care means care designed principally to assist a Member in engaging in the activities of daily living, or personal care, such as help in walking and getting in and out of bed; assistance in bathing, dressing, feeding, and using the toilet; preparation of special diets; and supervision of medication, which

can usually be self-administered, and which does not entail or require the continuing attention of trained medical or other paramedical personnel. This includes the healthcare related activities that people generally do themselves, such as placement of eye drops. Custodial care is normally, but not necessarily, provided in a nursing home, convalescent Hospital, or rest home or similar institution.

Deductible means the dollar amount, if any, shown in the Schedule of Benefits payable by the Member for covered benefits before the Plan provides payment for those benefits as described in this Certificate of Coverage.

Diabetes 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 diabetes complications. As new or improved diabetes equipment becomes available and is approved by the United States Food and Drug Administration, such equipment shall be covered if determined to be Medically Necessary and appropriate by a Participating Provider through a written order.

Diabetes Self-Management Training means any of the following training or instruction by a Participating Provider following the initial diagnosis of diabetes:

- Instruction in the care and management of the condition.
- Nutritional counseling.
- Counseling in the proper use of Diabetes Equipment and Supplies.
- Subsequent training or instruction necessitated by a significant change in the Member's symptoms or condition which impacts the self-management regime; and
- Appropriate periodic or continuing education as warranted by the development of new techniques and Treatment for diabetes.

Diabetes 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. As new or improved diabetes supplies become available and are approved by the United States Food and Drug Administration, such supplies shall be covered if determined to be Medically Necessary and appropriate by a Participating Provider through a written order.

Diagnostic Imaging means an imaging examination using mammography, ultrasound imaging, or magnetic resonance imaging that is designed to evaluate a subjective or objective abnormality detected by a Physician or patient in a breast; an abnormality seen by a Physician on a screening mammogram; an abnormality previously identified by a Physician as probably benign in a breast for which follow-up imaging is recommended by a Physician; or an individual with a personal history of breast cancer or dense breast tissue.

Digital Mammography means Mammography creating breast images that are stored as digital pictures.

Durable Medical Equipment or **DME** means equipment that:

- can withstand repeated use.
- is primarily and customarily used to serve medical purposes.
- generally, is not useful to a Member in the absence of an illness or injury; and
- is appropriate for use in the home.

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

Effective Date means the date the coverage for You and/or Your Covered Dependent(s) begins. It may be different from the Contract Date.

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

- Subscriber's current spouse as defined by Texas law.

- A child of the Subscriber's current spouse who is:
    - An applicant for coverage during the Open Enrollment Period; and
    - Under the Age of Ineligibility; or
    - Over the Age of Ineligibility who is:
        - Incapable of self-sustaining employment by reason of physical disability or mental incapacity; and
        - Chiefly dependent upon the Subscriber for support and maintenance.
- Subscriber's Son or Daughter who is:
    - An applicant for coverage during the Open Enrollment Period; and
    - Under the Age of Ineligibility; or
    - Over the Age of Ineligibility who is:
        - Incapable of self-sustaining employment by reason of physical disability or mental incapacity; and
        - Chiefly dependent upon the Subscriber for support and maintenance.
- Subscriber's grandson or granddaughter who is:
    - An applicant for coverage during the Open Enrollment Period.
    - A dependent of the Subscriber for federal tax purposes at the time of application of coverage for the grandchild is made.
    - Unmarried; and
    - Under the Age of Ineligibility; or
    - Over the Age of Ineligibility who is:
        - Incapable of self-sustaining employment by reason of physical disability or mental incapacity; and
        - Chiefly dependent upon the Subscriber for support and maintenance.
- Any child for whom the Subscriber is obligated to provide health coverage by a Qualified Medical Support Order pursuant to the terms of that order.

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 Plan. The term does not include:

- an employee who works on a part-time, temporary, seasonal or substitute basis; or
- 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.

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

Emergency Care is provided in a Hospital emergency Facility, Freestanding Emergency Medical Care Facility, or comparable Facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- Placing his or her health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.
- Serious disfigurement.
- In the case of a pregnant woman, serious jeopardy to the health of the fetus; or

- In the case of a woman having contractions, there is inadequate time to affect a safe transfer to another Hospital before delivery, or if transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergency Medical Services (EMS) Provider means a person who uses or maintains emergency medical services vehicles, medical equipment, and emergency medical services personnel to provide emergency medical services.

Employee means an individual employed by an Employer.

Employer means Group.

Enrollment Application is the document which must be completed by or on behalf of a person applying for coverage. The enrollment application along with any attachments and amendments is part of the entire Agreement between the Subscriber, Contract Holder, and the Issuer.

Essential Health Benefits is the term used to describe health benefits that are comprised of general categories and covered items and services within those categories, as defined by Section 1302(b) of the Patient Protection and Affordable Care Act (PPACA).

Experimental or **Investigational** means, in the opinion of the Medical Director, Treatment that has not been proven successful in improving the health outcomes of Members, in making such determinations, the Medical Director will rely on:

- 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.
- Communications about the Treatment that have been provided to Members as part of an informed consent.
- Communications about the procedure or Treatment that have been provided from the Physician studying the Treatment to the institution or government sponsoring the study.
- Documents or records from the institutional review board of the Hospital or institution studying the Treatment.
- Regulations and other communication and publications issued by the Food and Drug Administration and the Department of Health and Human Services; and
- The Member's medical records.

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

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

Extended Care Expense means the Usual and Customary Rate incurred for Medically Necessary benefits provided by a Skilled Nursing Facility, a Home Health Agency, or a Hospice.

Fertility Preservation means the collection and preservation of sperm, unfertilized oocytes, and ovarian tissue, and does not include the storage of such unfertilized genetic materials.

Facility means a healthcare or residential treatment center licensed by the state in which it operates to provide medical inpatient Treatment, outpatient Treatment, partial hospitalization, residential or day Treatment. Facility also means a treatment center for the diagnosis and/or Treatment of Chemical Dependency or Mental Illness.

Freestanding Emergency Medical Care Facility is a Facility, licensed under Health and Safety Code Chapter 254 (concerning Freestanding Emergency Medical Care Facilities), structurally separate and distinct from a Hospital, which receives a Member and provides Emergency Care as defined in Insurance Code §843.002.

Forced Organ Harvesting means the removal of one (1) or more organs from a living person by means of coercion, abduction, deception, fraud, or abuse of power or a position of vulnerability.

Formulary means the list that identifies those Prescription Drugs for which coverage may be available under this Plan. Members may determine the tier assigned to each Prescription Drug by visiting the Our website at **BSWHealthPlan.com** or by calling Us at **844.633.5325**.

Grace Period means a period of thirty (30) days after a Premium Due Date, during which Premiums may be paid to the Issuer without lapse of the Subscriber or Covered Dependent's coverage, if any, under this Certificate of Insurance. If payment is not received within thirty (30) days, coverage will be terminated, and the Subscriber will be responsible for any cost of benefits received during the grace period.

Group means Your Employer which is the party contracting with the Issuer 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.

Health Care Provider means an individual who is licensed, certified, or otherwise authorized to provide health care services in this state.

Health Professional means healthcare professionals, licensed in the State of Texas (or, in the case of Treatment rendered on referral, licensed in the state in which that care is provided). Health Professional includes a Doctor of Dentistry, a Doctor of Podiatry, a Doctor of Optometry, a Doctor or Chiropractic, a Doctor or 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 Counselor and Family Therapist, and other practitioners of the healing arts as specified in the Texas Insurance Code.

Heritable Metabolic Disease means an inherited disease that may result in mental or physical retardation or death.

Home Health Agency means a business that provides Home Health Care and is licensed, approved, or certified by the appropriate agency of the state in which it is located or be certified by Medicare as a supplier of Home Health Care.

Home Health Care means benefits that are provided under the Plan during a visit by a Home Health Agency to Members confined at home due to a sickness or injury requiring skilled healthcare on an intermittent, part-time basis.

Home Infusion Therapy means the administration of fluids, nutrition, or medication (including all additives and Chemotherapy) by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting. Home Infusion Therapy shall include:

- Drugs and IV solutions.
- Pharmacy compounding and dispensing services.

- All equipment and ancillary supplies necessitated by the defined therapy.
- Delivery services.
- Patient and family education; and
- Nursing services.

Over-the-counter products which do not require a Participating Provider's prescription, including but not limited to standard nutritional formulations used for enteral nutrition therapy, are not included within this definition.

Hospice means a Facility or agency primarily engaged in providing skilled nursing care and other therapeutic care for terminally ill patients and which is:

- Licensed in accordance with state law (where the state law provides for such licensing); or
- Certified by Medicare as a supplier of Hospice Care.

Hospice Care means benefits that are provided under the Plan by a Hospice to a Member confined at home or in a Hospice Facility due to a terminal sickness or terminal injury requiring skilled healthcare.

Hospital means a short-term acute care Facility which:

- Is duly licensed as a Hospital by the state in which it is located and meets the standards established for such licensing, including those either accredited by the Joint Commission on Accreditation of Healthcare Organizations or is certified as a Hospital Provider under Medicare.
- Is primarily engaged in providing inpatient diagnostic and therapeutic care for the diagnosis, Treatment, and care of injured and sick persons by or under the supervision of Physicians or Behavioral Health Provider for compensation from its patients.
- Has organized departments of medicine and major surgery, either on its premises or in facilities available to the Hospital on a contractual prearranged basis and maintains clinical records on all patients.
- Provides 24-hour nursing care by or under the supervision of a registered nurse; and
- Is not, other than incidentally, a Skilled Nursing Facility, nursing home, Custodial Care home, health resort, spa or sanitarium, place for rest, place for the aged, place for the Treatment of Chemical Dependency, Hospice, or place for the provision of rehabilitative care.

Identification Card or ID Card means the card provided to the Member by the Issuer indicating pertinent information applicable to the Member’s coverage.

Inpatient Hospital Expense means the Usual and Customary Rate incurred for the Medically Necessary care of a Member, if benefits are:

- Furnished at the direction or prescription of a Physician, Behavioral Health Provider or Health Professional; and
- Provided by a Hospital or a Chemical Dependency Treatment Center; and
- Furnished to and used by the Member during an inpatient Hospital admission.

Inpatient Hospital Expense shall include:

- Room accommodation charges.
- All other usual Hospital care, including Prescription Drugs and medications, which are Medically Necessary and consistent with the condition of the Member.

Not included are personal items or comfort items, including, but not limited to, TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, or hot tubs.

Medically Necessary Mental Health Care or Treatment of Serious Mental Illness or Treatment of Serious Mental Illness in a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, or a Residential Treatment Center for Children and Adolescents, in lieu of hospitalization, shall be Inpatient Hospital Expense.

Independent Review Organization or IRO means an organization which provides external review of Adverse Determinations as administered by the Department of Health and Human Services.

Infertility means the inability to conceive after sexual relations without contraceptives for the period of one (1) year, or if 35 years or older, inability to conceive after six (6) months; or maintain a pregnancy until fetal viability.

Issuer means Baylor Scott & White Insurance Company; also referred to as “We”, “Us” and “Our”.

Late Enrollee means an employee or dependent, eligible for enrollment in the Plan, who requests enrollment in the Plan after the expiration of the initial enrollment period established under the terms of the first Plan for which that employee or dependent is eligible through the Employer or after the expiration of an Open Enrollment Period.

Legend Drug means a drug that federal law prohibits dispensing without a written prescription.

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

Low-Dose Mammography means the x-ray examination of the breast using equipment dedicated specifically for Mammography, including an x-ray tube, filter, compression device, and screens, with an average radiation exposure delivery of less than one rad mid-breast and with two views for each breast.

Maintenance Prescription Drug means medication prescribed for a chronic, long-term condition and is taken on a regular, recurring basis.

Manipulative Therapy within the scope of rehabilitative care, includes benefits provided by a chiropractor or other provider licensed to provide the benefit, which is supportive or necessary to help Members achieve the same physical state as before an injury or illness, and that is determined to be Medically Necessary.

Mammography means the x-ray examination of the breast using equipment dedicated specifically for Mammography.

Maximum Out-of-Pocket means the total dollar amount of Out-of-Pocket Expenses which a Member is required to pay for covered benefits during a Calendar Year. Maximum Out-of-Pocket does not apply to any Treatments which are not Medically Necessary or not a covered benefit.

Medical Benefits refers to Medically Necessary covered benefits which are included in the **Medical Benefits** section of this Certificate of Coverage, any amendments, or Riders thereto, and which are performed, prescribed, or authorized by a Participating Provider, Participating Hospital, or a referral Physician.

Medical Director means any Physician designated by the Issuer who shall have responsibilities for assuring the continuity, availability, and accessibility of covered benefits. 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 a Treatment is Experimental or Investigational.

Medical-Surgical Expense means the Usual and Customary Rate incurred for Medically Necessary care of a Member, provided the benefits are:

- Furnished by or at the direction or prescription of a Physician, Behavioral Health Provider or Health Professional; and
- Not an excluded Inpatient Hospital Expense or Extended Care Expense in the Plan.

A benefit is furnished by or at the direction of a Physician, Behavioral Health Provider or Health Professional if the benefit is:

- Provided by a person employed by the directing Physician, Behavioral Health Provider or Health Professional; and
- Provided at the usual place of business of the directing Physician, Behavioral Health Provider or Health Professional; and
- Billed to the patient by the directing Physician, Behavioral Health Provider or Health Professional.

An expense shall have been incurred on the date the benefit was provided for which the charge is made.

Medically Necessary or Medical Necessity means those healthcare services which, in the opinion of the Member's Participating Provider or Participating Health Professional, 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:

- in accordance with the generally accepted standards of medical practice.
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease, and.
- not primarily for the convenience of the Member, Participating Provider, a physician, or any other healthcare provider and subject to clinical analysis, the most cost-effective type of service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's illness, injury, or disease**.**

Medication Synchronization Plan means a plan established for the purpose of synchronizing the filling or refilling of multiple prescriptions.

Medicare means Title XVII of the Social Security Act, and amendments thereto.

Member means You and/or Your Covered Dependent(s).

Mental Health Care means any of the following:

- The diagnosis or Treatment of a mental disease, disorder, or condition listed in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM), as revised, or any other diagnostic coding system used by Us, whether the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin.
- The diagnosis or Treatment of any symptom, condition, disease, or disorder by a Physician, Behavioral Health Provider or Health Professional (or by any person working under the direction or supervision of a Physician, Behavioral Health Provider or Health Professional) resulting from:
    - Individual, group, family, or conjoint psychotherapy,
    - Counseling,
    - Psychoanalysis,
    - Psychological testing and assessment,
    - The administration or monitoring of psychotropic drugs, or
    - Hospital visits or consultations in a Facility.
- Electroconvulsive Treatment.
- Psychotropic drugs; or,
- Any of the services listed above, performed in or by a Participating Provider.

Minimum Essential Coverage means health coverage that is recognized as coverage that meets substantially all requirements under federal law pertaining to adequate individual, group, or government health insurance coverage. For additional information on whether coverage is recognized as "Minimum Essential Coverage", please contact the Issuer at **844.633.5325** or visit **CMS.gov**.

Minimum Group Size means the minimum number of Eligible Employees required to be employed by the Employer in order to avoid termination of the Agreement. The minimum group size is two Eligible Employees.

Name Brand Prescription Drug means a Prescription Drug that has no generic equivalent or a Prescription Drug that is the innovator or original formulation for which the generic equivalent forms exist.

Neonatal Intensive Care Unit or NICU is also referred to as a special care nursery or intensive care nursery. Admission into NICU generally occurs but is not limited to when the newborn is born prematurely, if difficulty occurs during delivery, or the newborn shows signs of a medical problem after the delivery.

Network means Participating Providers that have contracted with the Issuer to provide covered benefits to Members.

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 an interview with a Member, a Member's family, or others.

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

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

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

Neurocognitive Therapy is therapy designed to address neurological deficits in informational processing and to facilitate the development of higher-level cognitive abilities.

Neurophysiological Testing means evaluation of the functions of the nervous system.

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

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.

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

Non-Participating Provider means a Hospital, Physician, Behavioral Health Provider, Health Professional, Urgent Care Facility or Pharmacy who has not contracted with the Issuer to provide benefits to Members of the Plan. We strongly encourage Members to use Participating Providers to assure the highest quality and lowest cost. Use of a Non-Participating Provider may result in additional charges to the Member that are not covered under the Plan. Requests for benefits performed by a Non-Participating Provider may be denied if there is a Participating Provider in the Network who can provide the same or similar benefit.

Open Enrollment Period means the period each calendar year, at the time mutually designated by the Issuer and the Group of not less than thirty-one (31) consecutive days which any eligible person who meets the eligibility provisions of the Agreement, including a Late Enrollee, on behalf of himself or his Eligible Dependents, may elect to become enrolled under the Agreement. A completed Enrollment Application form must be received by the Issuer within the open enrollment period and all other requirements of the Agreement must be met.

Oral Oncology Dispensing Program means a program that temporarily limits the quantity of oral oncology medication that can be dispensed. The first 4 fills of the Prescription Drug are restricted to a 14/15-day

supply until tolerability has been established. After this period, the Member may obtain the maximum daily supply allowed per the Schedule of Benefits.

Organ Transplant means the harvesting of a solid and/or non-solid organ, gland, or tissue from one individual and reintroducing that organ, gland, or tissue into another individual.

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

Out-of-Pocket Expenses means the portion of covered benefits for which a Member is required to pay at the time benefits are received. Benefits which are not covered by the Plan or are not Medically Necessary, are not included in determining Out-of-Pocket Expenses.

Outpatient Day Treatment means structured care provided to address deficits in physiological, behavioral and/or cognitive functions. Such care may be delivered in settings that include transitional residential, community integration, or non-residential Treatment settings.

Participating Facility means a healthcare or Treatment center licensed by the State of Texas as a Facility which has contracted or arranged with the Issuer to provide covered benefits to Members and is listed by the Issuer as a Participating Provider.

Participating Health Professional means a healthcare professional, licensed in the State of Texas (or, in the case of Treatment rendered on referral, licensed in the state in which that care is provided) who has contracted or arranged with the Issuer to provide covered benefits to Members and is listed by the Issuer as a Participating Provider.

Participating Hospital means an institution licensed by the State of Texas as a Hospital which has contracted or arranged with the Issuer to provide covered benefits to Members and is listed by the Issuer as a Participating Provider.

Participating Pharmacy means a pharmacy that has contracted with the Issuer to provide Prescription Drugs to Members.

Participating Provider means any person employed by an entity that has contracted directly or indirectly with the Issuer to provide covered benefits to Members. Participating Provider includes but is not limited to Participating Hospitals, Participating Physicians, Participating Behavioral Health Providers, Participating Health Professionals, Participating Urgent Care Facilities, Participating Pharmacies and Participating Specialty Pharmacy Provider within the Service Area.

Participating Specialty Pharmacy Provider means a pharmacy that has contracted with the Issuer to provide Specialty Drugs to Members.

Participation Percentage means the minimum percentage of total Eligible Employees of Your Employer who must participate in the Plan.

Participating Virtual Network Provider means a provider or Facility that has entered into an agreement with the Issuer, or with an organization contracting on the Issuer's behalf, to deliver covered benefits through live audio with video technology or audio only or online interview process.

Pharmacy Benefits refers to Medically Necessary Covered Prescription Drugs prescribed to treat a Member for an acute, chronic, disabling, or Life-Threatening Disease or Condition which are included in the **Pharmacy Benefits** section of this Certificate of Coverage, any amendments, or Riders thereto, and which are prescribed by a Participating Provider and filled by a Participating Pharmacy.

Phenylketonuria or PKU means an inherited condition that may cause severe developmental deficiency, seizures, or tumors, if not treated.

Physician means a person, when acting within the scope of his license to practice medicine in the State of Texas, who is a Doctor of Medicine or Doctor of Osteopathy. The terms Doctor of Medicine or Doctor of Osteopathy shall have the meaning assigned to them by the Texas Insurance Code.

Plan, Your Plan, The Plan means the covered benefits available to Members under the terms of the Agreement.

Policy is the term used to describe the Agreement between the Issuer and the Group as a means of providing benefits to the Eligible Employees and their Eligible Dependents.

Post-Acute Care Treatment means Treatment provided after acute care confinement and/or Treatment that is based on an assessment of the Member's physical, behavioral, or cognitive functional deficits, which includes a Treatment goal of achieving functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.

Post-Acute Transition means care that facilitates the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

Post-Stabilization means care that is:

- Related to an emergency medical condition.
- Provided to stabilize the Member's condition; or,
- Provided to maintain the stabilized condition, or, in certain circumstances, to improve or resolve the Member's condition.

Post-Delivery Care means postpartum care provided in accordance with accepted maternal or neonatal assessment 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 trials.

Preauthorization means a form of prospective Utilization Review by the Issuer or Issuer's Utilization Review agent of healthcare proposed to be provided to a Member.

Premium means periodic amounts required to be paid to the Issuer for or on behalf of a Covered Employee and Covered Dependents, if any, as a condition of coverage under the Agreement.

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

Premium Due Date means the first day of the month or quarter for which the payment is due.

Prescription Drug means any Legend Drug that has been approved by the Food and Drug Administration (FDA), is not Experimental or Investigational, and requires a prescription written by a duly licensed Physician.

Prescription Order means an authorization for a Prescription Drug issued by a Physician, who is duly licensed to write the authorization in the ordinary course of his professional practice.

Preventive Care means the following, as further defined, and interpreted by appropriate statutory, regulator, and agency guidance:

- Evidence-based items or services with an "A" or "B" rating from the U.S. Preventive Services Task Force (USPSTF).
- Immunizations for routine use in children, adolescents, and adults with a recommendation in effect from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

- Evidence-informed Preventive Care and screening for infants, children and adolescents provided by guidelines supported by the Health Resources and Services Administration (HRSA); and
- Evidence-informed Preventive Care and screening for women provided in guidelines supported by HRSA and not otherwise addressed by the USPSTF.

Primary Care Physician means a Participating Provider specializing in family medicine, community internal medicine, general medicine, geriatrics, or pediatrics selected by the Member to manage the Medical and Pharmacy Benefits which will be made available to the Member by the Issuer.

Prosthetic Device means an artificial device designed to replace, wholly or partly, an internal body organ or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ, or to replace an arm or leg.

Prosthetics/Orthotics Provider means a certified prosthetist that supplies both standard and customized prostheses and orthotic supplies.

Psychiatric Day Treatment Facility means an institution which is appropriately licensed and is accredited by the Joint Commission on Accreditation of Healthcare Organizations as a Psychiatric Day Treatment Facility for the provision of Mental Health Care and Serious Mental Illness services to Members for periods of time not to exceed eight hours in any 24-hour period. Any Treatment in a Psychiatric Day Treatment Facility must be certified in writing by the attending Physician or Behavioral Health Provider to be in lieu of hospitalization.

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

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

Qualified Medical Support Order means a court or administrative order which sets forth the responsibility for providing healthcare coverage for Eligible Dependents.

Remediation means the process(es) of restoring and improving a specific function.

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

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

Residential Treatment Center for Children and Adolescents means a child-care institution which is appropriately licensed and accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Association of Psychiatric Services for Children as a residential Treatment center for the provisions of Mental Health Care and Serious Mental Illness services for emotionally disturbed children and adolescents.

Rider means a supplement to the Plan that describes any additional covered benefits, changes in Member benefits or the terms of Member coverage under the Plan. We may provide Riders to Members at the time of enrollment in the Plan or at other times after that. A Rider, along with any attachments and amendments, is part of the entire Agreement between the Issuer and the Subscriber.

Routine Patient Care Costs means the costs of any Medically Necessary care provided under the Plan, without regard to whether the Member is participating in a clinical trial. Routine patient care costs do not include:

- The cost of an investigational new drug or device that is not approved for any indication by the United States Food and Drug Administration, including a drug or device that is the subject of the clinical trial.
- The cost of a service that is not a covered benefit, regardless of whether the service is required in connection with participation in a clinical trial.
- The cost or use of a service that is clearly inconsistent with widely accepted and established standards of care for a diagnosis.
- A cost associated with managing a clinical trial; or
- The cost of a service that is specifically excluded from coverage.

Schedule of Benefits is a document that lists covered benefits under the Plan along with associated Cost Sharing such as Copayments, Coinsurance, and Deductibles. The Schedule of Benefits along with any attachments and amendments is part of the entire Agreement between the Subscriber and the Issuer.

Serious and Complex Condition means with respect to a Member:
- in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm, or
- in the case of chronic illness or condition, a condition that is:
    - life-threatening, degenerative, potentially disabling, or congenital, and
    - requires specialized medical care over a prolonged period of time.

Serious Mental Illness includes the following psychiatric illnesses defined by the DSM:
- Bipolar disorders (hypomanic, manic, depressive, and mixed).
- Depression in childhood and adolescence.
- Major depressive disorders (single episode or recurrent).
- Obsessive-compulsive disorders.
- Paranoia and other psychotic disorders.
- Schizoaffective disorders (bipolar or depressive); and
- Schizophrenia.

Service Area is the geographic area in which the Issuer may offer this Certificate of Coverage.

Skilled Nursing Facility means a Facility primarily engaged in providing skilled nursing care and other therapeutic care and which is:
- Licensed in accordance with state law (where the state law provides for licensing of such Facility); or
- Medicare or Medicaid eligible as a supplier of skilled inpatient nursing care.

Son or Daughter means
- A child born to You or Your current legal spouse.
- A child who is Your legally adopted child with legal adoption evidenced by a decree of adoption, who is the object of a lawsuit for adoption, and You are a party to such lawsuit; or
- A child who has been placed with You for adoption.

Specialist Physician means a Physician or Health Professional who has entered into an agreement with the Issuer to participate as a provider of specialty care (generally, those practices other than general practice, family practice, internal medicine, pediatrics and OB/GYN).

Specialty Drug means drugs that are typically used to treat complex or chronic conditions, and which usually require close monitoring. These drugs may be administered by a health professional or be self-administered in the home by injection (under the skin or into a muscle), by infusion, by inhalation, by mouth, or on the skin. These drugs may also require special handling, special manufacturing processes, or have limited prescribing or limited pharmacy availability.:

Stabilization means the point at which no material deterioration of a condition is likely, within reasonable probability, to result from or occur during the Member's transfer.

Subrogation means recovery, from a third party of medical costs that were originally paid by the Issuer.

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 the Agreement and for or on behalf of whom the Premiums are paid by the Group.

Telehealth Service means a health service, other than a telemedicine medical service or a teledentistry dental service, delivered by a Health Professional licensed, certified, or otherwise entitled to practice in this state and acting within the scope of the Health Professional's license, certification, or entitlement to a patient at a different physical location than the Health Professional using telecommunications or information technology.

Telemedicine Medical Service means a healthcare service delivered by a Physician licensed in this state, or a Health Professional acting under the delegation and supervision of a Physician licensed in this state and acting within the scope of the Physician's or Health Professional's license to a patient at a different physical location than the Physician or Health Professional using telecommunication or information technology.

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

Triggering Event means an event which allows an individual to apply for enrollment in coverage outside of the Open Enrollment Period.

Urgent Care Facility means any licensed Facility that provides care for the immediate Treatment only of an injury or disease, and which has contracted with the Issuer to provide Members such care.

Urgent Care means care provided for the immediate Treatment of a medical condition that requires prompt medical attention but where a brief time lapse before receiving care 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.

Usual and Customary Rate means the amount based on a percentage of available rates published by Centers for Medicare and Medicaid Services (CMS) or a benchmark developed by CMS for the same or similar care within a geographical area; and that have been negotiated with one or more Participating Provider in a geographical area for the same of similar care. The amount payable may be increased by a fixed percentage for certain services or facilities as agreed to by the Plan.

Utilization Review means a system for prospective and/or concurrent review of the Medical Necessity, appropriateness, or determination that a Treatment currently provided or proposed to be provided by a Physician or Health Professional to a Member is Experimental, or Investigational. Utilization Review does not include elective requests by the Member for clarification of coverage.

Virtual Visit for Medical Benefits includes the diagnosis and Treatment of less serious medical conditions through live audio with video technology (video visits) or online interview process (eVisits) or audio only. Virtual visits provide communication of medical information in real-time between the Member and a distant Physician or Health Professional, through use of live audio with video technology or audio only or online interview process outside of a medical Facility (for example, from home or from work).

Waiting Period means the period specified by Group, but not longer than ninety (90) days, which must pass before a person becomes eligible for coverage under the Agreement.

You and **Your** means relating or pertaining to the Subscriber.

How the Plan Works

Our Right to Contract with Providers

We contract with providers of covered benefits as it is determined can reasonably provide them. The Issuer is not an agent of any Participating Provider, nor is any Participating Provider an agent of the Issuer. No Contract Holder or Member, in such a capacity, is an agent or representative of the Issuer 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.

Participating Providers shall make reasonable efforts to maintain an appropriate patient relationship with Members to whom they are providing care. Likewise, Members shall make reasonable efforts to maintain an appropriate patient relationship with the Participating Providers who are providing such care. Participating Providers determine the methods and form of Treatment provided to Members. Not every form of Treatment may be provided, and even though a Member's personal beliefs or preferences may conflict with the care as offered by Participating Providers, a Member will not be entitled to any specific class of licensed provider, school of approach to such care, or otherwise be able to determine the providers who will care for the Member other than as provided by the Agreement. This provision does not restrict the Member's right to consent or agree to any Treatment. The fact that Treatment has been prescribed or authorized by a Participating Provider does not necessarily mean that it is covered under the Agreement.

Plan Network

Members are entitled to the covered benefits from Participating and Non-Participating Providers subject to the conditions and limitations stated in the Schedule of Benefits and this Certificate of Coverage that are Medically Necessary. Members can access up-to-date lists of Participating Providers and other Plan Network information by visiting Our website at **BSWHealthPlan.com**.

Participating Providers

The Plan Network consists of Physicians, Specialist Physicians, Hospitals, and other healthcare facilities to serve Members throughout the Network Service Area. Refer to the provider directory or visit Our website at **BSWHealthPlan.com** to make Member selections. The list of Participating Providers may change occasionally, so make sure the providers selected are still Participating Providers at the time of service. An updated directory will be available at least annually or Members may access Our website at **BSWHealthPlan.com** for the most current listing to assist in locating a Participating Provider.

If a Member chooses a Participating Provider, the provider will bill Us, not the Member, for care provided. The provider has agreed to accept as payment in full the least of:

- The billed charges, or
- The Usual and Customary Rate, or
- Other contractually determined payment amounts.

The Subscriber is responsible for paying any Copayment, Coinsurance or Deductible amounts as set forth in the Schedule of Benefits. The Subscriber may be required to pay for limited or non-covered benefits. No Claim forms are required.

If there are two (2) tiers of Participating Providers indicated on Your Schedule of Benefits, Tier One Participating Providers and Tier Two Participating Providers are both under a contractual agreement with the Issuer. You may have a lower Copayment, Coinsurance, or Deductible for using a Tier One Participating Provider instead of a Tier Two Participating Provider. Differences in Copayments, Coinsurance, or Deductibles between the Tier One and Tier Two Participating Providers, if any, are indicated on Your Schedule of Benefits.

Non-Participating Providers

Covered Expenses for covered benefits provided by a Non-Participating Provider will not exceed the lesser of actual billed charges, eligible billed charges as outlined in the Hospital's Service Item Master Manual, or the Usual and Customary Rate as determined by the Issuer. These services may be subject to penalties or an additional Deductible.

Exception: If Medicare is the primary payor, Covered Expense does not include any charge:

- By a Hospital in excess of the approved amount as determined by Medicare; or
- By a Physician or other provider, in excess of the lesser of the maximum Covered Expense stated above, or
- For providers who accept Medicare assignment, the approved amount as determined by Medicare; or
- For providers who do not accept Medicare assignment, the limiting charge is determined by Medicare.

You will always be responsible for any expense incurred which is not covered under this Plan.

Covered Expenses for the services of a Non-Participating Provider will be paid according to the Participating Provider Schedule of Benefits under the following circumstances:

- To the extent the Issuer would have covered such services under the terms of the Agreement, Medically Necessary covered benefits which are prescribed by a Participating Provider but which are not reasonably available from a Participating Provider shall be authorized within a time appropriate to the circumstances relating to the delivery of services and the condition of the Member, but in no event to exceed five (5) business days after receipt of reasonably requested documentation, to be received from a Non-Participating Provider upon the request of the Participating Provider and the approval by the Medical Director. If approved, the Issuer:
    - will pay the Claim, at a minimum, at the Usual and Customary Rate for the service, less any Member Coinsurance, Copayment, or Deductible responsibility under the Plan.
    - will pay the Claim at the Participating Provider benefit level; and
    - in addition to any amounts that would have been credited had the provider been a Participating Provider, credit any Out-of-Pocket amounts shown by the Member to have been actually paid to the Non-Participating Provider for charges for covered services that were above and beyond the Usual and Customary Rate toward the Member's Deductible and annual Maximum Out-of-Pocket applicable to Participating Provider services. You will also be responsible for charges and services, supplies, and procedures that are not covered under the Plan; or
- When the services are for Emergency Care as outlined in the **Medical Benefits** section of this Certificate of Coverage. 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 this Certificate of Coverage 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.
- 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. We will make a payment directly to the provider not later than the 30th day after the date We receive a clean Claim for those services that includes all information necessary for Us to pay the Claim.

The Issuer 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 Certificate of Coverage.

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 for:

- 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 Member receives notice of the contract termination and shall continue until the earlier of ninety (90) days after the Member's receipt of the notice, 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.

Refusal to Accept Treatment

Should a Member refuse to cooperate with or accept the recommendations of Participating Providers regarding healthcare for that Member, Participating Providers may regard such refusal as obstructing the delivery of proper medical care. In such cases, Participating Providers shall make reasonable efforts to accommodate the Member. However, if the Participating Provider determines that no alternative acceptable to the Participating Provider exists, the Member shall be so advised. If a Member continues to refuse to follow the recommendations, then neither We nor Our Participating Providers shall have any further responsibility under the Agreement to provide care for the condition under Treatment.

Medical Necessity

Benefits available under the Plan must be Medically Necessary as described in the **Definitions** section of this Certificate of Coverage.

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**. Refer to the Schedule of Benefits regarding penalties for failure to obtain Preauthorization of benefits other than Emergency Care.

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.

Case Management Program

Case Management helps coordinate services 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 care manager will work with the Member, the Member's family, and Physician to aid and coordinate the services necessary to meet the Member's care needs to achieve the best possible outcome and the greatest value for the Member's benefits. Some of the ways a care manager can provide include:

- Help with finding medical or Behavioral Health Providers that can meet the Member's needs.
- Help with getting community resources that may be available to the Member.
- Information and resources to help Members better understand their conditions and how to better manage them; and,
- Help with learning how to navigate the healthcare system and better understand benefits.

If Members have a health condition or disease for which We operate a case management program, Members may be contacted by Us or Our designated case management vendor and offered the opportunity to participate in case management.

Disease Management Program

We have a disease management program offered to Members at no additional cost. The program helps Members with certain conditions to learn more about how to manage them. These conditions include:

- Asthma
- Coronary Artery Disease
- Chronic Obstructive Pulmonary Disease
- Diabetes
- Heart Failure

Participation in disease management is completely voluntary and Members may opt in or out at any time without affecting their benefits. Members who agree to participate receive phone calls from specially trained nurses, as well as helpful information in the mail.

Proof of Coverage

The Issuer will provide You with proof of coverage under the Agreement. Such evidence shall consist of an original copy of the 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 Issuer and the benefits provided under the Agreement.

Identification Card

The Identification Card (ID Card) tells Participating Providers that Members are entitled to benefits under the Plan with Us. The ID Card offers a convenient way of providing important information specific to a Member's including, but not limited to, the following:

- Member ID.
- Any Cost-Sharing amounts that may apply to a Member's coverage; and
- Important telephone numbers.

Always remember to carry the Identification Card and present it to Participating Providers or Participating Pharmacies when receiving covered benefits.

Refer to the **Eligibility and Enrollment** section of this Certificate of Coverage for instructions when changes are made. Upon receipt of the change in information, We will provide a new ID Card.

Identification cards are the property of the Issuer and are for identification purposes only. Possession of an Issuer Identification Card confers no right to benefits under the Agreement. To be entitled to such benefits the holder of the card must, in fact, be a Member on whose behalf all Required Payments under the Agreement have been paid. Any person receiving benefits to which the person is not then entitled pursuant to the provisions of the Agreement shall be subject to charges at the provider's then prevailing rates. If a Member permits the use of an Issuer Identification Card by any other person, such card may be retained by Us, and all rights of the Member, covered pursuant to the Agreement, shall be terminated sixteen (16) days after written notice.

Termination of Coverage for Members

Coverage under the Agreement shall terminate for a Member as follows:

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

If a Member is totally disabled on the date of termination of the Policy, coverage will be extended. Benefits will continue to be paid under the terms of the Policy for Eligible Expenses due to the disabling condition. Extension of benefits will continue until the earlier of:

- the date payment of the maximum benefit occurs.
- the date the Member ceases to be totally disabled; or
- the end of ninety (90) days following the date of termination. This extension of benefits is not applicable if the Policy is replaced by another carrier providing substantially equivalent or greater benefits.

Termination or Non-Renewal of Coverage for the Group

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

(1) The Group fails to pay a Required Payment as required by the Agreement.
(2) Fraud or intentional misrepresentation of a material fact by the Group.
(3) The Group fails to comply with the terms and conditions of the Agreement.
(4) The Group fails to meet the 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) The Issuer elects to cease providing coverage to all small employers or large employers in its Service Area.
(7) The Issuer elects to discontinue a coverage; or
(8) The Group elects to terminate the Agreement.

Notice of Termination or Non-Renewal of the Group

If termination or non-renewal is due to reason (1) or (3) above, the Issuer shall give the Group thirty (30) days advance written notice. If termination is due to reason (2) above, the Issuer shall give the Group at least fifteen (15) days advance written 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 six (6) consecutive month period during which the Group failed to maintain the Minimum Group Size. If termination is due to reason (5) above, the Issuer shall give the Group at least sixty (60) days advance notice. If termination is due to reason (6), the Issuer shall give all affected Group at least one hundred eighty (180) days advance written notice. If termination is due to reason (7), the Issuer shall give the Group at least ninety (90) days advance written notice and offer the Group the option to purchase other coverage. If termination is due to reason (8), the Group shall give the Issuer at least sixty (60) days advance written notice; however, if termination is due to a material change by the Issuer to any provisions required to be disclosed to the Group or Members pursuant to State law or regulation which adversely affects benefits or services provided, the Group shall give the Issuer at least thirty (30) days advance written notice.

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

Loss of Eligibility

Members who lose eligibility under the Agreement may be eligible to continue coverage under the Agreement according to state or federal law. If elected by the Group, continuation administrative services will be provided by the Issuer or its designee at no additional expense to the 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 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 the 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) the 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 (3) consecutive months immediately prior to termination.

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 the Group does not provide written notice, the Issuer must provide timely notice of continuation privileges available to each employee, member, dependent, or enrollee whose coverage is terminating. Such notice is presumed timely if it is given at least thirty (30) days and no more than sixty (60) days prior to the scheduled termination of coverage. If any Member is granted the right to continue coverage beyond the date when Member's coverage would otherwise terminate, this Plan will be deemed to allow continuation of coverage to the extent necessary to comply with COBRA requirements. Members should contact the Employer or Contract Holder for verification of eligibility and to obtain procedures for obtaining benefits.

Additional Continuation Provisions

Upon completion of any continuation of coverage as provided under COBRA, any Member whose coverage under the Agreement has been terminated for any reason except involuntary termination for cause, and who has been continuously covered under the 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 no later than sixty (60) days following the latter 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, the Premiums, plus 2% of the total Premium when due. The continuation Premium must be made not later than the 45th day after the date of the initial election for continuation coverage and on the due date of each payment thereafter. Following the first payment made after the initial election for continuation coverage, Premium payment is considered timely if made on or before the 30th day after the date on which the Premium is due.
(3) Continuation coverage will continue until the earliest of:
    a. nine (9) months after the date the election for continuation coverage is made if the Member is not eligible for continuation coverage under COBRA.
    b. six (6) additional months following any period of continuation under COBRA if the Member is eligible for continuation coverage under COBRA.
    c. the date on which failure to make payments would terminate coverage.
    d. the date the Member is or could be covered by Medicare.
    e. the date on which the Member is covered for similar services and benefits by another health plan; or
    f. the date on which the 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 the 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 the Agreement for less than one (1) year, except for covered dependent children less than one

(1) year of age. The Premiums charged for this continuation coverage shall be no more than the Premiums charged for all other individuals covered by the Agreement. To elect this continuation coverage, the Subscriber, his or her personal representative or the Covered Dependent must notify the 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 the Agreement within sixty (60) days of the Subscriber's retirement, or divorce. Coverage under the 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 the 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.

Eligibility and Enrollment

Types of Coverage

Employee

Employee and Spouse
You and Your spouse who is an Eligible Dependent as defined in this Certificate of Coverage.

Employee and Child(ren)
You and Your child who is an Eligible Dependent as defined in this Certificate of Coverage.

Employee and Family
You and Your family who are Eligible Dependents as described in this Certificate of Coverage.

Eligibility Provisions

Eligible Employee

Except for continuation coverage, to be eligible for coverage You must be:

- An Eligible Employee of the Contract Holder; and
- Work, live or reside in the Service Area.

Eligible Dependent

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

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 Plan.

Eligible Dependents may reside inside or outside the Service Area. For a child covered under a Qualified Medical Support Order who resides outside of the Service Area, We shall not enforce any otherwise applicable provisions which deny, limit, or reduce benefits because the child resides outside the Service Area, including, but not limited to Emergency Care only while outside the Service Area. However, We may utilize an alternative delivery system to provide alternative coverage. If the coverage is not identical to coverage under this Certificate of Coverage, it shall be at least actuarially equivalent to the coverage We provide to other dependent children under this Certificate of Coverage.

Enrollment Periods and Effective Dates of Coverage

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

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

- a completed Enrollment Application which must be received by Us during the enrollment period, and
- payment of the Premium when due.

If You fail to pay a Required Payment when due, You may be disenrolled from the Plan, in accordance with the procedures set forth in the Agreement.

If the Group fails to pay a Required Payment when due, the Group (and its enrollees) may be disenrolled from the Plan, in accordance with the procedures set forth in the Agreement.

Initial Eligibility

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

- If You are eligible on the Contract Date and the application is received by Us prior to or within thirty-one (31) days following such date, the Effective Date for You and Your Eligible Dependents for whom an application was submitted is the Contract Date.
- If You and Your Eligible Dependents enrolled during an Open Enrollment Period, the Effective Date is the date mutually agreed to by Group and the Issuer. 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.
- If an Eligible Employee is subject to a Waiting Period, and if application is received within thirty-one (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.
- 4If You become eligible after the Contract Date and if Your application is received by Us within the first thirty-one (31) days following Your Eligibility Date, Your Effective Date is the first day of the month following the date You satisfy the requirements of the Agreement, unless another date is specified in the Agreement.

Late Enrollee

If Your application is not received within thirty-one (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 provision, Your dependent will be considered a Late Enrollee. As a Late Enrollee, You or Your dependent are ineligible for coverage until the next Open Enrollment Period.

Avoidance of Late Enrollee Designation

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

- 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
- You declined coverage under the Plan in writing, based on coverage under another health benefit plan or self-funded health benefit plan.
- You provide written proof that Your prior health benefit plan or self-funded plan:
    - Continuation coverage has been exhausted; or
    - 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
    - Was ended as a result of termination of the other plan's coverage; and
- You request to enroll no later than thirty-one (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 Issuer.

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

Dependent Special Enrollment

Newborn Children

To be an Eligible Dependent, a newborn must be a child of You or Your spouse. To make sure Your child has continued coverage, You must provide oral or written notice to Us within thirty-one (31) days of birth, and pay any required Premium within that thirty-one (31) day period consistent with the next billing cycle. If

You notify Us after that 31-day period, Your newborn child will be considered a Late Enrollee and will not be eligible for coverage until the next Open Enrollment Period.

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

To be an Eligible Dependent, an adopted child must be a child of You or Your spouse. A proposed adopted child is eligible for coverage on the same basis as a natural child during any waiting period prior to the finalization of the child's adoption. 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. To make sure Your adopted child has continued coverage, You must notify Us, either verbally or in writing, of the addition of Your child as a dependent within thirty-one (31) days. If You notify Us after that 31-day period, Your adopted child will not be eligible for coverage until the next Open Enrollment Period.

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 thirty-one (31) days after We receive notice of the court order. The Effective Date will be the day application for coverage is received by Us and the required Premium is received. If You notify Us after the 31-day period, the dependent child will be considered a Late Enrollee.

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 thirty-one (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 thirty-one (31) days, Your spouse will be considered a Late Enrollee.

Employee or Dependent Loss of Coverage Under a Governmental Program

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

Employee or Dependent Becomes Eligible for State Premium Assistance

If You or Your dependent becomes eligible for premium assistance, with respect to the Issuer, 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 sixty (60) days after the date on which You or Your dependent became eligible for premium assistance. If application is not made within the initial sixty (60) days, You or Your dependent, as applicable, will be considered a Late Enrollee.

Other Dependents

Written application must be received within thirty-one (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 thirty-one (31) days, then Your dependent will be considered a Late Enrollee.

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.

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

Employee Special Enrollment

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 thirty-one (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.

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 thirty-one (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 Issuer.

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 the period of enrollment is a Late Enrollee.

Incontestability

All statements made by You on the Enrollment Application shall be considered representations and not warranties. The statements are 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:

- it is in a written Enrollment Application signed by You, and
- a signed copy of the Enrollment Application is or has been furnished to You.

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

Additional Requirements

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

Any retroactive changes in eligibility or coverage by a Group for any of its Members must be approved by the Issuer, and the liability of Issuer to refund Premiums for any Member whose coverage is terminated or changed to a different category shall be no greater than two (2) months Premium paid by or on behalf of the Member. The Issuer may consider any amounts paid for covered benefits for any period for which the Member's Premium was refunded as a Required Payment.

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

It is Your responsibility to inform:

- Your Group immediately of all changes that affect Your eligibility and that of Your Covered Dependents, including, but not limited to:
    - marriage of a dependent grandchild, and
    - death.

- The Issuer immediately of all changes that affect administration of Your, and Your Covered Dependents, Plan benefits, including, but not limited to:
    - address changes.

The Group must inform the Issuer in writing of all enrollments, terminations, or changes as they occur on forms required by the Issuer and provide information necessary to allow the Issuer to comply with its legal obligation regarding the issuance of certificates of Creditable Coverage.

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

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

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.

Embedded Deductible

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 and Coinsurance

Some benefits Members receive under the Plan will require that a Copayment or Coinsurance 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 or Coinsurance 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, Copayment and Coinsurance 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.

Maximum Out-of-Pocket Expense Credit

We will credit cash payments made by a Member directly to a provider, regardless of network status, towards the Member's Deductible and Maximum Out-of-Pocket under the following circumstances:

- The Claim must not be submitted to Us, and
- The amount paid by the Member must be less than the average discounted rate for the service under the Plan.

For information regarding procedures and documentation necessary to claim a credit refer to **BSWHealthPlan.com.**

Premiums

Premiums are due in the office of the Issuer, 1206 W. Campus Dr., 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.

Medical Benefits

Refer to the Schedule of Benefits for Copayment and Coinsurance amounts and any benefit limitations that may apply for certain services.

Medical Services

Members are entitled to the Medically Necessary professional services of Participating Providers on an inpatient and outpatient basis. Medical Necessity is determined by a Participating Provider, subject to the review of Our Medical Director. Treatment of congenital defects of newborns will be treated on the same basis as any other covered illness or injury.

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

- Allergy tests.
- Allergy serum.
- Chemotherapy and radiation therapy for cancer.
- Specialist consultations.
- Diagnostic procedures including lab and x-ray.
- Dialysis.
- Home Health Care.
- Injections.
- Newborn hearing screening and necessary diagnostic follow-up care.
- Office visits.
- Outpatient surgery.
- Physical exams for medical or diagnostic purposes.
- Treatment for diseases of the eye.

Covered Prescription Drugs Billed Under the Medical Benefit

Covered Prescription Drugs obtained under the Medical Benefit may be subject to a separate Copayment or Coinsurance as listed in the Schedule of Benefits. If obtained in conjunction with other Medical Benefits (e.g., office visit, etc.), this may result in a separate Copayment or Coinsurance for the Covered Prescription Drug and other Medical Benefits (e.g., office visit, etc.). These Covered Prescription Drugs may require Preauthorization by the Medical Director in order to be covered as part of the Member's Medical Benefit.

Clinician-Administered Drugs

Coverage of clinician-administered drugs does not:

- require the use of a Participating Pharmacy,
- limit coverage when a prescription is not dispensed by a Participating Pharmacy,
- require a provider to be reimbursed through the pharmacy benefit, without:
    - informed written consent of the Member, and
    - a written attestation by the Member's Physician or Health Care Provider that a delay in the drug 's administration will not place the Member at an increased health risk; or
- require a Member to pay an additional fee or other additional cost-sharing when a prescription is not dispensed by a Participating Pharmacy.

This provision applies:

- to a Member who has a chronic, complex, rare, or life-threatening medical condition, and
- if the Member's Physician determines that a delay of care would make disease progression probable, use of a Participating Pharmacy would make death or Member harm probable, the use

of a Participating Pharmacy would potentially cause a barrier to adherence, or if timeliness of delivery necessitates delivery by a different pharmacy.

This provision does not apply to a Hospital, Hospital Facility-based practices, or hospital outpatient infusion center.

Telehealth Service and Virtual Visits

Network Benefits are available only when services are delivered through a Participating Virtual Network Provider. Members can find a Participating Virtual Network Provider by calling the telephone number on their ID Card or locating the Customer Service telephone number on **BSWHealthPlan.com**.

Not all medical conditions can be treated through Virtual Visits. The Participating Virtual Network Provider will identify any condition for which treatment by an in-person Physician contact is needed. Benefits do not include email, fax and standard telephone calls, or for Telehealth Service or Telemedicine Medical Service visits that occur within medical facilities (CMS defined originating facilities).

Other Telehealth Service and Telemedicine Medical Service

Benefits include Telehealth Services and Telemedicine Medical Services. An in-person consultation is not required between the healthcare provider and the Member for benefits to be provided. Covered benefits provided by telemedicine and telehealth are subject to the same terms and conditions under the Certificate of Coverage as any benefit provided in-person. You may find additional information regarding Telehealth Services or Telemedicine Medical Services at **BSWHealthPlan.com**.

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 this Certificate 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 this Certificate 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.

Urgent Care

Urgent Care provides for the immediate Treatment of a medical condition that requires prompt medical attention but where a brief time lapse before receiving care will not endanger life or permanent health. Unless designated and recognized by Us as an Urgent Care Facility, neither a Hospital nor an emergency room will be considered an Urgent Care Facility.

Ambulance Transportation

Ground, Sea, or Air Ambulance transportation, when and to the extent it is Medically Necessary, is covered when transportation in any other vehicle would endanger the Member's health. We will not cover air transportation if ground transportation is medically appropriate and more economical. If these conditions are met, We will cover Ambulance transportation to the appropriate Hospital or Skilled Nursing Facility.

Emergency medical care provided by Ambulance personnel for which transport is unnecessary or is declined by Member will be subject to the Copayment or Coinsurance listed in the Schedule of Benefits. Subject to the paragraph above, if the Ambulance transports the Member after receiving medical care from Ambulance personnel, the Emergency Medical Services Copayment or Coinsurance is waived.

Sea or Air non-emergency interfacility Ambulance transport as Medically Necessary is covered when Medically Necessary and is Preauthorized by Our Medical Director. For example, the Member is discharged from an inpatient Facility and needs to be moved to a Skilled Nursing Facility.

Preventive Care

The following Preventive Care benefits from a Participating Provider that are required by Section 2713 of the Patient Protection and Affordable Care Act (PPACA) will not be subject to Copayment, Cost share, or Deductible:

(a) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).
(b) Immunizations for routine use recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention (CDC) with respect to the individual involved.
(c) Evidence-informed Preventive Care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents; and
(d) With respect to women, such additional Preventive Care and screening as provided for in comprehensive guidelines supported by HRSA.
(e) With respect to female contraception, unless excluded by certain religious employers, all FDA approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity, as prescribed are covered.

The benefits listed below may include requirements pursuant to state regulatory mandates and are to be covered at no cost to the Member.

The Preventive Care services described in items (a) through (d) may change as USPSTF, CDC, and HRSA guidelines are modified and will be implemented by Baylor Scott & White Insurance Company in the quantities and at the times required by applicable law or regulatory guidance. For more information, You may access Our website **BSWHealthPlan.com** or contact customer service at **844.633.5325**.

Examples of covered benefits include routine annual physicals, immunizations, well-child care, cancer screening mammograms, bone density test, screening for prostate cancer and colorectal cancer, smoking cessation counseling services, and healthy diets counseling and obesity screening/counseling.

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

Preventive Care services included in items (a) through (d) above by a Participating Provider will not be subject to Copayment, Coinsurance and Deductibles.

Preventive Care services included in items (a) through (d) above provided by a Non-Participating Provider will be subject to Copayment, Coinsurance and Deductibles. Copayments, Coinsurance, and Deductibles are not applicable to immunizations covered under Childhood Immunizations.

The determination of whether a benefit is Preventive Care may be influenced by the type of care for which your Participating Provider bills Us. Specifically:

- If a recommended preventive service is billed separately from an office visit, then the Plan may impose Cost-Sharing requirements with respect to the office visit.
- If a recommended preventive service is not billed separately from an office visit and the primary purpose of the office visit is the delivery of the preventive service, then the Plan may not impose Cost-Sharing requirements with respect to the office visit.
- If a recommended preventive service is not billed separately from an office visit and the primary purpose of the office visit is not the delivery of a preventive service, then the Plan may impose Cost-Sharing requirements with respect to the office visit.

Coverage of counseling for a condition or disease as Preventive Care does not equate to Treatment of that condition or disease. While the counseling visit may be Preventive Care and thus not subject to a Deductible, Copayment or Coinsurance, the Treatment of such condition or disease will be subject to appropriate Deductible, Copayment or Coinsurance and to the **Exclusions and Limitations** section in this Certificate of Coverage.

Routine Exams and Immunizations

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

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

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

Injections for allergies are not considered immunizations under this benefit provision.

Childhood Immunizations

The following immunizations from birth through the date of the child's sixth (6th) birthday are covered for:

- diphtheria
- haemophilus influenzae type b
- hepatitis B
- measles
- mumps
- pertussis
- polio
- rotavirus
- rubella
- tetanus
- varicella
- any other immunization that is required for the child by law.

Certain Tests for Detection of Prostate Cancer

Benefits are available for an annual medically recognized diagnostic physical examination for the detection of prostate cancer, and a prostate-specific antigen test used for the detection of prostate cancer for each male Member under the Plan who is at least:

- Fifty (50) years of age and asymptomatic; or
- Forty (40) years of age with a family history of prostate cancer or another prostate cancer risk factor.

Tests for Detection of Colorectal Cancer

Benefits are available for a diagnostic, medically recognized screening examination for the detection of colorectal cancer for Members who are forty-five (45) years of age or older and who are at normal risk for developing colon cancer:

- All colorectal cancer examinations, Preventive Care, and laboratory tests assigned a grade of "A" or "B" by the United States Preventive Services Task Force for average-risk individuals, including the services that may be assigned a grade of "A" or "B" in the future; and
- An initial colonoscopy or other medical test or procedure for colorectal cancer screening and a follow-up colonoscopy if the results of the initial colonoscopy, test, or procedure is abnormal.

Medically Necessary colonoscopy consultations are covered as Preventive Care.

Detection and Prevention of Osteoporosis

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

Qualified Individual means:

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

Mammography Screening

Benefits are available for:

- Annual screening Mammography provided for female Members thirty-five (35) years of age and older; and
- Diagnostic Imaging that is no less favorable than the coverage for a screening mammogram.

Screenings are provided by Low-Dose Mammography, Digital Mammography and Breast Tomosynthesis, to detect breast cancer. Refer to the **Definitions** section of this Certificate of Coverage for further explanation of Mammography procedures.

For purposes of this benefit provision, the current recommendations of the USPSTF regarding breast cancer screening and Mammography and prevention will be considered the most current.

Certain Tests for Detection of Human Papillomavirus and Cervical Cancer

Benefits are available for certain tests for detection of Human Papillomavirus and Cervical Cancer for each woman enrolled in the Plan who is eighteen (18) years of age or older for an annual medically recognized diagnostic examination for the early detection of cervical cancer. Coverage includes, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods as approved by the United States Food and Drug Administration alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus. The well-woman examination may be performed by the Member's Primary Care Physician or designated obstetrician or gynecologist.

Early Detection Test for Ovarian Cancer

Benefits are available once every twelve (12) months for each woman enrolled in the Plan who is eighteen (18) years of age or older for:

- a Cancer Antigen 125 (CA 125) blood test; and
- any other test or screenings approved by the United States Food and Drug Administration for the detection of ovarian cancer.

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 this Certificate 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 this Certificate 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, Copayments or Coinsurance are required for the administered Prescription Drugs.

Skilled Nursing Facility

The Plan covers authorized inpatient care in a Skilled Nursing Facility if it meets all these conditions:

- Care is delivered under the supervision of a Participating Provider and are delivered by and require the judgment of a qualified and appropriately licensed provider, such as a registered nurse, physical therapist, occupational therapist, respiratory therapist, or speech-language pathologist.
- Services are reasonable to treat a specific health condition, illness, or injury.
- Services are expected to result in a significant and measurable improvement in the Member's medical condition or functional capabilities.
- The skilled care needed cannot be provided in a less-intense setting, such as through intermittent home health skilled nursing visits and custodial support.
- Services are supported by evidence-based medical guidelines or literature as being specific, effective, and reasonable Treatment for the Member's diagnosis and physical condition.

Mental Health Care

Inpatient and outpatient benefits for mental health conditions is covered under the same terms and conditions applicable to the Plan's medical and surgical benefits and coverage. The Plan will not impose any quantitative or nonquantitative Treatment limits on such benefits that are more restrictive than those imposed on benefits for medical or surgical expenses.

Short-Term Mental Health

Medically Necessary short-term diagnostic and therapeutic treatment for mental illnesses and emotional disorders are covered when all these conditions are met:

- The mental illness or disorder being treated is listed in the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM), at the time benefits are provided.
- The initial evaluation, diagnosis, medical management, and ongoing medication management of attention deficit disorder (ADD) and attention deficit hyperactivity disorder (ADHD) are also covered. Visits for medication management are not included in the maximum allowed visits.

Serious Mental Health

Medically Necessary diagnostic and therapeutic treatment for Serious Mental Illness is covered if the mental illness or emotional disorder being treated is one of the following psychiatric illnesses as defined by the most current DSM:

- Schizophrenia.
- Paranoia and other psychotic disorders.

- Bipolar disorders (hypomanic, manic, depressive, and mixed).
- Major depressive disorders (single episode or recurrent).
- Schizoaffective disorders (bipolar or depressive).
- Obsessive-compulsive disorders; and
- Depression in childhood and adolescence.

Chemical Dependency

Benefits are provided to Members for the Medically Necessary Treatment for Chemical Dependency which includes abuse of psychological or physical dependence on, or addiction to alcohol or a controlled substance and detoxification on the same basis as physical illness generally, subject to the Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers, adopted by the Texas Department of Insurance.

Rehabilitative and Habilitative Therapy

Medically Necessary outpatient rehabilitative and habilitative therapy benefits are available for Medically Necessary physical, speech, hearing, manipulative, and occupational therapies that meet the following conditions:

- The Member's Participating Provider orders such therapy services; and
- The services can be expected to meet or exceed the goals established for the Member by the Member's Participating Provider; and
- The services are given by a doctor, a licensed therapist, or chiropractor; and
- The Member is progressing toward the goals in response to participating in the therapy.

For a Member with a physical disability, goals may include maintenance of functioning or prevention of or slowing of other deterioration.

Therapies for Children with Developmental Delays

The Plan includes benefits for the Treatment of "Developmental Delays", which means a significant variation in normal development as measured by appropriate diagnostic instruments and procedures in one or more of the following areas:

- Cognitive.
- Physical.
- Communication.
- Social or Emotional; or
- Adaptive.

Treatment includes the necessary rehabilitative and habilitative therapies in accordance with an "Individualized Family Service Plan", which is the initial and ongoing Treatment plan developed and issued by the Interagency Council on Early Childhood Intervention under Chapter 73 of the Human Resources Code for a Dependent child with Developmental Delays, including:

- Occupational therapy evaluations and services.
- Physical therapy evaluations and services.
- Speech therapy evaluations and services; and
- Dietary or nutritional evaluations.

You must submit an Individualized Family Service Plan to Us before the Member receives any benefits, and again if the Individualized Family Service Plan is changed. After a child is three (3) years of age and services under the Individualized Family Service Plan are completed, the standard contractual provisions in this Certificate of Coverage and any benefit exclusions or limitations will apply.

Manipulative Therapy and Chiropractic Care

Benefits are available to Members for outpatient Manipulative Therapy from Participating Providers licensed to perform that therapy, including chiropractors. The benefits are generally furnished for the diagnosis and/or Treatment of neuromusculoskeletal conditions associated with an injury or illness, including examinations and manipulations.

Home Health Care

The Plan covers Medically Necessary Preauthorized Home Health Care consisting of:

- Skilled nursing by a registered nurse or licensed vocational nurse under the supervision of at least one registered nurse and at least one Physician.
- Physical, occupational, speech and respiratory therapy.
- The services of a home health aide under the supervision of a registered nurse; and
- The furnishing of medical equipment and supplies other than Prescription Drugs and medicines.

Home Health Care provides benefits for payment or other consideration in a patient's residence under a plan of care that is:

- Established, approved in writing, and reviewed at least every two (2) months by the attending Physician; and
- Certified by the attending Physician as necessary for medical purposes.

Home Health Care is provided unless the attending Physician certifies that hospitalization or confinement in a Skilled Nursing Facility would be required if Home Health Care were not provided.

Skilled care benefits are provided within Home Health Care from:

- A licensed Home Health Agency; or
- Private duty nursing, when Preauthorized in the following limited set of circumstances:
    - Skilled care that exceeds the capacity of periodic home care from a licensed Home Health Agency.
    - The Member’s care can be safely managed in the home setting.
    - The Member’s Participating Provider is willing and able to follow the Member during private duty nursing service; and
    - The care is not being used for the purpose of providing Custodial Care or for the reason of the Member or the Member’s family convenience.

Home Infusion Therapy

As recommended by a Participating Provider and approved by Our Medical Director as Medically Necessary, Home Infusion Therapy is available for high technology services, including:

- line care.
- Chemotherapy.
- pain management infusion.
- antibiotic, antiviral, or antifungal therapy; and
- Specialty Drugs.

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 enteral formula, and covered Durable Medical Equipment, not related to the Home Infusion Therapy some of which may be covered under other provisions of this Certificate of Coverage, and subject to additional Copayments or Coinsurance.

In some situations, the Plan may require infusions to be delivered in the home, in lieu of a Participating Provider’s office or outpatient setting. These situations include when the home setting is both clinically appropriate and cost-effective.

Hospice Care

Hospice Care benefits are included under the Plan when provided by a Hospice to a Member confined at home or in a Participating Facility due to a terminal sickness or terminal injury requiring skilled care if Preauthorized and the following conditions are met:

- The benefits are provided to Member by a Participating Provider licensed by the State of Texas; and,
- The Participating Provider certified the Member has a limited life expectancy of six (6) months or less due to a terminal illness.

Hospice Care includes the provision of pain relief, symptom management and supportive benefits to terminally ill Members and their immediate families on both an outpatient and inpatient basis.

Maternity Care

The Plan provides maternity care benefits including:

- Participating Provider prenatal and postnatal obstetrical care.
- Labor and delivery services.
- Hospital room and board for the mother.
- The care of complicated pregnancies in conjunction with the delivery of a child or children by a Member. Complications of Pregnancy are treated as any other illness or sickness. Routine deliveries are to be under the care of a Participating Provider at a Participating Hospital; and
- In-home care for high-risk pregnancy.

Prenatal obstetrical care is considered well woman care and is not subject to a Copayment or Coinsurance under Preventive Care.

Copayments or Coinsurance is required for each day of inpatient care for the mother, and for each day of inpatient care for the newborn for the amount and days as stated in the Schedule of Benefits. The Plan covers inpatient care for the mother and newborn child in a healthcare Facility for a minimum of:

- forty-eight (48) hours following an uncomplicated vaginal delivery; and
- ninety-six (96) hours following an uncomplicated delivery by caesarean section.

If the Member's newborn qualifies as an Eligible Dependent and requires confinement in a Neonatal Intensive Care Unit (NICU), then any applicable Deductible, Copayment or Coinsurance will be applied separately to the Member's newborn, for any covered benefits associated with that confinement. This is in addition to any applicable Mother Deductible, Copayment or Coinsurance.

Comprehensive Hospital benefits for routine nursery care of a newborn child, including newborn screening tests, including the cost and administration of the test kit, are available so long as the child qualifies as an Eligible Dependent as defined in the **Eligibility and Enrollment** section of this Certificate of Coverage.

The determination of whether a delivery is complicated shall be made by the Participating Provider. If the decision is made to discharge a mother or newborn child from inpatient care before the expiration of the above time frames, The Plan shall provide coverage for timely Post-Delivery Care, to be provided by a Participating Provider, registered nurse or other appropriate Participating Health Professional and may be provided at the mother's home, Participating Provider's office, Participating Facility, or other appropriate location. Post-Delivery Care means postpartum benefits provided in accordance with accepted maternal and neonatal physical assessments. The term includes:

- Parent education.
- Assistance and training in breast-feeding and bottle feeding; and
- The performance of any necessary and appropriate clinical tests.

In the event a Member delivers at a Non-Participating Hospital, a routine delivery, which does not meet the definition of Emergency Care, shall not be considered Emergency Care, and will not be covered under the Plan.

Family Planning

Family Planning benefits shall be provided as Medically Necessary. Examples include:

- counseling.
- sex education instruction in accordance with medically acceptable standards.
- diagnostic procedures to determine the cause of Infertility of the Member. Treatment of Infertility is not a covered benefit under this provision.
- vasectomies and tubal ligations.
- laparoscopies.

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

Coverage of prescription contraceptive drugs provides for a Member to obtain:

- a three (3) month supply of the covered prescription contraceptive drug when it is first prescribed; and
- a twelve (12) month supply of the covered prescription contraceptive drug for subsequent prescriptions of the same drug regardless of whether the Member was previously covered by the Plan for the first prescription.

A Member may obtain only one (1) twelve (12) month supply of a covered prescription contraceptive drug per Calendar Year.

Fertility Preservation

The Plan provides coverage for fertility preservation services to a Member who will receive a Medically Necessary Treatment for cancer, including surgery, chemotherapy, or radiation, that the American Society of Clinical Oncology or the American Society for Reproductive Medicine has established may directly or indirectly cause impaired fertility.

Durable Medical Equipment and Devices

Medically Necessary Durable Medical Equipment, Orthotic Devices, or Prosthetic Devices shall be covered under this Certificate of Coverage. The Medical Director in consultation with the treating Physician 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.

Consumable Supplies

Consumable supplies are non-durable medical supplies that:

- are usually disposable in nature.
- cannot withstand repeated use by more than one Member.
- are primarily and customarily used to serve medical purposes.
- generally, are not useful to a Member in the absence of illness or injury; and
- may be ordered and/or prescribed by a Physician.

Consumable supplies are a covered benefit only if the supply is required in order to use with covered Durable Medical Equipment, Orthotic Device, or Prosthetic Device. Repair, maintenance, and cleaning due to abnormal wear and tear or abuse are the Member's responsibility.

Durable Medical Equipment

Durable Medical Equipment may be covered as a purchased or rented item at the discretion of the Plan. Rented or loaned equipment must be returned in satisfactory condition and the Member is 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 cost if purchased by the Issuer from a Participating Provider. We shall have no liability for installation, maintenance, or operation of such equipment for home-based use.

Orthotic Devices

The Plan provides benefits for the following Medically Necessary devices consisting of the initial device, professional services for fitting and use, and replacement of the device, if replacement is not due to misuse or loss of the device and normal repairs:

- orthopedic or corrective shoes.
- shoe inserts.
- arch supports.
- orthotic inserts and other supportive devices including ankle braces required for recovery after surgery.

Orthotic Device coverage is limited to the most appropriate model of Orthotic Device that adequately meets the Member's needs as determined by the Member's Participating Provider, the Plan shall provide coverage for Orthotic Devices subject to the applicable Copayments or Coinsurance specified in the Schedule of Benefits.

Prosthetic Devices

Prosthetic Devices may require Preauthorization to be covered under conditions determined by Our Medical Director as Medically Necessary to replace defective parts of the body following injury or illness. Members should contact Us to confirm whether the device requires Preauthorization. Examples of Medically Necessary covered devices including the initial device, professional services for fitting and use, and replacement of the device if replacement is not due to misuse or loss of the device, and normal repairs are:

- artificial arms, legs, hands, feet, eyes.
- breast prostheses, and surgical brassieres after mastectomy for breast cancer.

Prosthetic Device coverage is limited to the most appropriate model of Prosthetic Device that adequately meets the Member's needs as determined by the Member's Participating Provider. For Prosthetics, the Plan shall provide coverage subject to the applicable Copayments or Coinsurance specified in the Schedule of Benefits.

Hearing Aids and Cochlear Implants

The Plan provides the following benefits for hearing aids or cochlear implants:

- Fitting and dispensing services and the provision of ear molds as necessary to maintain optimal fit of hearing aids.
- Any Treatment related to hearing aids and cochlear implants, including coverage for habilitation and rehabilitation as necessary for educational gain; and
- For a cochlear implant, an external speech processor and controller with necessary component replacements every three (3) years.

We will not deny a Member's claim for hearing aids solely because the hearing aid is more expensive than the plan benefit, however, We are not required to pay more than the Plan's benefit for the hearing aid.

Limitations:

- One (1) hearing aid in each ear every three (3) years for Members through the age of 18; and
- Hearing aid prescription must be written by:

    - A Physician certified as an otolaryngologist or otologist; or
    - An audiologist who
        - is legally qualified in audiology; or
        - holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements; and who performs the exam at the written direction of a legally qualified otolaryngologist or otologist.
- When alternate hearing aids can be used, the Plan's coverage may be limited to the cost of the least expensive device that is:
    - Customarily used nationwide for Treatment, and
    - Deemed by the medical profession to be appropriate for Treatment of the condition in question. The device must meet broadly accepted standards of medical practice, considering your physical condition. Members should review the differences in the cost of alternate Treatment with their Physician. A Member and their Physician may still choose the more costly Treatment method however the Member is responsible for any charges in excess of what The Plan will cover.
- One cochlear implant in each ear with internal replacement as medically or audio logically necessary.

Coverage required under this section is subject to any provision that applies generally to coverage provided for Durable Medical Equipment benefits under the Plan, including a provision relating to Deductibles, Copayments, Coinsurance or Preauthorization. Preauthorization may be required.

Imaging and Radiology

Imaging and radiological exams shall be covered as Medically Necessary and as prescribed and authorized by a Participating Provider. Preauthorization may be required. Examples of such services include:

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

An ultrasound or cardiac angiogram shall not be subject to an imaging and radiological exam Copayment or Coinsurance, but if performed in conjunction with an office visit or outpatient surgery, the Member will be responsible for the appropriate office visit or outpatient surgery Copayment or Coinsurance as listed in the Schedule of Benefits.

Cardiovascular Disease Screening

Benefits are available for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five (5) years when performed by a laboratory that is certified by a recognized national organization:

- Preauthorized as Medically Necessary Computed tomography (CT) scanning measuring coronary artery calcifications; or
- Ultrasonography measuring carotid intima-media thickness and plaque.

Tests are available to each Member who is:

- A male older than 45 years of age and younger than 76 years of age, or
- A female older than 55 years of age and younger than 76 years of age.

The Member must have diabetes or have a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher.

Cosmetic, Reconstructive, or Plastic Surgery

Benefits available for Cosmetic, Reconstructive, or Plastic Surgery require Preauthorization and must meet one of the following criteria or is otherwise deemed Medically Necessary:

- Treatment provided for the correction of defects incurred in an Accidental Injury sustained by a Member.
- Treatment provided for reconstructive surgery following cancer surgery.
- Surgery is performed for the Treatment or correction of a congenital defect.
- Surgery for craniofacial abnormalities to improve the function of, or attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infection, or disease.
- Breast reconstruction following mastectomy as described below.

If a Member has had or will have a mastectomy to treat disease, trauma, or physical complications, coverage for breast reconstruction incident to mastectomy shall be provided under the same terms and conditions of this Certificate of Coverage as for the mastectomy, as deemed medically appropriate by the Participating Provider 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 Certificate of Coverage 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.

Temporomandibular Joint Pain Dysfunction Syndrome (TMJ)

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

Limited Accidental Dental

The Plan provides limited coverage for dental benefits that would be excluded from coverage but are determined by Our Medical Director to be Medically Necessary and incident to and an integral part of a covered medical procedure. Examples could include the following:

- Treatment of, including removal of broken teeth as necessary to reduce a fractured jaw.
- Reconstruction of a dental ridge resulting from removal of a malignant tumor.
- Extraction of teeth prior to radiation therapy of the head and neck.
- Dentures as a result of radiation therapy of the head and neck or replacement dentures due to changes in the mouth as a result of radiation therapy of the head and neck.
- Removal of cysts of the mouth (except for cysts directly related to the teeth and their supporting structures).

The Plan provides limited coverage for initial restoration and correction of damage caused by external violent Accidental Injury to natural teeth and/or jaw if:

- The fracture, dislocation, or damage results from an Accidental Injury.
- The Member seeks treatment within forty-eight (48) hours of the time of the accident or upon the Effective Date of coverage, whichever comes later.

- Restoration or replacement is completed within six (6) months of the date of the injury or upon the Effective Date of coverage, whichever comes later.

The Plan provides benefits for certain oral surgeries including maxillofacial surgical procedures that are limited to:

- Excision of neoplasm, including benign, malignant, and pre-malignant lesions, tumors and non-odontogenic cysts.
- Incision and drainage of cellulitis and abscesses; and
- Surgical procedures involving accessory sinuses, salivary glands, and ducts.

The Plan provides benefits for Medically Necessary dental procedures when required to be performed in a Participating Facility for the delivery of necessary and appropriate dental care when the dental care cannot be safely provided in a dentist's office due to the Member's physical, mental, or medical condition.

Amino Acid-Based Elemental Formulas

The Plan includes benefits for Medically Necessary Amino Acid-Based Elemental Formulas as ordered by a Participating Provider.

Regardless of the formula delivery method, Amino Acid-Based Elemental Formulas provided under the written order of a Participating Provider is covered for the Treatment or diagnosis of:

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

Phenylketonuria or Heritable Metabolic Disease

Coverage for specialty dietary formulas necessary to treat Phenylketonuria or a Heritable Metabolic Disease are available to Members as prescribed by a Participating Provider. The formulas are provided to the extent this Plan provides coverage for other drugs that are available upon Physician orders. Heritable Metabolic 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.

Diabetes Care

If a Member has been diagnosed with insulin dependent diabetes, non-insulin dependent diabetes, or abnormal elevated blood glucose levels induced by pregnancy or another medical condition, as Medically Necessary and prescribed by a Participating Provider, Members are eligible for coverage for:

- Diabetes Self-Management Training.
- Diabetes Education.
- Diabetes Care Management.
- Diabetes Equipment; and
- Diabetes Supplies.

Coverage shall be provided on the same basis as other comparable chronic medical conditions. Benefits shall also be provided for new or improved Diabetes Supplies or Diabetes Equipment, upon approval of the United States Food and Drug Administration, as Medically Necessary and prescribed by a Participating Provider.

Refills of diabetes supplies will not be covered until the Member is reasonably due for a refill as calculated based upon the supplies being utilized at the prescribed and appropriate intervals.

Organ and Tissue Transplants

Subject to the conditions described below, benefits are provided to a Member by a Participating Provider related to an organ or tissue transplant will be determined as follows, but only if all the following conditions are met:

- The transplant procedure is not Experimental or Investigational in nature.
- Donated human organs or tissue or an FDA-approved artificial device are used.
- The recipient is a Member under the Plan.
- The transplant procedure is Preauthorized as required under the Plan.
- The Member meets all the criteria used by Us to determine Medical Necessity for the transplant.
- The Member meets all the protocols and has been approved for transplant by the Participating Facility in which the transplant is performed.
- Benefits related to an organ or tissue transplant, or FDA approved artificial device include, but are not limited to, imaging studies (e.g., x-rays, CT scan, MRI, scan), laboratory testing, Chemotherapy, radiation therapy, Prescription Drugs, procurement of organs or tissues from a living or deceased donor, and complications arising from such transplant.
- Services are coordinated through Our health services department.
- The Member uses a Preauthorized transplant network which may be different than the Member's Plan Network.

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

Coverage of each type of solid Organ Transplant is limited to:

- one (1) initial transplant; and
- one (1) subsequent re-transplant due to rejection.

Member transplant medical costs for the removal of organs, tissues, or bone marrow from a live donor are covered, but only to the extent that such costs are not covered by the donor's group or individual health plan, benefit contract, prepayment plan, or other arrangement for coverage of medical costs, whether on an insured or uninsured basis.

If the donor is also a Member, coverage is subject to all procedures, limitations, exclusions, Copayments, Coinsurance and Deductibles that apply under the donor-Member's plan only if all the above conditions are met.

Acquired Brain Injury

Coverage includes:

- Cognitive Rehabilitation Therapy.
- Cognitive Communication Therapy.
- Neurocognitive Therapy and Rehabilitation.
- Neurobehavioral, Neuropsychological, Neurophysiological and Psychophysiological Testing and Treatment.
- Neurofeedback Therapy.

- Remediation.
- Post-Acute Transition and Community Reintegration Services, including Outpatient Day Treatment; and
- Post-Acute Care Treatment

Treatment for an Acquired Brain Injury may be provided at a Hospital, an acute or post-acute rehabilitation Hospital, an assisted living Facility or any other Facility at which appropriate benefits may be provided.

Service means the work of testing, Treatment, and providing therapies to a Member with an Acquired Brain Injury.

Therapy means the scheduled remedial Treatment provided through direct interaction with the Member to improve a pathological condition resulting from an Acquired Brain Injury.

To ensure that appropriate Post-Acute-Care Treatment Service is provided, the Plan includes benefits for reasonable expenses related to periodic reevaluation of the care of a Member who:

- Has incurred an Acquired Brain Injury.
- Has been unresponsive to treatment; and
- Becomes responsive to treatment later.

Treatment goals for the Member may include the maintenance of functioning or the prevention of or slowing of further deterioration.

Benefits for the Medically Necessary Treatment of an Acquired Brain Injury will be determined on the same basis as Treatment for any other physical condition.

Autism Spectrum Disorder

Benefits are provided for generally recognized services in relation to Autism Spectrum Disorder by a Participating Provider in a Treatment plan recommended by that provider. An individual providing Treatment for Autism Spectrum Disorder must be:

- A Participating Health Professional:
  - licensed, certified, or registered by an appropriate agency in the state of Texas.
  - whose professional credential is recognized and accepted by an appropriate agency of the United States; or
  - certified as a provider under the TRICARE military health system.
- An individual acting under the supervision of a Participating Health Professional is described under this provision.

Generally recognized services include, but are not limited to:

- screening a child at the ages of 18 and 24 months.
- treatment to a Member from the date of diagnosis.
- evaluation and assessment services.
- applied behavior analysis.
- behavior training and management.
- speech, physical, and occupational therapy; and
- medications used to address symptoms of the Autism Spectrum Disorder.

Benefits for the Treatment of an Autism Spectrum Disorder will be determined on the same basis as Treatment for any other physical condition. Benefit limits do not apply for Autism Spectrum Disorder.

Clinical Trials – Routine Patient Care

Benefits are available to Members for Routine Patient Care Costs in connection with the Member participating in a phase I, phase II, phase III, or phase IV clinical trial if the clinical trial is conducted in

relation to the prevention, detection, or Treatment of cancer or other Life-Threatening Disease or Condition and is described in any of the following paragraphs:

- Federally funded trials for the study or investigation are approved or funded by one or more of the following:
  - The Centers of Disease Control and Prevention of the United States Department of Health and Human Services.
  - The National Institutes of Health.
  - The Agency for Health Care Research and Quality.
  - The Centers for Medicare and Medicaid Services.
  - Cooperation group or centers of any of the entities described in clauses (i)-(iv) of the Department of Defense or the Department of Veteran Affairs.
  - A qualified non-government research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
  - An institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.
  - Any of the following, if the study or investigation conducted by such Department has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review of studies and investigations used by the National Institute of Health and assured unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
    - the United States Department of Defense.
    - the United States Department of Veterans Affairs.
    - the United States Department of Energy.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

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

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

We do not provide benefits for routine patient care services provided by Non-Participating Providers.

We may not cancel or refuse to renew coverage solely because a Member participates in a clinical trial.

Biomarker Testing

We provide coverage for biomarker testing for the purpose of diagnosis, treatment, appropriate management, or ongoing monitoring of a Member's disease or condition to guide treatment when the test is supported by the following kinds of medical and scientific evidence:

- a labeled indication for a test approved or cleared by the United States Food and Drug Administration,
- an indicated test for a drug approved by the United States Food and Drug Administration,
- a national coverage determination made by the Centers for Medicare and Medicaid Services, or a local coverage determination made by a Medicare administrative contractor,
- nationally recognized clinical practice guidelines; or
- consensus statements.

Coverage is provided in a manner that limits disruptions in care, including the number of biopsies and biospecimen samples.

Pharmacy Benefits

Covered Prescription Drugs, Pharmaceuticals and Other Medications

The only Covered Prescription Drugs, pharmaceuticals, or other medications (referred to as "drug" or "drugs") covered under this Certificate of Coverage are those which, under Federal or State law, may be dispensed following a Prescription Order from a licensed Participating Health Professional with appropriate law enforcement agency registrations, which are prescribed by:

- A Participating Provider.
- In connection with Emergency Care Treatment, a Participating Provider or Participating Health Professional in attendance to a Member at an Emergency Care Facility.
- A Participating Health Professional to whom a Member has been referred to by a Participating Provider, which is used for the Treatment of an illness or injury covered under this Certificate of Coverage; or
- Filled through a Participating Pharmacy in accordance with this Certificate of Coverage.

As medically appropriate, you may be required to substitute any Prescription Drug for another Prescription Drug or form of Treatment which, based upon the recommendations of the Pharmacy and Therapeutics Committee, and Our Medical Director's professional judgment, provides equal or better results at a lower cost.

Benefits for Medically Necessary Covered Prescription Drugs prescribed to treat a Member for an acute, chronic, disabling, or Life-Threatening Disease or Condition are available under this Certificate of Coverage if the Prescription Drug:

- has been approved by the Food and Drug Administration (FDA) for at least one indication; and
- is recognized for Treatment of the indication for which the drug is prescribed by the following:
  - a standard reference compendium, or
  - substantially accepted peer reviewed medical literature.
- evaluated for financial considerations based on the review of market trends and driving the lowest net cost products where applicable.

Refer to the **Exclusions and Limitations** section of this Certificate of Coverage for details regarding pharmacy benefit exclusions.

Evidence Based Formulary

We provide coverage for Prescription Drugs in accordance with an evidence-based Formulary developed by Physicians and pharmacists comprising the Pharmacy and Therapeutics Committee. A Formulary is a list of Prescription Drugs for which We provide coverage. The Pharmacy and Therapeutics Committee meets at least quarterly to review the scientific evidence, economic data, and a wide range of other information about drugs for potential Formulary placement and coverage. Based upon that review, the committee selects the Prescription Drugs it believes to be the safest and most effective of those Prescription Drugs which meet the desired goals of providing appropriate therapy at the most reasonable cost. Once such determination is made, We may obtain or access contracts with the manufacturer of the Prescription Drugs for rebates. The committee will not select a Prescription 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 defines this timeframe as one hundred eighty (180) days of availability. The committee determines which Prescription Drugs to add or delete, supply and dosage limitations, sequence of use, and all other aspects about Our Formulary. We will provide written notice of the modification to the Prescription Drug Formulary to the commissioner and each affected Member, not later than the 60th day before the date the modification is effective.

Request for Formulary Information

A Member may contact Us to find out if a specific Prescription Drug is on the Formulary. We must respond to the Member's request about the Prescription Drug Formulary no later than the third business day after the date of the request to disclose whether a specific Prescription Drug is on the Formulary. However, the presence of a Prescription Drug on a Formulary does not guarantee that the Member's Participating Provider will prescribe the drug for a medical condition or mental illness or that the Prescription Drug will be covered.

Formulary Lists

Copayments or Coinsurance vary based upon the tier level a Prescription Drug has been placed on by Us. Prescription Drugs on Our Formulary, which are preferred generic Prescription Drugs, require the lowest Copayment or Coinsurance. Prescription Drugs on Our Formulary, which are preferred Name Brand Prescription Drugs require an increased Copayment or Coinsurance. Prescription Drugs, which are non-preferred, may not be covered by Us or may require a larger Copayment than preferred drugs, depending on the Plan selected. If the negotiated or Usual and Customary Rate of a drug is less than the Copayment, the Member is only required to pay the lower cost.

Member Choice for Name Brand Prescription Drug Option

Name Brand Prescription Drugs with a generic equivalent may not be covered by Us If a Member, the Member's Participating Provider, or their Participating Health Professional, requests a Name Brand Prescription Drug when a generic equivalent is available, We provide the Member the option to pay the difference in cost, plus the brand or non-preferred Copayment depending on the Plan selected. The difference in cost is calculated by subtracting the Participating Pharmacy's contracted rate for the Name Brand Prescription Drug from the rate for the generic equivalent. This difference in cost does not apply to any Medical Deductible, Pharmacy Deductible, or the Maximum Out-of-Pocket for the Plan. The differential cost will continue applying if the Member exceeds their Maximum Out-of-Pocket. See the Formulary Lists section of this Evidence of Coverage for a description of the prior authorization process available to request an exception for Medical Necessity. If the request is approved, the Member pays the non-preferred Copayment or the largest Copayment depending on the Plan.

Prescription Drugs designated on the Formulary as Specialty Drugs that are dispensed at a Participating Pharmacy and self-administered or administered in the office of a Participating Provider may be covered under this Certificate of Coverage, subject to the Specialty Pharmacy Copayments, Cost Share, and Deductibles indicated in the Schedule of Benefits.

Prescription Drugs on Our Formulary may require Preauthorization or be subject to coverage requirements.

If a Prescription Drug appeared on Our Formulary at the beginning of the Calendar Year, We shall make such Prescription Drug available at the contracted benefit level until the end of the Calendar Year, regardless of whether the Prescription Drug has been removed from Our Formulary.

Prescription Drugs not listed on Formulary may be covered if:

- The drug is not excluded from coverage.
- The drug meets Medically Necessary criteria.
- The Formulary alternatives have been tried but were insufficient to treat the Member's condition, or there are clinically significant reasons why the Formulary alternatives would not be appropriate.

To request coverage for a non-Formulary medication, A Member, or the prescribing Participating Provider or Participating Health Professional must submit a request for Preauthorization to the Utilization Review agent for consideration of coverage. If the request is denied, the Member has the right to appeal. Refer to **BSWHealthPlan.com** for details regarding the appeal submission process for pharmacy benefit drugs.

Specialty Drugs

Most Specialty Drugs obtained under the pharmacy benefit must be dispensed from one of the Participating Specialty Pharmacy Providers. Specialty Drugs dispensed by a Participating Specialty Pharmacy Provider will be subject to the Formulary Copayment or Coinsurance for Specialty Drugs specified in the Schedule of Benefits. Failure to obtain Specialty Drugs from the Participating Specialty Pharmacy Provider may result in denial of coverage for the Specialty Drug. A Member may contact Us to obtain a copy of the Specialty Drugs which must be obtained from the Participating Specialty Pharmacy Providers. Specialty Drugs may require Preauthorization or be subject to coverage requirements.

Authorization Requirements

Certain medications have restrictions in place to ensure they are being used appropriately and safely. Such restrictions may include:

- Quantity limits on the amount of a Prescription Drug the Member can receive over a period.
- Step therapy requiring trial of an alternative Prescription Drug(s) before a Prescription Drug is covered.
- Preauthorization requires the provider to submit documentation that the Prescription Drug is Medically Necessary before a Prescription Drug is covered.

Coverage of Prescription Drugs for stage-four advanced, metastatic cancer and associated conditions will not require that the Member fail to successfully respond to a different drug or prove a history of failure of a different drug. This applies only to a drug the use of which is:

- consistent with best practices for the treatment of stage-four advanced, metastatic cancer or an associated condition,
- supported by peer-reviewed, evidence-based literature; and
- approved by the United States Food and Drug Administration.

Coverage of Prescription Drugs for Serious Mental Illness will not require that the Member who is eighteen (18) years of age or older fail to respond to more than one (1) different drug for each drug prescribed, excluding generic or pharmaceutical equivalents for the prescribed drug. For continued coverage of a prescribed drug, once in a Calendar Year, a Plan may implement a step therapy protocol to require a trial of a generic or pharmaceutical equivalent of a prescribed Prescription Drug if the generic or pharmaceutical equivalent is added to the Plan's Formulary.

No more than one (1) preauthorization per Member annually per Prescription Drug is required to fulfill a Prescription Drug to treat an autoimmune disease, hemophilia, or Von Willebrand disease. This does not apply to:

- opioids, benzodiazepines, barbiturates, or carisoprodol,
- prescription drugs that have a typical treatment period of less than twelve (12) months,
- drugs that:
    - have a boxed warning assigned by the United States Food and Drug Administration for use; and
    - must have specific provider assessment; or
- the use of a drug approved for use by the United States Food and Drug Administration in a manner other than the approved use.

If coverage for a Prescription Drug or quantity of Prescription Drug is denied, the Member and the Member's Participating Provider or Participating Health Professional may Appeal the denial. Refer to **BSWHealthPlan.com** for details regarding the appeal submission process for pharmacy benefit drugs. The Member's Participating Provider or Participating Health Professional may submit a request for an exception to step therapy protocol. If a step therapy exception request is not denied within seventy-two (72) hours of the request, the request will be considered granted. If the prescribing Participating Provider or Participating Health Professional feels that a denial of the step therapy exception request would result in death or serious harm, the request will be considered granted if not denied within twenty-four (24) hours of the request.

Prescription Drug Refill

Refills of a Prescription Drug will not be covered until the Member is reasonably due for a refill as calculated based upon the Prescription Drug being taken at the prescribed dosage and appropriate intervals.

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

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

Maintenance Prescription Drugs

Prescription Drugs taken for chronic conditions as defined by Us are designated as maintenance Prescription Drugs and will be considered for Medical Synchronization as follows:

- Meet Preauthorization criteria.
- Used for Treatment and management of a chronic illness.
- May be prescribed with refills.
- A formulation that can be effectively dispensed in accordance with the Medication Synchronization Plan.
- Not a Schedule II or III controlled substance, and
- May qualify for synchronizing refills and pro-rated Cost Sharing amounts for partial supplies of certain medications.

Emergency refills of Diabetes Equipment or Diabetes Supplies dispensed to the Member will be covered in the same manner as for non-emergency refills of Diabetes Equipment or Diabetes Supplies. Insulin/insulin analogs and supplies (e.g., needles, syringes, cartridges, prefilled pens, glucose meters and/or test strips, continuous glucose meter supplies) are allowed for the lesser of a 30 days' supply or smallest package size when specified conditions are met per Texas law.

Copayment, Coinsurance and Deductible

A Member must pay the Copayment or Coinsurance for each Prescription Drug based on the quantity and days' supply dispensed as stated in the Schedule of Benefits. Any Deductible, and/or Copayments or Coinsurance for Prescription Drugs shall be considered Out-of-Pocket Expenses for purposes of meeting the Member's Maximum Out-of-Pocket. The amount a Member pays for a Prescription Drug will not be more than the Copayment or Coinsurance, as stated in the Schedule of Benefits, the Usual and Customary Rate for the Prescription Drug, the contracted rate for the Prescription Drug, or the actual price of the Prescription Drug.

We will apply any third-party payment, financial assistance, discount, product voucher, or other reduction of Out-of-Pocket Expenses for a Covered Drug to the Member's Deductible, Copayment, Coinsurance, Cost Share, or Maximum Out-of-Pocket.

This only applies when:

- A generic or interchangeable product does not exist; or

A generic or interchangeable product exists but the Member was approved by the health plan to use the drug.

Direct Member Reimbursement

When prescriptions are processed through the Member's Plan, there is a maximum contracted rate that can be charged by the Participating Pharmacy. When requesting reimbursement for Medically Necessary and covered medications purchased out-of-pocket by the Member, reimbursement is calculated based on the Participating Pharmacy's contracted rate less the Copayment or Coinsurance and Deductible amounts due. Medications for which reimbursement is requested must still adhere to any coverage restrictions.

Oral Anticancer Medications

Oral anticancer medications, covered on a basis no less favorable than intravenously administered or injected cancer medications, are covered under the Specialty Drug benefit and are subject to the Cost Sharing amounts applied to Specialty Drugs in the Schedule of Benefits.

Prescription Drugs included in the Oral Oncology Dispensing Program will be restricted to a 14/15-day supply for the first two (2) months of therapy. Note that for Members with a Copayment or Coinsurance, drugs included in the Oral Oncology Dispensing Program will be subject to 50% of the applicable Copayment or Coinsurance amount as listed in the Schedule of Benefits. Following the first four (4) fills of a drug in the Oral Oncology Dispensing Program, Members continuing therapy may fill their prescription for a maximum day supply allowed per the Schedule of Benefits.

Discontinuance of Prescription Drugs or Intravenous Infusions

We shall provide notice of an Adverse Determination for a review of the provision of Prescription Drugs or intravenous infusions for which the Member is receiving covered benefits under the Evidence of Coverage not later than the 30th day before the date on which the provision of Prescription Drugs or intravenous infusions will be discontinued.

Exclusions and Limitations

The benefits under this Certificate 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 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 this Certificate 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 as associated surgery except when Medically Necessary to treat craniofacial abnormalities as described in the **Medical Benefits** section of the Certificate 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 this Certificate 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 this Certificate 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 this Certificate 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 this Certificate 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 this Certificate 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 this Certificate of Coverage.

Mental Health
Services for mental illness or disorders are limited to those services described in the "Mental Health Care" provision of this Certificate 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 this Certificate 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, 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 this Certificate 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 this Certificate 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 a member with a chronic, complex, rare, or life-threatening medical condition, 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 unless listed on Our formulary.
- Initial or refill prescriptions the supply of which would extend past the termination of this Certificate 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 this Certificate 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 (unless covered by a Rider); 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 this Certificate 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 this Certificate 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 (unless covered by a Rider), and gym memberships are excluded, even if the Member has medical condition or is prescribed by a Physician or Healthcare Professional.

Claim Filing, Complaints and Appeal Procedures

The Issuer has the authority to review Claims in accordance with the procedures contained herein to determine if the Claims are covered by the Agreement.

Claim Filing Procedure

Members will not ordinarily need to pay any provider or Facility for benefits provided under the Agreement. However, if a Member receives benefits from facilities which do not routinely contract with Us, for example in case of an emergency, Members may be asked to pay that provider or Facility directly. Members are entitled to reimbursement for such payment to the extent that those benefits are covered under the Agreement provided:

- Members submit written proof of and Claim for payment to Us at Our office.
- The written proof and Claim for payment are acceptable to Us.
- We received the written proof and Claim for payment within ninety (90) days of the date the benefits were received by the Member; and
- The Member has complied with the terms of the Agreement.

Failure to File a Claim Within 90-Days

Failure to submit written proof of and Claim of payment within the ninety (90) day period shall not invalidate or reduce the Members entitlement to reimbursement provided it was not reasonably possible for the Member to submit such proof and Claim within the time allowed and written proof 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 benefits were received.
- Date the benefit was provided.
- Amount paid for the benefit; and
- Diagnosis for visit.

Claims for reimbursement should be sent to:

Baylor Scott & White Insurance Company
Attn: Claim Department
1206 W. Campus Drive, Temple, TX 76502

In no event will We have any obligation under the Agreement if such proof of and Claim for payment is not received by Us within one (1) year of the date the benefits were provided to the Member.

Acknowledgement of Claim

Not later than the fifteenth (15th) day after receipt of Your Claim, We will acknowledge in writing receipt of the Claim; begin any investigation of the Claim; and require from the Member any necessary information, statements, or forms. Additional requests for information may be made during the investigation.

Acceptance or Rejection of Claim

Not later than the fifteenth (15th) business day after receipt of all requested items and information, We will notify the Member in writing of the acceptance or rejection of the Claim and the reason, if rejected; or notify the Member that additional time is needed to process the Claim and state the reason We need additional time. If additional time is needed to decide, We shall accept or reject the Claim no later than the forty-fifth (45th) day after the Member has been notified of the need for additional time.

Payment of Claim

Claims will be paid no later than the fifth (5th) business day after notification of acceptance. If the Issuer provides coverage for a minor child who qualifies as a dependent of a Group member, the Issuer may pay benefits on the child's behalf to a person who is not a Group member if an order providing for the appointment of a possessory or managing conservator of the child has been issued by a court in this or another state. A person who is not a Group member is entitled to be paid benefits under this section only if the person presents to the Issuer, with the claim application.

- written notice that the person is a possessory or managing conservator of the child on whose behalf the claim is made; and
- a certified copy of a court order designating the person as possessory or managing conservator of the child or other evidence designated by rule of the commissioner that the person is eligible for the benefits as this section provides.

Payment to Physician or Provider

Payment by Us to the provider or Facility providing the service to the Member shall discharge Our obligation under this section.

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

Limitations on Actions

No action at law or in equity shall be brought to recover payment of a Claim under the Agreement prior to the expiration of ninety (90) days from the date written proof of and Claim for payment, as described above, was received by the Issuer. In no event shall such action be brought after three (3) years from such date.

Payment to Texas Health and Human Services Commission

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

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

Payment to a Managing Conservator

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

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

Physical Examination or Autopsy

We retain the right and opportunity to:

- Conduct a physical examination of a Member for whom a Claim is made when and as often as We reasonably require during the pendency of the Claim under the Agreement; and
- In the case of a death, may require that an autopsy be conducted, unless the autopsy is prohibited by law.

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.

Voluntary Binding Arbitration

If You are enrolled in a plan provided by Your Employer that is subject to ERISA, any dispute involving an Adverse Determination must be appealed under Claim procedure rules outlined above. After the Member has followed the Appeal procedures, any dispute regarding an Adverse Determination may be submitted to voluntary binding arbitration, if both parties agree.

For a Member enrolled in an Employer plan subject to ERISA, any dispute regarding an Adverse Determination, or any dispute which does not involve an Adverse Determination; or for a Member enrolled in a n Employer plan not subject to ERISA, any dispute, may be subject to binding arbitration if:

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

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

Medicare and Subrogation

Medicare

Regardless of any other provisions of the Agreement to the contrary, on and after the first day You or Your Covered Dependent become covered under Medicare and in instances where Medicare would be the primary payor of benefits, You or Your Covered Dependent shall agree to:

1. You and Your Covered Dependent shall qualify for, and remain continuously qualified for, coverage under 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 healthcare benefits, including coverage under other terms of the Agreement, and perform such acts as shall be necessary and desirable to facilitate the maximum reimbursement by Medicare, the Issuer, and Participating Providers for the services provided.

Effect on the Benefits of the Plan

The Issuer will pay the difference between the Allowable Expense and the amount paid by Medicare in accordance with the Medicare explanation of medical benefits. Benefits will be reduced proportionally whenever a reduction is required under this provision. The Issuer will then charge these amounts against any applicable benefit limitations.

Method of Payment

The Issuer will have the right, exercisable alone in its sole discretions, to pay directly to any organization making such other payments any amount it determines to be warranted in order to satisfy the intent of this provision. Amounts so paid will be deemed to be benefits under the Plan. These payments will fully discharge the Issuer from all further liability.

Subrogation /Lien/Assignment/Reimbursement

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

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

Regardless of the foregoing, the Plan will comply with the requirements of any applicable state law.

Right to Recovery

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

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

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

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

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

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

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

Assignment

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

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

Reimbursement

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

Plan's Actions

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

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

Obligations of the Plan Participant to the Plan

- If a plan participant receives services or benefits under the Plan, the plan participant must immediately notify the Plan Sponsor of the name of any individual or entity against whom the plan participant might have a Claim as a result of illness or injury (including any insurance company that provides coverage for any party to the Claim) regardless of whether the plan participant intends to make a Claim. For example, if a plan participant is injured in an automobile accident and the person

who hit the plan participant was at fault, the person who hit the plan participant is a person whose act or omission has caused the plan participant's illness or injury.

- A plan participant must also notify any third-party and any other individual or entity acting on behalf of the third-party and the plan participant's own insurance carriers of the Plan's rights of Subrogation, lien, reimbursement, and assignment.
- A plan participant must cooperate with the Plan to provide information about the plan participant's illness or injury including, but not limited to providing information about all anticipated future Treatment related to the subject injury or illness.
- A plan participant authorizes the Plan to pursue, sue, compromise, and settle any claim described herein, and agrees to execute a medical authorization in furtherance of the plan's prosecution of its claim.
- The plan participant agrees to obtain consent of the Plan before settling any Claim or suit or releasing any party from liability for the payment of medical expenses resulting from an injury or illness. The plan participant also agrees to refrain from taking any action to prejudice the Plan's recovery rights.
- The Plan may designate a person, agency, or organization to act for it in matters related to the Plan's rights described herein, and the plan participant agrees to cooperate with such designated person, agency, or organization the same as if dealing with the Plan itself.

Wrongful Death/Survivorship Claims

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

Death of Plan Participant

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

Payment

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

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

Severability

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

Coordination of Benefits

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

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

Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) "Allowed amount" is the amount of a billed charge that a carrier determines to be covered for services provided by a nonpreferred healthcare provider or Physician. The Allowed Amount includes both the carrier's payment and any applicable Deductible, Copayment, or Coinsurance amounts for which the insured is responsible.

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

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

Order of Benefit Determination Rules

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

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

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

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

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

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

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

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

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

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

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

(A) For a dependent child, whose parents are married or are living together, whether they have ever been married:

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

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

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

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

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

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

iv. if there is no court order allocating responsibility for the dependent child's healthcare expenses or healthcare coverage, the order of benefits for the child is as follows:

(I) the plan covering the custodial parent.

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

(III) the plan covering the noncustodial parent; then.

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

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

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

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

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

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

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

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

Effect on the Benefits of this Plan

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

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

Compliance with Federal and State Laws Concerning Confidential Information

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

Facility of Payment

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

Right of Recovery

If the amount of the payments made by Organization responsible for COB administration is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid or any other person or organization that may be responsible for the benefits

or services provided for the Member. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

General Provisions

Assignment

All Benefits payable by the Issuer under this Plan and any amendment hereto are personal to the Member and are not assignable in whole or in part by the Member, but the Issuer has the right to make payment to a Hospital, Physician, or other provider (instead of to the Member) for covered benefits which they provide while:

- there is in effect between the Issuer and any such Hospital, Physician, or other provider, an agreement calling for the Issuer to make payment directly to them,
- if payment relates to an emergency or its attendant episode of care as required by law, or
- if payment relates to specialty or other healthcare services at the request of the Issuer or Physician or provider because the services are not reasonably available within the network.

In the absence of such direct payments by the Issuer to Hospital, Physician, or other provider, the Issuer will pay to the Member and only the Member those benefits called for herein and the Issuer will not recognize a Member's attempted assignment to, or direction to pay, another, unless and to the extent this Plan is subject to Texas Insurance Code §1204.053.

Confidentiality

In accordance with applicable law, all records and information pertaining to the diagnosis, Treatment, or health of a Member, or to an application obtained from a Member, or received from any provider shall be held by the Issuer in confidence and shall not be disclosed to any person except:

- to the extent it is necessary to carry out the purpose of the Agreement and administer the Agreement.
- with a Member's express authorization; or
- when required or authorized by law, regulation, or court order; or
- in the event of claim or litigation between a Member and the Issuer.

More details about how We may use or disclose Member medical information can be found in Our Notice of Privacy Practices on Our website **BSWHealthPlan.com**.

Conformity with State Law

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

Modification of Agreement Terms

During the term of the Agreement, the Agreement shall be subject to amendment, modification, or termination in accordance with any provision hereof; by mutual agreement between the Issuer and Contract Holder; or as required by law. The Issuer will provide notice of the modification to You not later than sixty (60) days prior to the date on which the modification will become effective. By electing coverage pursuant to the Agreement or by accepting benefits hereunder, You and the Contract Holder agree to all terms, conditions, and provisions hereof.

Not a Waiver

The failure of the Issuer to enforce any provision of the Agreement shall not be deemed or construed to be a waiver of the past or future enforceability of such provision. Similarly, the Issuer's failure to pursue any

remedy arising from a default with a term of the Agreement shall not be deemed or construed to be a waiver of such default.

Notice

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

If to the Issuer:
Baylor Scott & White Insurance Company
1206 W. Campus Drive
Temple, Texas 76502

If to You:
To the latest address provided by You

If to a Contract Holder:
When We provide written notice to the Contract Holder, that notice is deemed notice to all affected Subscribers and Covered Dependents. The Group is responsible for giving notice to You.

Office of Foreign Assets Control (OFAC) Notice

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

Records

The Issuer is entitled to maintain records on Members necessary to administer the Agreement. The records of a Member which have a bearing on the Agreement shall be made available to the Issuer for inspection at any reasonable time.

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

Subject to all applicable confidentiality requirements, We are entitled to receive a Member's information from any Physician or provider of healthcare in connection with the administration of the Agreement. By accepting benefits under the Agreement, You authorize every Physician or provider rendering healthcare to a Member to disclose, as permitted by law, all information and records pertaining to a Member's care, Treatment and physical condition to Us, any other Physician or provider who is a Participating Provider, or referral Physician rendering services to a Member, and to render reports and permit copying of such records and reports by Us or other such Physicians and providers.

Recovery

If any action at law or in equity is brought to enforce or interpret the provisions of the 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.

The Issuer is also entitled to recover from the Contract Holder, Subscriber or Member any overpayment or other inappropriate payment, including, but not limited to, a payment for non-covered benefits 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 payment to Issuer may result in legal action by Issuer.

Reporting Healthcare Fraud

Our mission is to make healthcare smart and simple. Our goal is to empower Members with information to help guide their healthcare decisions, including how to protect themselves and the Issuer against healthcare fraud.

Healthcare fraud occurs when someone intentionally provides false or misleading information to obtain health benefits or money.

Healthcare fraud places a burden on both the Issuer and Members. Providers who engage in fraud may be willing to prioritize their own financial gain over quality of Treatment and diagnosis. Also, healthcare fraud raises the cost of health insurance for everyone.

Healthcare fraud can be committed by a number of people including providers, hospitals, labs, medical equipment suppliers, and even Members.

Examples of provider fraud:

- Billing for services that were not performed.
- Using a falsified diagnosis to bill tests or procedures that are not Medically Necessary.
- "Upcoding" or billing for more expensive services than the ones that were performed.
- Accepting money from another provider for Member referrals or a "kickback"; and
- Waiving a Member's Cost Share in order to bill the insurer more.

Examples of member fraud:

- Using someone else's plan coverage or ID Card.
- Falsely alleging the theft of medical equipment; and
- Reselling medical items.

We keep Member personal health data safe, and it is important that Members take steps to protect their information as well.

When a Member goes to the doctor, the Member should ask questions about the care received. Once a Member receives a medical bill from a provider, the bill should be compared to the Member's Plan explanation of benefits. If a Member has questions about what was charged, the Member should contact Us at **844.633.5325**. If a Member has any questions about the Claim procedure or the review procedure, the Member should contact Us at **844.633.5325** or visit Our website at **BSWHealthPlan.com**.

We have a Special Investigations Unit (SIU) to investigate allegations of fraud. If a Member suspects fraud, report concerns to Our Special Investigations Unit:

- Email: **HPCompliance@BSWHealth.org**.
- Toll-free fraud hotline: **888.484.6977**; or
- Reports submitted by mail:
  Attn: Compliance Department
  Baylor Scott & White Insurance Company
  1206 W. Campus Drive
  Temple, TX 76502

When leaving the Issuer's SIU a message, please provide as much information as possible (names of those involved, locations, and any other details), so that We can investigate and take appropriate action. We do

not trace calls and will not try to identify the caller. Reports can be made without worry of retaliation or intimidation.

Severability

In the event of the unenforceability or invalidity of any section or provision of the Agreement, such invalidity or unenforceability shall not otherwise affect any other section of the Agreement, and the Agreement shall otherwise remain in full force and effect.

Venue

The Agreement shall be governed by the laws of the State of Texas, and federal laws where applicable. Any action at law or in equity, including any suit to enforce any of the terms, conditions, rights, or privileges under the Agreement, shall be brought in a court located within the ICSW Service Area.

Required Notices

Your Rights with a Preferred Provider (PPO) Health Plan - 28 TAC §3.3705(f)(1)

Notice from the Texas Department of Insurance

Your Plan

Your health plan contracts with doctors and facilities to treat its members at discounted rates. These providers make up a plan's network. You can go to any doctor or facility you choose, but your costs will be lower if you use one in the plan's network.

Your Plan's Network

Your health plan must have enough doctors and facilities within its network to provide every service the plan covers. This is called "network adequacy." If you can't find the care you need, ask your health plan for help. You have the right to receive the care you need under your in-network benefit.

If you don't think the network is adequate, you can file a complaint with the Texas Department of Insurance at **www.tdi.texas.gov** or by calling 800.252.3439.

Health Care Costs

You can ask health care providers how much they charge for health care services and procedures. You can also ask your health plan how much of the cost they'll pay.

List of Doctors

You can get a directory of doctors, facilities, and other health care providers that are in your plan's network.

You can get the directory online at **BSWHealthPlan.com** or by calling **844.633.5325**.

If you used your health plan's directory to pick an in-network doctor or facility and the doctor or facility turns out to be out-of-network, you might not have to pay the extra cost that out-of-network doctors and facilities charge.

Health Care Bills

If you want to see a doctor or facility that isn't in your plan's network (called "out-of-network"), you can still do so. You'll probably get a bill and have to pay the amount your health plan doesn't pay.

If you got health care from a doctor that was out-of-network when you were at an in-network facility, and you didn't pick the doctor or facility, you won't have to pay more than your regular copay, coinsurance, and deductible. Protections also apply if you got emergency care at an out-of-network facility or lab work or imaging in connection with in-network care.

If you get a bill for more than you're expecting, contact your health plan. Learn more about how you're protected from surprise medical bills at **www.tdi.texas.gov**.

Mandatory Benefit Notices

This notice is to advise you of certain coverage and/or benefits provided in the plan provided by Us. This notice is required by legislation to be provided to you. If you have questions regarding this notice, call us at **844.633.5325**. If you have any questions about the claim procedures or the review procedure, call us at **844.633.5325** or write to us at 1206 W. Campus Drive, Temple, Texas 76502.

Mastectomy or Lymph Node Dissection - 28 TAC §21.2106(b)(1)

Minimum Inpatient Stay: If due to treatment of breast cancer, any member covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of:

- 48 hours following a mastectomy; and
- 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the member receiving the treatment and the attending physician determine that a shorter period of inpatient care is appropriate.

Prohibitions: We may not (a) deny any member eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours; (b) provide money payments or rebates to encourage any member to accept less than the minimum inpatient hours; (c) reduce or limit the amount paid to the attending physician, or otherwise penalize the physician, because the physician required a member to receive the minimum inpatient hours; or (d) provide financial or other incentives to the attending physician to encourage the physician to provide care that is less than the minimum hours.

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy - Enrollment - 28 TAC §21.2106(b)(2)

Coverage and/or benefits are provided to each member for reconstructive surgery after mastectomy, including:

- All stages of the reconstruction of the breast on which mastectomy has been performed.
- Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
- Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

The coverage and/or benefits must be provided in a manner determined to be appropriate in consultation with the member and the attending physician.

Deductibles and copayment amounts will be the same as those applied to other similarly covered inpatient hospital expenses or medical-surgical expenses, as shown on the Schedule of Benefits.

Prohibitions: We may not (a) offer the member a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above; (b) condition, limit, or deny any member's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above; or (c) reduce or limit the amount paid to the physician or provider, nor otherwise penalize, or provide a financial incentive to induce the physician or provider to provide care to a member in a manner inconsistent with the coverage and/or benefits shown above.

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy - Annual - 28 TAC §21.2106(b)(3)

Your contract, as required by the federal Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

Examinations for Detection of Prostate Cancer - 28 TAC §21.2106(b)(4)

Benefits are provided for each male member for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include:

- A physical examination for the detection of prostate cancer; and
- A prostate-specific antigen test for each covered male who is:
  - At least 50 years of age; or
  - At least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

Inpatient Stay Following Birth of a Child - 28 TAC §21.2106(b)(5)

For each member covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a healthcare facility for a minimum of:

- 48 hours following an uncomplicated vaginal delivery; and
- 96 hours following an uncomplicated delivery by cesarean section.

This benefit does not require a female member who is eligible for maternity/childbirth benefits to (a) give birth in a hospital or other healthcare facility; or (b) remain in a hospital or other healthcare facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours have expired, we will provide coverage for post-delivery care. Post-delivery care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. Care will be provided by a physician, registered nurse or other appropriately licensed healthcare provider, and the mother will have the option of receiving the care at her home, the healthcare provider's office, or a healthcare facility.

Prohibitions: We may not (a) modify the terms of this coverage based on any member requesting less than the minimum coverage required; (b) offer the mother financial incentives or other compensation for waiver of the minimum number of hours required; (c) refuse to accept a physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians; (d) reduce payments or reimbursements below the usual and customary rate; or (e) penalize a physician for recommending inpatient care for the mother or the newborn child.

Coverage for Tests for Detection of Colorectal Cancer - 28 TAC §21.2106(b)(6)

Benefits are provided, for each member in the plan who is 45 years of age or older and at normal risk for developing colon cancer, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include:

- All colorectal cancer examinations, preventive services, and laboratory tests assigned a grade of “A” or “B” by the United States Preventive Services Task Force for average-risk individuals, including the services that may be assigned a grade of “A” or “B” in the future.
- An initial colonoscopy or other medical test or procedure for colorectal cancer screening and a follow-up colonoscopy if the results of the initial colonoscopy, test, or procedure are abnormal.

Coverage of Tests for Detection of Human Papillomavirus, Ovarian Cancer, and Cervical Cancer - 28 TAC §21.2106(b)(7)

Coverage is provided, for each woman enrolled in the plan who is 18 years of age or older for expenses incurred for an annual, medically recognized diagnostic examination for the early detection of ovarian cancer and cervical cancer. Coverage required under this section includes:

- a CA 125 blood test,

- a conventional pap smear screening or a screening using liquid- based cytology methods, as approved by the FDA, alone or in combination with a test approved by the FDA for the detection of the human papillomavirus, and
- any other test or screening approved by the FDA for the detection of ovarian cancer.

Coverage for Acquired Brain Injury – 28 TAC §21.3107(a)

Your health benefit plan coverage for an acquired brain injury includes the following services when they are medically necessary:

- Cognitive rehabilitation therapy
- Cognitive communication therapy
- Neurocognitive therapy and rehabilitation
- Neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing and treatment
- Neurofeedback therapy and remediation
- Post-acute transition services and community reintegration services, including outpatient day treatment services or other post-acute-care treatment services.
- Reasonable expenses related to periodic reevaluation of the care of an individual covered under the plan who has incurred an acquired brain injury, has been unresponsive to treatment, and becomes responsive to treatment at a later date, at which time the cognitive rehabilitation services would be a covered benefit.

The fact that an acquired brain injury does not result in hospitalization or acute-care treatment does not affect the right of the insured or the enrollee to receive the preceding treatments or services commensurate with their condition. Post-acute-care treatment or services may be obtained in any facility where those services may legally be provided, including acute or post-acute rehabilitation hospitals, and assisted living facilities regulated under the Health and Safety Code.

COVID-19

Baylor Scott & White Insurance Company will not require a prospective or current Member to provide any documentation certifying receiving a COVID-19 vaccination or post-transmission recovery as a condition for obtaining coverage or receiving benefits under this Plan.

If any member has questions concerning the above, please call us at **844.633.5325** or write to us at 1206 W. Campus Drive, Temple, Texas 76502.

How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
  - Up to $500,000 for health benefit plans, with some exceptions.
  - Up to $300,000 for disability income benefits.
  - Up to $300,000 for long-term care insurance benefits.
  - Up to $200,000 for all other types of health insurance.
- **Life insurance:**
  - Up to $100,000 in net cash surrender or withdrawal value.
  - Up to $300,000 in death benefits.
- **Individual annuities:** Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.
- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.
- **Individual aggregate limit:** Up to $300,000 per person, regardless of the number of policies or contracts. A limit of $500,000 may apply for people with health benefit plans.
- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

To learn more about the Association and your protections, contact:	For questions about insurance, contact:
Texas Life and Health Insurance Guaranty Association 1717 West 6th Street, Suite 230 Austin, TX 78703-4776 1-800-982-6362 or www.txlifega.org	**Texas Department of Insurance** P.O. Box 12030 Austin, TX 78711 1-800-252-3439 or www.tdi.texas.gov

Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.

BAYLOR SCOTT & WHITE INSURANCE COMPANY
PPO SERVICE AREA

Subscribers must work, live, or reside within the Service Area to be eligible under the policy.

Service Area Description:
The following counties in Texas: Andrews, Armstrong, Austin, Bailey, Bastrop, Bell, Bexar, Blanco, Borden, Bosque, Brazos, Brewster, Briscoe, Brown, Burleson, Burnet, Caldwell, Callahan, Carson, Castro, Childress, Cochran, Coke, Coleman, Collin, Collingsworth, Comal, Comanche, Concho, Coryell, Cottle, Crane, Crockett, Crosby, Dallam, Dallas, Dawson, Deaf Smith, Denton, Dickens, Donley, Eastland, Ector, El Paso, Ellis, Erath, Falls, Fayette, Fisher, Floyd, Freestone, Gaines, Garza, Glasscock, Gray, Grayson, Grimes, Guadalupe, Hale, Hall, Hamilton, Hansford, Hartley, Haskell, Hays, Hemphill, Hill, Hockley, Hood, Houston, Howard, Hutchinson, Irion, Johnson, Jones, Kent, Kimble, King, Knox, Lamb, Lampasas, Lee, Leon, Limestone, Lipscomb, Llano, Loving, Lubbock, Lynn, Madison, Martin, Mason, McCulloch, McLennan, Menard, Midland, Milam, Mills, Mitchell, Moore, Motley, Navarro, Nolan, Ochiltree, Oldham, Parmer, Pecos, Potter, Randall, Reagan, Reeves, Roberts, Robertson, Rockwall, Runnels, San Saba, Schleicher, Scurry, Shackelford, Sherman, Somervell, Stephens, Sterling, Stonewall, Sutton, Swisher, Tarrant, Taylor, Terry, Throckmorton, Tom Green, Travis, Upton, Walker, Waller, Ward, Washington, Wheeler, Williamson, Winkler, and Yoakum counties.

BaylorScott&White Insurance Company

Large Group
Medical Schedule of Benefits
Preferred Provider Organization
BSW Access PPO
UHC25_4000_04
UHB5J4J2

The following is a summary of the cost share amounts members must pay when receiving the covered benefits listed below. Refer to the Certificate 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 and 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	
	Participating Provider	***Non-Participating Provider***
Medical Deductible	$4,000 per Member $8,000 per Family	$8,000 per Member $16,000 per Family
Maximum Out-of-Pocket *Includes Medical Deductible, Pharmacy Deductible, Copayments, and Coinsurance.*	$8,000 per Member $16,000 per Family	$24,000 per Member $48,000 per Family
Coinsurance	0% coinsurance, after deductible	50% coinsurance, after deductible
Annual Maximum	Unlimited	
Preauthorization Penalty for Benefits Requiring Preauthorization *For preauthorization requirements refer to* **BSWHealthPlan.com**	Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of $500 or 50% reduction in benefits.	Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of $500 or 50% reduction in benefits.
Except for services received from a Participating Provider facility, Emergency Care, Air Ambulance Transportation services, and EMS Provider Transportation services and covered supplies, a Member may be balance billed and will be responsible for Non-Participating Provider balance billing charges over the Usual and Customary Rate. The balance billing charges will not be applied toward the Maximum Out-of-Pocket.		

Medical Benefits	*Participating Provider Member Cost Share*	*Non-Participating Provider Member Cost Share*
Adult PCP Office Visit 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.*	No charge for the first non-preventive sick visit in the calendar year. $15 copayment per visit for subsequent visits in that calendar year, deductible does not apply	50% coinsurance, after deductible

Medical Benefits	*Participating Provider Member Cost Share*	*Non-Participating Provider Member Cost Share*
Pediatric PCP Office Visit 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.*	No charge per visit, deductible does not apply	50% coinsurance, after deductible
Specialist Physician Office Visit 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.*	$40 copayment per visit, deductible does not apply	50% coinsurance, after deductible
Annual Routine Eye Exam	Not covered	Not covered
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	50% coinsurance, after deductible
Allergy Testing, Serum, and Injections	0% coinsurance, after deductible	50% coinsurance, after deductible
Diagnostic Test Routine lab, EKG, and X-rays.	No charge	50% coinsurance, after deductible
Imaging and Radiology (Including Facility and Physician charges) Angiography, CT Scans, MRIs, Myelography, PET Scans, Stress Tests.	$250 copayment per visit, deductible does not apply	50% coinsurance, after deductible
Cardiovascular Disease Screening*	$250 copayment per visit, deductible does not apply	50% coinsurance, after deductible
Outpatient Surgery Procedure Facility charges, Covered Prescription Drugs, Specialty Drugs, Medical Supplies, Observation Unit, Surgical Procedures, Pain Management.	0% coinsurance, after deductible	50% coinsurance, after deductible

Medical Benefits	*Participating Provider Member Cost Share*	*Non-Participating Provider Member Cost Share*
Outpatient Physician Services	0% coinsurance, after deductible	50% coinsurance, after deductible
Emergency Care Copayment waived if episode results in hospitalization for the same condition within 24 hours.	$500 copayment per visit, deductible does not apply	$500 copayment per visit, deductible does not apply
Ambulance Transportation Ground, Sea, or Air.	$500 copayment per service, deductible does not apply	$500 copayment per service, deductible does not apply
Urgent Care	$50 copayment per visit, deductible does not apply	$50 copayment per visit, deductible does not apply
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.	0% coinsurance, after deductible	50% coinsurance, after deductible
Skilled Nursing Facility*	0% coinsurance, after deductible	50% coinsurance, after deductible
Adult Outpatient Mental Health Care, Serious Mental Illness and Chemical Dependency	$15 copayment per visit, 0% coinsurance, after deductible for all other outpatient services	50% coinsurance, after deductible
Pediatric Outpatient Mental Health Care, Serious Mental Illness and Chemical Dependency	No charge per visit, deductible does not apply	50% coinsurance, after deductible
Maternity Care and Family Planning Postnatal Care, Family Planning (as medically necessary).	$15 copayment per visit, deductible does not apply	50% coinsurance, after deductible
Infertility (Diagnosis Only)	$40 copayment per visit, deductible does not apply	50% coinsurance, after deductible
Rehabilitation* Physical Therapy, Occupational Therapy, Speech Therapy, Chiropractic Care.	$15 copayment per visit, deductible does not apply	50% coinsurance, after deductible
Habilitation* Physical Therapy, Occupational Therapy, Speech Therapy, Chiropractic Care.	$15 copayment per visit, deductible does not apply	50% coinsurance, after deductible

Medical Benefits	*Participating Provider Member Cost Share*	*Non-Participating Provider Member Cost Share*
Chiropractic Care*	$15 copayment per visit, deductible does not apply	50% coinsurance, after deductible
Home Health Care*	0% coinsurance, after deductible	50% coinsurance, after deductible
Hospice Care	No charge, deductible does not apply	50% coinsurance, after deductible
Durable Medical Equipment (DME) Orthotics, Prosthetics.	0% coinsurance, after deductible	50% coinsurance, after deductible
Diabetes Management Diabetes Self-Management Training, Diabetes Education, Diabetes Care Management.	$15 copayment per visit, deductible does not apply	50% coinsurance, after deductible
Diabetes Equipment and Supplies	Same as DME or pharmacy, as appropriate	50% coinsurance, after deductible
Nutritional Counseling	$15 copayment per visit, deductible does not apply	50% coinsurance, after deductible
Hearing Aids* and Cochlear Implants	0% coinsurance, after deductible	50% coinsurance, after deductible
Telehealth Service and Virtual Visits	No charge, deductible does not apply	50% coinsurance, after deductible
Other Telehealth Service and Telemedicine Medical Service	The amount of the deductible, copayment or coinsurance may not exceed the amount of the deductible, copayment or coinsurance required for a comparable medical benefit provided through a face-to-face consultation.	50% coinsurance, after deductible
Amino Acid Based Elemental Formulas	Same as DME or pharmacy as appropriate	50% coinsurance, after deductible
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	50% coinsurance, after deductible
All Other Covered Medical Benefits (not specified herein)	0% coinsurance, after deductible	50% coinsurance, after deductible

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.* *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.* *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.*

BaylorScott&White Insurance Company

Large Group
Pharmacy Schedule of Benefits
Preferred Provider Organization
LGRXCore
LRXPGC25

The following is a summary of the cost share 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	
	Participating Provider	***Non-Participating Provider***
Pharmacy Deductible	$0 per Member $0 per Family	$0 per Member $0 per Family
Maximum Out-of-Pocket *Includes Medical Deductible, Pharmacy Deductible, Copayments and Coinsurance.*	Integrated with Medical per Member Integrated with Medical per Family	Integrated with Medical per Member Integrated with Medical per Family
Annual Maximum	Unlimited	

A Member may be balance billed and will be responsible for Non-Participating Provider balance billing charges over the Usual and Customary Rate. The balance billing charges will not be applied toward the Maximum Out-of-Pocket.

Pharmacy Benefit	***Participating Provider Member Cost Share***		***Non-Participating Provider Member Cost Share***
	30-day Standard	*90-day Maintenance**	
ACA preventive drugs	No charge	No charge	50% coinsurance
Tier 1 Preferred generic drugs	No charge	No charge	50% coinsurance
Tier 2 Non-preferred generic drugs	$8 copayment per prescription	$20 copayment per prescription	50% coinsurance
Tier 3 Preferred brand drugs	$45 copayment per prescription	$112.50 copayment per prescription	50% coinsurance
Tier 4 Non-preferred brand drugs	$100 copayment per prescription	$250 copayment per prescription	50% coinsurance
Specialty Tier 1 Specialty preferred generic drugs	$75 copayment per prescription	Not covered	50% coinsurance
Specialty Tier 2 Specialty preferred brand drugs	$150 copayment per prescription	Not covered	50% coinsurance
Specialty Tier 3 Specialty non-preferred brand drugs	$300 copayment per prescription	Not covered	50% coinsurance

Pharmacy Benefit	*Participating Provider Member Cost Share*		*Non-Participating Provider Member Cost Share*
	30-day Standard	*90-day Maintenance**	
Preferred diabetic test strips for blood glucose monitors	No charge	No charge	50% coinsurance
Non-preferred diabetic test strips for blood glucose monitors	$45 copayment per prescription	$112.50 copayment per prescription	50% coinsurance

*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 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 applicable brand name drug copayment plus the difference in cost of the brand name drug and generic equivalent drug.

BaylorScott&White Insurance Company

Diabetes Wellness Rider

The BSW Be Well with Diabetes program ("Program") is a voluntary wellness program offered by Baylor Scott & White Insurance Company ("BSWIC") 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 Insurance Company 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 Insurance Company 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 BSWIC, which may be sent to the member's home address on record with BSWIC, 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 BSWIC 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 Certificate 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.bswhp.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	50% coinsurance
Tier 1 Preferred generic drugs	No charge	No charge	50% coinsurance
Tier 2 Non-preferred generic drugs	$8 copayment per prescription	$20 copayment per prescription	50% coinsurance
Tier 3 Preferred brand drugs	$45 copayment per prescription	$112.50 copayment per prescription	50% coinsurance
Tier 4 Non-preferred brand drugs	$100 copayment per prescription	$250 copayment per prescription	50% coinsurance
Specialty Tier 1 Specialty preferred generic drugs	$75 copayment per prescription	Not covered	50% coinsurance
Specialty Tier 2 Specialty preferred brand drugs	$150 copayment per prescription	Not covered	50% coinsurance
Specialty Tier 3 Specialty non-preferred brand drugs	$300 copayment per prescription	Not covered	50% coinsurance
Preferred diabetic test strips for blood glucose monitors	No charge	No charge	50% coinsurance
Non-preferred diabetic test strips for blood glucose monitor	$45 copayment per prescription	$112.50 copayment per prescription	50% coinsurance
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	50% coinsurance
*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 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 applicable brand name drug copayment plus the difference in cost of the brand name drug and generic equivalent drug.			

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).

BaylorScott&White Insurance Company

Nondiscrimination Notice

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-844-633-5325 (TTY: 711).

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

Baylor Scott & White Insurance Company:

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

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

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

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

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

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

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

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

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

Language Assistance/ Asistencia de idiomas

BaylorScott&White Insurance Company

English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-844-633-5325 (TTY: 711).

Spanish:
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-633-5325 (TTY: 711).

Vietnamese:
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-633-5325 (TTY: 711).

Chinese:
注意：如果 使用繁體中文, 可以免費獲得語言援助服務。請致電 1-844-633-5325 (TTY：711)。

Korean:
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-633-5325 (TTY: 711) 번으로 전화해 주십시오.

Arabic:
هاتف الصم والبكم: 711 .ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-633-5325 (رقم

Urdu:
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال 1-844-633-5325 (TTY: 711). کریں

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-633-5325 (TTY: 711).

French:
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-633-5325 (ATS : 711).

Hindi:
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-633-5325 (TTY: 711) पर कॉल करें।

Persian:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-844-633-5325 (TTY: 711) تماس بگیرید.

German:
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-633-5325 (TTY: 711).

Gujarati:
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-844-633-5325 (TTY: 711).

Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-633-5325 (телетайп: 711).

Japanese:
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-633-5325 (TTY:711) まで、お電話にてご連絡ください。

Laotian:
ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-844-633-5325 (TTY:711).