FirstCare™
HEALTH PLANS
PART OF BAYLOR SCOTT & WHITE HEALTH

Member Handbook

For Commercial PPO Plans

FirstCare™

HEALTH PLANS

PART OF BAYLOR SCOTT & WHITE HEALTH

We put you first.

Thank you for being a member.

Your benefits are provided by Southwest Life & Health (SWL&H) Insurance Company—a wholly owned subsidiary of FirstCare Health Plans. FirstCare provides administrative functions, such as claims processing, customer service, and medical management to Southwest Life & Health members.

FirstCare Health Plans was born and bred in Texas. We're extremely proud of that heritage. With the support of our owners—Covenant Health in Lubbock and Hendrick Health System in Abilene—we carry on the tradition of offering health plans that work for Texans. Our mission is: Founded as a Christian ministry of healing, Baylor Scott & White Health promotes the well-being of all individuals, families and communities.

We value the relationships we've built with the members in our community and are focused on their health and well-being. Through our disease management programs, our members receive information and support for their chronic conditions like diabetes and hypertension.

We also pride ourselves in providing a patient-focused medical management program. Medical decisions are made locally by doctors who understand how health care is delivered in your town—not by some big corporation in another state.

At FirstCare, our goal is to ensure our members get the most quality and value out of their health plan. We do that by helping our members get the right care, at the right time and place, for the right price.

To help you understand your benefits, please review the guidelines presented in this member handbook. The member handbook is not intended to provide you with a complete representation of plan benefits, covered health services, exclusions, limitations, requirements or other provisions. **You can find a complete plan description of benefits in your Southwest Life & Health Certificate of Insurance.**

You and your insured dependents will be provided a list of "preferred" or "in-network providers" from whom you or your dependents may receive covered health care services. You may however, choose to receive covered health care services from any other licensed non-preferred provider at a reduced benefit and subject to our determination of Non-Preferred Provider Reimbursement (NPPR) amount. If you use any non-preferred provider, you will pay higher coinsurance and deductible amounts as shown in your Schedule of Benefits and you will be responsible for any amounts over our determination of NPPR. See the definition of NPPR in Section 1 of the Certificate of Insurance.

FirstCare provides prepaid medical, hospital, and related comprehensive health care services to HMO subscribers and their enrolled dependents within our approved service area. FirstCare also owns Southwest Life & Health Insurance Company which offers the FirstCare EPO, PPO and life insurance products.

Important Contact Information

When you contact FirstCare, you'll discover why so many Texans have chosen us as their health plan. Our goal is to provide friendly service and neighborly care.

PPO Customer Service	**Call toll-free phone number on your ID card**
Language Interpretation Service	**Call toll-free phone number on your ID card**
TTY/TDD	**711**

Customer Service Hours: Monday - Friday, 8 a.m. - 5 p.m. ***(Hablamos español)***

We have free interpreter services to answer any questions you may have about our health or drug plan benefits. To get an interpreter, call the Customer Service number on your ID card.

Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, llame al servicio al cliente. El número de teléfono está en usted tarjeta de identificación.

Mailing Address:

Customer Service
FirstCare Health Plans
1901 W Loop 289, Suite 9
Lubbock, TX 79407

Regional Offices:

Abilene
3300 South 14th Street,
Abilene, TX 79605
1-325-933-2408

Amarillo
6900 West I-40,
Suite 295
Amarillo, TX 79101
1-806-467-3200

Lubbock
1901 W Loop 289, Suite 9
Lubbock, TX 79407
1-806-784-4300

Corporate offices are located in Austin, TX.

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Enrollment & Membership

At FirstCare, we believe that Texans and their communities should be healthy. We treat our members like friends and neighbors because we live and work in the same communities you do. We're Texans too, and we take pride in providing friendly service and neighborly care.

Your Member ID Card

You will be issued up to three member ID cards for you and any dependents on your plan. You will need to show your ID card every time you receive health care services. Your ID card includes the following:

- **Group #:** This is the group number given to your individual, family, or employer group health plan.
- **Benefit Effective Date:** This is the date you became a member or the date your benefit plan became effective.
- **Member Name:** Your name.
- **Member #:** This is your identification number or the member number for your dependents.
- **DOB:** Your date of birth listed with FirstCare by month, day, and year.

Please be sure to read the back of your ID card for more information. If you find a mistake on your ID card, or need additional cards, please contact Customer Service. Below is a sample ID card. Information shown on your ID card may vary based on your plan benefits.

Family Status Changes

You are responsible for reporting any changes in the number of dependents to be covered and for paying any applicable premium.

If you experience any of the following events, **changes must be reported within 31 days to your benefits office and/or your agent:**

- Birth of a child
- Change in a dependent's status
- Marriage
- Divorce
- Death of a dependent
- Adoption
- Legal guardianship of a child

To make sure your child has continued coverage, you must notify us, either verbally or in writing, of the addition of your newborn as a dependent within 31 days following your child's birth and pay any additional premium charges. If you notify us after that 31-day period, your newborn will not be eligible for coverage until the next open enrollment period.

Covered Benefits & Services

This section summarizes which health care services are covered under your plan, along with any limits on coverage for specific services. This is only a summary. For a complete description of your covered services and benefits, please refer to your Southwest Life & Health Certificate of Insurance.

Certificate of Insurance

It is important to understand your benefits and how your plan works. This information is found in your Certificate of Insurance. This comprehensive document details the benefits and services that are included in and excluded from your medical and prescription drug coverage.

A **Preferred Provider** is a hospital, facility, home health agency, or other health care provider that is located within our service area and has contracted with Southwest Life & Health Insurance Company (SWL&H) to provide services and treatment under your policy.

A **Non-Preferred Provider** is any hospital, facility, home health agency, or other health care provider that has not contracted with SWL&H.

You can view your Certificate of Insurance by logging on to my.FirstCare.com Online Self-Service Portal.

Benefits & Services

The following is a summary of your covered benefits and services. For complete descriptions of your covered benefits and services, please refer to your Certificate of Insurance.

Inpatient Services

- Semi-Private Room & Board Charges
- Obstetrical Services[1]
- Mastectomy or Related Procedures[2]
- Other Hospital Services and Supplies
- Blood and Blood Products

Outpatient Services

- Health Care Provider Services[3][4]
- Outpatient Surgery
- Laboratory & Radiology Services

Preventive Health Care Services

- Annual Routine Physical Exam
- Well-Baby & Well-Child Preventive Care
- Routine Immunizations
- Ophthalmologic Exams
- Routine Sight, Speech, & Hearing Screening
- Screening Test for Hearing Impairments in newborns
- Diagnostic and Screening Mammograms[5]

[1]We will approve inpatient admissions for obstetrical services in accordance with the standards described below. Inpatient care is provided for the mother and her newborn child in a Health Care Facility for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarean section, unless the mother requests and the attending Physician agrees to discharge prior to the expiration of the minimum length of stay. If a decision is made to discharge the mother or newborn child from inpatient care before the expiration of the minimum hours of inpatient care, post-delivery care will be provided by a Physician, registered nurse, or other appropriate licensed Health Care Provider in either the mother's home, a provider's office, or a Health Care Facility. The plan provides coverage for the administration of a newborn screening test, including the cost of the test kit.

[2]We will approve inpatient admissions for mastectomy or related procedures in accordance with the standards described below. We cover inpatient care following a mastectomy or related procedures for the treatment of breast cancer for a minimum of 48 hours and 24 hours following a lymph node dissection, unless You and Your attending Physician determine that a shorter period of inpatient care is appropriate. We cover reconstruction of a breast incident to mastectomy, including surgical reconstruction to restore or achieve breast symmetry or balance of a breast on which mastectomy surgery has not been performed.

[3]Includes maternity care and physician services for pre- and post-natal care.

[4]Complications of Pregnancy—medical conditions that require inpatient care before the end of the pregnancy or that endanger the pregnancy or that are aggravated by the pregnancy. Complications of Pregnancy are conditions requiring diagnoses that are distinct from pregnancy but that are adversely affected by pregnancy. Complications of pregnancy are treated as any other illness.

Covered Benefits & Services (continued)

- Screening for the Detection of Colorectal Cancer
- Bone Mass Measurement[6]
- Prostate Cancer Testing
- Pap Smear Screening[7]
- Cardiovascular Disease Testing
- All Other Preventive Services

Family Planning Services

- Family Planning
- Infertility Services[8]

Telemedicine and Telehealth Services

Other Health Care Services

- Rehabilitation Services
- Habilitation Services
- Reconstructive Surgery Services
- Prosthetic and Orthotic Devices
- Internal Implantable Devices
- Anti-smoking Programs
- Pain Management Services
- Therapies for Children with Developmental Delays
- Acquired Brain Injury
- Second Surgical Opinion
- Dialysis Services
- Organ and Stem Cell Transplant
- Chemical Dependency Services
- Short-Term Mental Health Services
- Serious Mental Illness Services
- Autism Spectrum Disorder
- Durable Medical Equipment
- Medical Supplies
- Limited Accidental Dental Related Services
- Temporomandibular Joint Disorder (TMJ)
- Home Health Care Services
- Skilled Nursing Facility
- Hospice Care
- Medical Injectable Drugs[98]
- Home Infusion Therapy
- Hearing Aids and Cochlear Implants
- Diabetes Services[9]
- Amino Acid-Based Elemental Formulas
- Clinical Trials – Routine Patient Care
- Nutritional Counseling

Emergency & Urgent Care Services

- Emergency Care
- Ambulance Services
- Urgent Care Services

[5]Covered annually by all forms of Low-Dose Mammography, including Digital Mammography and Breast Tomosynthesis, to detect breast cancer according to guidelines as developed by the United States Preventive Services Task Force (USPTF).

[6]Services include bone mass measurement for the detection of low bone mass and to determine the risk of osteoporosis and fractures associated with osteoporosis.

[7]For women age 18 years or older enrolled in the Plan We provide an annual diagnostic examination for the early detection of ovarian cancer and cervical cancer. Coverage includes a CA 125 blood test and 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 screening test is performed in accordance with the guidelines adopted by the American College of Obstetricians and Gynecologists or another similar national organization of medical professionals recognized by the State of Texas.

[8]We cover medically injectable drugs, defined hybrid injectables, radiation therapy, specified transplant anti-rejection therapy, specified cancer chemotherapy and defined associated agents, and orally administered anticancer medications. Refer to the Schedule of Benefits for details.

[9]Including select Diabetes Equipment and Supplies. The following medications for the treatment of diabetes are covered: Insulin; Insulin analog preparations; Prescriptive and non-prescriptive medications for controlling blood sugar levels; Glucagon emergency kits. Select Diabetes self-management individual and group training programs are covered when ordered by Your Physician and provided by a licensed provider or a certified diabetes educator or dietician. Refer to Schedule of Benefits for details.

Covered Benefits & Services (continued)

Prescription Drug Services

We cover prescription drugs included in the approved FirstCare formulary (drug list) when they are prescribed by a Primary Care Physician (PCP) or other authorized referral prescribers.

Pharmacy Network

The FirstCare pharmacy network was designed to make sure you have convenient access to the quality medications you need at an appropriate price.

To receive plan benefits, you may fill your prescription at an in-network or out-of-network pharmacy.

The pharmacies in our network can change at any time. To find a network pharmacy near you, visit us online at FirstCare.com. If you need additional assistance, please call Customer Service at the phone number on your ID card.

Prescription Drug List

Your plan uses a drug list known as a formulary. A formulary is a list of prescription drugs covered by your plan. A group of doctors and pharmacists review and update the list monthly to make sure all the drugs are safe, effective, and affordable.

A 30/60/90-day supply of prescription eye drops to treat a chronic eye disease or condition may be refilled for a 21/42/63-day supply if You pay at the point of sale the maximum amount allowed and the original prescription states that additional quantities of the eye drops are needed; the refill does not exceed the total quantity of dosage units authorized by the prescribing provider on the original prescription, including refills; and the refill is dispensed on or before the last day of the prescribed dosage period.

Your plan's drug list contains a wide range of generic and brand-name drugs that have been approved by the U.S. Food and Drug Administration (FDA). Your doctor can use this list to choose medications for you. If you use drugs on the formulary, you can save money by reducing your out-of-pocket costs.

We may periodically add, remove, or make changes to the formulary based on reviews. If we make any drug list change that limits your ability to fill a prescription, we will notify you before the change is made.

- If we place a medication on a higher tier during the Policy Year, You will continue to pay the Copayment for the drug at the lower cost tier until Your next Plan renewal date. We will provide written notice of the modification to the affected Employer Group and each affected Insured Person not later than the 60th day before the Effective Date of the modification.
- If a medication is removed from the formulary during the Policy Year, it will continue to be covered at the tier Copayment the drug was originally listed at, until Your next plan renewal date. We will provide written notice of the modification to the affected Employer Group and each affected Insured Person not later than the 60th day before the Effective Date of the modification.

For a complete prescription drug list, visit FirstCare.com.

Pharmacy Benefit Manager

FirstCare uses Optum Rx as a pharmacy benefit manager (PBM). Optum Rx helps manage our pharmacy network, conducts drug utilization reviews, as well as oversees many other aspects for our members. Optum Rx also fills the FirstCare prescription mail order program.

OPTUM Rx®

Emergency & Urgent Care

You never know when you may need medical help, so it is important for you to know in advance how you will contact your doctor. You are covered for medical emergencies both inside and outside the service area.

Emergency Services

If you are having an emergency and need immediate medical care, go to the nearest emergency room (ER) or call 9-1-1. They can send an ambulance to help you get to the ER.

If you're not sure how urgent your symptoms are, or would like to speak with a nurse, contact FirstCare's 24/7 Nurseline at 1-855-828-1013. A registered nurse can guide you through your next recommended course of action.

If you do end up seeking emergency services, call your doctor and FirstCare to let us know you needed and received emergency services. You will also need to schedule your follow-up care with your doctor. If you are unable to make this call, a family member should contact Customer Service within 24 hours, or as soon as possible, following treatment or hospitalization.

If you are required to pay for emergency services at the time of service, please call or email Customer Service to request a reimbursement form. You should complete this form and return it to FirstCare along with a copy of the medical report and the itemized bill for the services you received.

You must file a claim with us within 90 days from the date you incurred covered health services. We may grant an exception to the 90-day filing rule if you can provide documentation about why the claim could not be filed within 90 days.

Reimbursement will not be allowed if a claim is made after one year from the date that the health services were provided.

What is an URGENT condition?

- Earache
- Cuts and scrapes
- Severe diaper rash
- Low-grade fever
- Repeated vomiting
- Repeated diarrhea
- Cold and flu
- Persistent cough
- Sprain
- Fainting or blackouts

What is an EMERGENCY situation?

- Chest pain
- Choking
- Poisoning
- Severe wound
- Heavy bleeding
- Broken bones
- Severe burns
- Drug overdose
- Sudden trouble breathing
- Severe spasms/convulsions
- Loss of speech
- Sudden loss of feeling
- Paralysis
- Severe dizzy spells
- Loss of consciousness

If you are having an emergency and need immediate medical care, go to the nearest emergency room (ER) or call 9-1-1.

Hospitalization

Your Primary Care Physician (PCP) or referral specialist will determine when hospitalization is required. Your admitting doctor and/or hospital will notify FirstCare.

Every hospital admission is monitored by a nurse or case manager from the day of admission to the day of discharge. This helps ensure that you receive the care that you need.

Our FirstCare nurses help with discharge planning to make sure that you also receive the care you need once you are home.

If you are admitted to a hospital as a result of an emergency, you must notify FirstCare within 24 hours of admission to the hospital (or as soon as possible).

This will help with the coordination between the emergency care you receive and any follow-up care you may require.

Costs associated with authorized or emergency hospital care are covered according to your Certificate of Insurance. Care that is not authorized or that is not deemed to be a true emergency will be your financial responsibility.

Getting Care While Traveling

In a true emergency, go to the nearest emergency room. Then call Customer Service at the number on your ID card as soon as possible.

If you need medical care while traveling, call the Customer Service number on your ID card and we will help you find a provider for the care you need. FirstCare does not cover medical service outside of the U.S.

After-Hours Care

If you need medical care after business hours, call your PCP's office or the after-hours phone number.

If your PCP is not available, you will be taken care of through the on-call arrangement established by your PCP. It is important to ask your PCP how the on-call process works.

Your PCP or an on-call doctor will be available to provide medical advice and instruction. Please limit after-hours calls and weekend calls to emergencies or urgent care situations.

Out-of-Network Coverage

Your plan includes out-of-network benefits. To search for providers outside of your plan's network, visit

Emergency & Urgent Care (continued)

FirstCare.com/FindAProvider and select the network name listed on your ID card. To view instructions on using the Provider Finder tool, click here. For additional provider information, such as provider credentials, not found in the Provider Finder, please contact Customer Service using the phone number on the back of your FirstCare member ID card.

Understanding Your Plan

This section explains your financial responsibility as a member, including your premium, copayments, deductible and out-of-pocket maximum. This is only a brief overview. For a complete description of these costs, please refer to your Certificate of Insurance.

Premium

Your premium is the amount you pay for your health insurance every month.

Copayments

Copayments are what you owe for specific services, which are due at the time of service. Doctors who are part of the FirstCare network have agreed to accept our payment along with your copayment as the entire cost of the services. If you receive a bill for any covered service from a plan provider, please contact Customer Service.

Deductible

For members enrolled in a consumer choice plan, the deductible is the amount you are responsible for paying for covered services until you reach your deductible amount, if any. Once you've met your deductible, FirstCare will begin paying for covered services.

NOTE: Unless stated, your deductible typically does not include costs such as office visit copays.

Out-of-Pocket Maximum

If your deductible and coinsurance payments reach the plan's out-of-pocket maximum, you are done paying. FirstCare will pay 100% of covered services for the remainder of your plan year. This limit is there to protect you and your covered dependents in case of a major medical event.

Claim Submission

FirstCare does not expect you to make payment for covered health services, beyond the required copayments/coinsurance, when seeking care from a FirstCare network provider. However, if you pay for covered health services in addition to the required copayment(s), you must file a claim with FirstCare within 180 days from the date you received those covered health services, unless you can document, as soon as reasonably possible after the 180-day period, a good cause as to why the claim could not be filed within this time period.

NOTE: Reimbursement will not be allowed if a claim is made beyond one year from the date of service the covered health services were first acquired.

You can obtain forms for the submission of written proof of payment by contacting Customer Service at the phone number listed on your ID card for more information.

Once you fill out the claim form, mail it to:

FirstCare Health Plans
P.O. Box 85395
Richardson, TX 75085-3935

For questions about submitting claims, contact Customer Service.

NOTE: You may be able to reduce some of your out-of-pocket costs for an out-of-network medical or health care claim that is eligible for mediation by contacting the Texas Department of Insurance at www.tdi.texas.gov and 1-800-252-3439.

Limitations and Exclusions

The following is a list of benefits and services that are not covered by your PPO plan. For complete descriptions of excluded benefits and services, please refer to your Certificate of Insurance.

Prescription Drug Limitations

- Drugs that by law do not require a prescription unless listed in the Formulary.
- Prescriptions written in connection with any treatment or service that is not a covered benefit unless listed in the Formulary.
- With the exception of contraceptive devices, devices of any kind, even those requiring a prescription, including but not limited to therapeutic devices, health appliances, hypodermic needles or similar items.
- Any medication that is not Medically Necessary. Denials for medications that are not Medically Necessary are subject to the Member Complaint and Appeal Procedures outlined in Section 9 of your Certificate of Insurance.
- Any over-the-counter medications that are not required by the Patient Protection & Affordable Care Act (PPACA).
- Vitamins, minerals, and/or nutritional supplements that are not required by the PPACA (regardless of whether or not these are Legend or over-the-counter).
- Medications prescribed for non-FDA approved indications, referred to as off-label drug use, are not covered. This includes experimental, investigational, and any disease or condition that is excluded from coverage under the Certificate of Insurance; or that the FDA has determined to be contraindicated for treatment of the current indication. Off-label drug use may be covered if the drug is approved by the FDA for at least one indication; and is recognized for treatment of the indication for which the drug is prescribed in substantially accepted peer-reviewed medical literature.
- Appetite suppressants; anti-smoking aids in excess of what is required by Section 2713 of the Patient Protection & Affordable Care Act; medications used for any cosmetic improvement, including wrinkles, uncomplicated nail fungus regardless of ambulation or pain; hair loss, growth or removal; idiopathic non-growth hormone deficiency short stature; and, DESI Drugs.
- Prescriptions or refills that replace lost, stolen, spoiled, expired, spilled or are otherwise misplaced or mishandled by you.
- Prescriptions written for the treatment of infertility.
- Compound Medications
- Anything which is not specified as covered or not defined as a drug, such as therapeutic devices, appliances,

Limitations and Exclusions (continued)

machines including syringes, except disposable syringes for insulin dependent Members, glucometers, and asthma spacers;
- Drugs used for Treatments or medical conditions not covered by this Certificate of Insurance;
- Any initial or refill prescription dispensed more than one (1) year after the date of the Health Professional's order;
- Except for medical emergencies, drugs not obtained at a Network Pharmacy;
- Drugs given or administered to You or a Covered Dependent while at a hospital, skilled nursing facility, or other facility;
- Blood, blood plasma, and other blood products; except as covered by Medical benefits under the Certificate of Insurance;
- A prescription that has an over the counter alternative;
- Initial or refill prescriptions the supply of which would extend past the termination of this Certificate of Insurance, even if the Health Professional's order was issued prior to termination.

Medical Limitations

1. Additional expenses incurred as a result of the Insured's failure to follow a Plan Provider's medical orders.
2. Ambulance services/transportation are not covered:
   - When another mode of transportation is clinically appropriate;
   - For stable, non-emergency conditions, unless pre-authorized;
   - When provided for the convenience of the Insured, family, companion, ambulance provider, Hospital, or attending Physician;
   - Where no transportation of an Insured occurs.
3. Assistant Surgeons, unless determined to be Medically Necessary.
4. Biofeedback services, except for the treatment of acquired brain injury and for rehabilitation of acquired brain injury.
5. Circumcision in any male other than a newborn (age 30 days or less), unless Medically Necessary.
6. Personal comfort, hygiene or convenience items, services or supplies not directly related to the Insured's care, including, but not limited to: guest meals, accommodations, telephone charges, admission kits, radio, television, beauty/barber services, wigs, clothing, take-home supplies, travel or travel time, even if prescribed by a physician.
7. The following cosmetic, plastic, medical, or surgical procedures, and cosmetic therapy and related services or supplies, including, but not limited to hospital confinements, prescription drugs, diagnostic laboratory tests, and x-rays or surgery and other reconstructive procedures (including any relates prosthesis, except breast prosthesis following mastectomy and craniofacial reconstruction). Among the procedures that We do not cover are:
   - Excision or reformation of any skin on any part of the body, hair transplantation, removal of port wine stains, chemical peels or abrasions

Limitations and Exclusions (continued)

of the skin, removal of superficial veins, tattoos or tattoo removal, the enlargement, reduction, implantation, or change in the appearance in a portion of the body unless determined to be Medically Necessary;
- Removing or altering sagging skin;
- Changing the appearance of any part of Your body (such as enlargement, reduction or implantation, except for breast reconstruction following a mastectomy);
- Hair transplants or removal;
- Peeling or abrasion of the skin;
- Any procedure that does not repair a functional disorder; and
- Rhinoplasty and associated surgery, except when Medically Necessary to correct deviated septum.

8. Cryotherapy devices such as PolarCare™.
9. Custodial Care, respite, or domiciliary care. Custodial care is care that:
   - Primarily helps with or supports daily living activities (such as, cooking, eating, dressing and eliminating body wastes. bathing, dressing); or
   - Can be given by people other than trained medical personnel.
10. All expenses associated with routine dental care or oral surgery (except for corrective treatment of an accidental Injury to natural teeth) or any treatment relating to the teeth, jaws, or adjacent structures (for example, periodontium), including but not limited to:
    - Cleaning the teeth;
    - Any services related to crowns, bridges, filings, or periodontics;
    - Rapid palatal expanders;
    - X-rays or exams;
    - Dentures or dental implants;
    - Dental prostheses, or shortening or lengthening of the mandible or maxillae, correction of malocclusion, and any non-surgical dental care involved in the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome, such as oral appliances and devices;
    - Treatment of dental abscess or granuloma;
    - Treatment of gingival tissues (other than for tumors);
    - Surgery or treatment for overbite or underbite and any malocclusion associated thereto, including those deemed congenital or developmental anomalies; and
    - Orthodontics, such as splints, positioners, extracting teeth, or repairing damaged teeth.
11. The following devices, equipment, and supplies are excluded:
    - Corrective shoes, shoe inserts, arch supports, orthotic inserts and devices except for those described in Section 4 of your Certificate of Insurance, or for the treatment of diabetes.
    - Comfort or convenience items, such as bathtub chairs, whirlpool tubs, safety grab bars, stair gliders or elevators, over-the-bed tables, bed boards, saunas, exercise equipment, and institutional equipment, such as air fluidized beds and diathermy machines.
    - Environmental control equipment, such as air conditioners, purifiers, humidifiers, dehumidifiers, electrostatic

Limitations and Exclusions (continued)

machines, and heat lamps;
- 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.
- Sequential lymphedema compression devices, except for treatment after a mastectomy.

12. The following drugs, equipment, and supplies, except immunizations and prescribed treatment of Phenylketonuria (PKU), diabetes and Autism Spectrum Disorder.
    - Outpatient prescription drugs, except as covered by a Rider.
    - Medications for use outside of the hospital or other inpatient facility, including take-home and over-the-counter drugs, except those used in the treatment of diabetes or as covered by a Rider.
    - Experimental drugs and agents; or
    - Drugs used to treat cosmetic conditions.
    - Drug Efficacy Study Implementation (DESI) Drugs
13. Educational testing and therapy, motor or language sills, or services that are educational in nature or are for vocational testing or training except in cases of Autism Spectrum Disorder and Acquired Brain Injuries.
14. Special education, counseling, therapy, care, evaluation, training, and treatment of learning disabilities, disorders, deficiencies, or behavioral problems.
15. Electron Beam Tomography (EBT)
16. Treatments, services, or supplies for non-emergency care at an emergency room.
17. Weekend admission charges for non-emergency care services.
18. Non-Emergency confinement, treatment, services, or supplies received outside the United States.
19. Equine or Hippo therapy, except for Autism Spectrum Disorder (as covered under this Policy).
20. The following equipment and supplies, except as provided for the treatment of diabetes, and Autism Spectrum Disorder (as covered under this Policy):
    - All Durable Medical Equipment, except as provided herein; and
    - Disposable or consumable outpatient supplies, such as needles, blood or urine testing supplies (except supplies used in the treatment of diabetes and allergy syringes) and sheaths, bags, elastic garments and bandages, home testing kits, vitamins, dietary supplements, and replacements, special food items and formulas (except for formulas necessary to treat phenylketonuria or other heritable diseases).
21. Experimental or investigational drugs, devices, treatments, or procedures. This includes any drug, device, treatment, or procedure that would not be used in the absence of the experimental or investigational drug, device, treatment, or procedure. We consider a 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

Limitations and Exclusions (continued)

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 requires it to be reviewed and approved by that committee. This exclusion also applies if the informed consent form used with the 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 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 III 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 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 drug, device, treatment, or procedure.

22. Routine foot care, including treatment of weak, strained or flat feet, corns, calluses, or medications such as Lamisil or Sporanox for the treatment of uncomplicated nail fungus. We also do not cover corrective orthopedic shoes, arch supports, splints or other foot care items, except for the treatment of diabetes. This will not apply to the removal of nail roots.
23. Genetic counseling and testing, with the exception of those required under applicable state or federal law and Medically Necessary perinatal genetic counseling. Genetic testing related to pre-implantation of embryos for in-vitro fertilization is not covered. 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.
24. Hearing Devices: 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.
25. All charges for inpatient hospital days that exceed the medically recommended length of stay for the diagnosis.

Limitations and Exclusions (continued)

26. Health care services for any work-related illness or injury.
27. Illegal acts: Charges for services received as a result of injury or sickness caused by or contributed to by the covered person engaging in an illegal act or occupation or by committing or attempting to commit a crime, criminal act, assault or other felonious behavior. 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 covered person 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.
28. Illness or injury incurred as a result of war or any act of war, whether declared or undeclared, and whether or not the Insured served in the military.
29. Infertility treatment, infertility drugs, reversal of voluntary sterilization; gamete intra-fallopian transfer (GIFT); zygote intra-fallopian transfer (ZIFT); in vitro fertilization (IVF); any costs related to surrogate parenting; sperm banking for future uses; medical services for artificial insemination; or any assisted reproductive technology or related treatment, unless an additional Rider is purchased.
30. Any services or items for which you have no legal obligation to pay, or for which no charge would ordinarily be made, unless we have authorized such services in advance, or the care provided was of an emergent or urgent nature. Examples of this include care for conditions related to your military service, care will you are in the custody of any government authority, and any care that is required by law to be given in a public facility.
31. Appearance at court hearings and other legal proceedings.
32. Massage therapy, unless associated with physical therapy modality provided by a licensed physical therapist.
33. Mastectomy for relief of pain, prophylactic mastectomy to reduce the risk of breast cancer occurrence to prevent breast cancer, (except when you have been previously diagnosed with breast cancer), or due to any disease or illness other than for the treatment of breast cancer.
34. Inpatient and outpatient treatment, surgery, service, procedures, or supplies that are not Medically Necessary; even if they are prescribed or recommended by a health care provider, dentist, or ordered by a court of law, except when prescribed for the treatment of diabetes. Any denials for Experimental/Investigational drugs, devices, treatments or procedures are eligible for review by an IRO. See Section 9 of the Certificate of Insurance for information on Complaints and Appeal Procedures.
35. Mental health services for the following conditions: mental retardation; senile deterioration, such as progressive dementia of Alzheimer's and Alzheimer's like diseases; sleep disorders and factitious disorders. Marriage counseling, is not a

Limitations and Exclusions (continued)

covered health service.

36. Charges for missed appointments and charges for completion of claim forms.
37. Charges that exceed Non-Preferred Provider Reimbursement amounts.
38. If a service is not covered under your policy, we will not cover any services that are related to it. Related services are:
    - Services provided in preparation for the non-covered service;
    - Services provided in connection with providing the non-covered service; or
    - Services that are usually provided following the non-covered service, such as follow-up care or therapy after surgery.
    - All care related to services that are not covered, including direct complications and pre or post care except for complications of pregnancy.
39. Obesity: Services intended primarily to treat obesity, such as gastric bypasses and balloons, vertical sleeve gastrectomy, bileo-pancreatic diversion (duodenal switch), vertical banding, stomach stapling jaw-wiring, , gastric plication, vagal blocking therapy, AspireAssist, intragastric balloon, weight reduction programs, gym memberships, gym equipment, prescription drugs or other treatments for obesity (except preventive services related to obesity including screening for obesity in adults, counseling and behavioral interventions to promote sustained weight loss, diet and behavioral counseling in primary care to promote healthy maintenance of hyperlipidemia and cardiovascular risk factors along with other diet-related chronic disease factors) even if prescribed by a physician you have medical conditions that might be helped by weight loss, regardless of Medical Necessity. Any complications/services related to the treatment of obesity will not be covered under this policy.
40. Prophylactic oophorectomy: removal of one or both ovaries in the absence of malignant disease to reduce the risk of ovarian cancer occurrence.
41. Orthotripsy and related procedures.
42. Outpatient services received in federal facilities or any items or services provided in any institutions operated by any state government or agency when you have no legal obligation to pay for such items or services, except for treatment provided in a tax supported mental health institution or by Medicaid.
43. Intradiscal Electrothermal Annuloplasty (IDET) procedures for pain management.
44. Physical examinations, health reports, and treatments and/or evaluations required for employment, flight clearance, camp, insurance, school, sports, or legal proceedings.
45. Physicals are limited to one per policy year unless Medically Necessary.
46. Physical therapy services, unless rendered by a physical therapist or any other provider acting in the scope of the provider's license.
47. Elective, non-therapeutic termination of pregnancy (abortions), including any abortion-inducing medications, except where the life of the mother would be endangered if the fetus were to be carried to term or a medical emergency places the woman in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed.

Limitations and Exclusions (continued)

48. All internal and external prosthetic items and devices, except for those that are medically necessary and specified in Section 4 of the Certificate of Insurance. We do not cover splints unless they are needed for urgent or emergency treatment and/or in lieu of castings or surgery.
49. Reports: Special medical reports not directly related to treatment.
50. Long-term rehabilitative services. Long-term is defined as more than two months. Limitations do not apply to Acquired Brain Injury, Therapies for Children with Developmental Delays or Autism Spectrum Disorder as specified in Section 4, *What is Covered* of the Certificate of Insurance.
51. Any services or supplies furnished at a facility which is primarily a place of rest, a place for the aged, a nursing home, or similar institution.
52. All services or supplies provided while the insured is not covered under this policy; either before the Effective Date of coverage or after this Certificate of Insurance ended.
53. Services associated with autopsy or post-mortem examination unless requested by us.
54. Services provided and independently billed by interns, residents, or other employees of hospitals, laboratories, or other medical facilities.
55. Services that are provided, paid for, or required by state or federal law where the Certificate of Insurance is delivered, except under Medicaid, when in the absence of insurance, there is no charge for that service.
56. Services, except dental services that are supplied by a person who ordinarily resides in Insured's home or is a family member of the Insured.
57. Services received while not under the care and treatment of a physician.
58. Services not completed in accordance with the attending physician's orders.
59. Services required as a result of Experimental/Investigational drug testing done voluntarily by you without our authorization. Any denials for Experimental/Investigational drugs, devices, treatments or procedures are eligible for review by an IRO. See Section 9 in your Certificate of Insurance for information on Complaints and Appeal Procedures.
60. Volunteer services, which would normally be provided at no charge to you.
61. The following types of therapy, counseling, and related services, or supplies:
    - For or in connection with marriage, family, child, career, social adjustment, finances, or medical social services;
    - Acupuncture, naturopathy, psychosurgery, megavitamin, and nutritionally based alcohol therapy;
    - Hypnotherapy or hypnotic anesthesia, or biofeedback; or
62. Reversal of a sterilization procedure regardless of Medical Necessity.
63. Infertility drugs, reversal of voluntary sterilization; gamete intra-fallopian transfer (GIFT); zygote intra-fallopian transfer (ZIFT); in vitro fertilization (IVF); any costs related to surrogate parenting; or any assisted reproductive technology or related treatment, unless an additional rider has been purchased.
64. Sports cords and transcutaneous electrical

Limitations and Exclusions (continued)

nerve stimulation (TENS) units.

65. Sports rehabilitation refers to continued treatment for sports related injuries in an effort to improve above and beyond normal ability to perform activities of daily living (ADLs). Sports-related rehabilitation or other similar avocational activities is not covered 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.
66. Oral appliances and devices for temporomandibular joint (TMJ) syndrome.
67. Transportation, except for ambulance or air ambulance used for transport in a medical emergency or when we have preauthorized services for medical transport purposes only (e.g. from a hospital to a skilled nursing facility).
68. Treatment a school system is required to provide under any law.
69. Adult Vision Care Services (for Insureds over the age of 19): Eye examinations to determine the need for corrective lenses, or the presence of vision problems; eyeglasses (including eyeglasses and contact lenses prescribed following vision surgery); contact lenses, except for treatment of Keratoconus; any other items or services for the correction of Your eyesight, including but not limited to eye exercises, orthoptics, vision training, vision therapy, radial keratotomy (RK), automated lamellar keratoplasty (ALK or LK), astigmatic keratotomy (AK) and photo refractive keratectomy (PRK-laser) unless specifically provided in Section 4, What Is Covered, or as provided by a Rider.
70. Pediatric Vision Care Services (for Insureds through the age of 18:
    - Routine eye exam do not include professional services for contact lenses
    - Laser eye surgery (LASIK)
    - Any vision service, treatment or materials not specifically listed as a covered service;
    - Services and materials not meeting accepted standards of optometric practice;
    - Telephone consultations;
    - Any services that are strictly cosmetic in nature including, but not limited to, charges or personalization or characterization of Prosthetic appliances;
    - Special lens designs of coatings other than those described in this benefit;
    - Replacement of lost/stolen eyewear;
    - Non-prescription (Plano) lenses;
    - Two pairs of eyeglasses in lieu of bifocals;
    - Insurance of contact lenses.

Prior Authorization & Step Therapy

Prior Authorization & Step Therapy

The Pharmacy and Therapeutics Committee (P&T) is a group of doctors, pharmacists, and other health care professionals that review pharmaceutical drugs.

These health care professionals are dedicated to ensuring members have access to safe and cost-effective medications. The P&T Committee manages the drug formulary. To ensure drugs are used safely and appropriately, they may place restrictions on certain medications such as prior authorization, step therapy requirements, or quantity limits.

Prior authorization is commonly used to manage appropriate medication use. Certain medications require prior authorization to be covered. This requires your doctor to submit clinical documentation to demonstrate that the drug is medically necessary to treat your condition

Step therapy is the practice of starting a prescription treatment with the most cost effective and safest drug therapy, and progressing to other more costly or risky therapy, only if necessary.

Step therapy protocols do not apply to drugs used to treat Stage 4 Advanced Metastatic Cancer or associate conditions.

In addition, some drugs have limitations on how much can be filled. This is known as a quantity limit.

The P&T Committee reviews the drug formulary and restrictions monthly and as new drugs and drug therapies become available.

If your medication is not in the formulary, there is an exceptions process. This allows you or your prescriber to request access to drugs not listed on formulary if your prescriber believes the drug is medically necessary.

To find out more about how to submit a prior authorization or exception request visit FirstCare.com or call the Customer Service number on your ID card.

Authorizations for Special Care

Program Overview

To provide the right care at the right time, in the right place, FirstCare's utilization management program helps determine the care and treatment needed for our members.

The utilization management program reviews various requirements and determines appropriate medical coverage for initial and ongoing care needs.

FirstCare reviews requests on a case-by-case basis, so that we consider what's best for the member and to ensure we follow evidence-based care guidelines.

FirstCare does not use incentives to encourage barriers to care and services, specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service care, or provide incentives for utilization review decision makers that result in underutilization. Utilization management decision making is based only on the appropriateness of care and service and the existence of coverage.

Prior Authorization

Some medical services may need to be approved before the service is covered. Refer to the pre-authorization list posted on FirstCare.com or contact Customer Service at the phone number on your ID card to determine if a specific service requires pre-approval.

Your provider is responsible for contacting FirstCare and requesting the approval for the service or treatment. FirstCare will review the request and respond to a request for preauthorization within the following time periods:

- For non-hospitalized requests, a determination will be issued and transmitted not later than the third calendar day after the date the request is received by us.
- If the proposed medical or health care services are for concurrent hospitalization care, we will issue and transmit a determination indicating whether proposed services are preauthorized within 24 hours of receipt of the request.
- If the proposed medical care or health care services involve post-stabilization treatment, or a life-threatening condition we will issue and transmit a determination indicating whether proposed services are preauthorized within the time appropriate to the circumstances relating to the delivery of the services and Your condition, but in no case to exceed one hour from receipt of the request.

Your Physician may submit a request to renew an existing authorization at least 60 days before the authorization expires. We shall, if practicable, review the request for medical necessity and issue a determination before the existing authorization expires

FirstCare follows all of the required approval time frames to prevent the delay of needed

If you have questions about authorization of services, you can reach our Utilization Management department by calling the Customer Service number listed on your ID card. Utilization Management representatives are available from 8 a.m. to 5 p.m., Monday through Friday; and 9 a.m. to noon on weekends and holidays.

care. Prior authorizations are never required for urgent or emergent care, such as a visit to an urgent care center or to the emergency room. Please review your Certificate of Insurance for more information about definitions for emergent or urgent care.

Medical Coverage Decisions

FirstCare uses the Texas Department of Insurance coverage guidelines, nationally recognized guidelines, and guidelines from national medical specialty organizations to make decisions about medical coverage.

FirstCare works together with the member's provider to review clinical information needed to make appropriate and prompt decisions.

Members or providers can learn more about coverage requirements for a specific service or treatment by contacting Customer Service.

Medical coverage decisions can be made in advance of the treatment or services; during the service to review for ongoing Medical Necessity, or after the treatment to verify that the services were medically needed.

FirstCare educates our network providers about how the medical coverage decision process works, and how they can ensure that FirstCare has all of the required information in order to make medical decision.

When a FirstCare network provider refers members to non-network providers, FirstCare works with the referring provider and member to educate about providers available that can provide the service within the FirstCare network. This is so that our members can receive care from providers that are known to deliver quality and best-practice recommended care to our members.

Continuity of Care

In the event that you are under the care of a provider who stops participating in the FirstCare network, you will be notified. Special circumstances may exist where we will continue to provide coverage for that provider's services even though he or she is no longer in the FirstCare network.

Special Circumstances

Special circumstances may include a person with a disability, an acute condition, a life-threatening illness, undergoing a course of treatment, or who is past the 24th week of pregnancy.

We will continue to provide coverage only if all the following conditions are met:
The provider submits a written request to us for continued coverage of your care. The request must (a) identify the condition for which you are being treated and (b) indicate that the provider reasonably believes that discontinuing his or her treatment of you could cause harm to you; and the provider agrees to continue accepting the same rate of reimbursement which applied when he or she was still a plan provider, and agrees not to seek payment from you for any amounts for which you would not be responsible if the provider were still participating in the FirstCare network.
The continuity of coverage available under this section shall not exceed 90 days beyond the date the provider's termination takes effect, except for members who are past the 24th week of pregnancy at the time the provider's termination takes effect. Coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six weeks of delivery. You will continue to be responsible for appropriate copayments.

Complaint Procedures

If a problem should arise concerning the provision of health services or benefits, please discuss your concern with your physician, or call FirstCare at the Customer Service number on your ID card.

Filing a Complaint

A written complaint may be directed to FirstCare as explained in the "Member Complaint Procedure" section of your Certificate of Insurance. Send your letter to:

SHA, L.L.C. dba FirstCare
Director, Complaints & Appeals
1901 West Loop 289, Suite 9
Lubbock, TX 79407

Any member who is dissatisfied with any aspect of FirstCare's operation may file a complaint with our Complaint and Appeals Department. We will resolve your complaint within 30 days of receiving a written complaint. Your complaint concerning an emergency or denial of continued stay for hospitalization will be resolved in one business day of receipt of your complaint. This investigation and resolution shall be concluded in accordance with the medical immediacy of the case.

Filing an Appeal

If you disagree with our resolution, you may appeal our decision. A panel of staff members, physicians or other providers, and FirstCare members will hear the appeal. You may appear in person before the appeal panel and present evidence.

You may appeal our decision that a service is not Medically Necessary. A provider who was not involved in the initial decision will review our decision. A complaint filed concerning dissatisfaction or disagreement with an adverse determination constitutes an appeal of that adverse determination. The procedures for appealing an adverse determination may be appealed orally or in writing by:

1. an enrollee;
2. a person acting on the enrollee's behalf; or
3. the enrollee's physician or other health care provider

Independent Review Organization

If you disagree with our decision on your appeal or if the situation is an emergency, you have the option to appeal to an independent review organization (IRO). We will provide information on how to appeal to an IRO at the time of the denial of the appeal, and we will provide the prescribed form which needs to be completed and returned to us to begin the independent review process. In life-threatening situations, you may contact us by telephone to request the review and provide the required information.

We welcome your complaints and we will not retaliate against any member or employer group because a complaint is filed.

Other Health Care Services

FirstCare has established relationships with local doctors, clinics, and hospitals in your area to ensure you have access to quality, affordable care.

Finding a Provider

To search for an PPO participating provider, visit FirstCare.com/FindAProvider and select the network named, FirstCare PPO. Or, you can contact Customer Service at the phone number on your ID card.

For additional provider information, such as provider credentials not found in the Provider Finder, to obtain a non-electronic copy of the current Provider Directory, or to obtain assistance to find available in-network providers, please call the Customer Service phone number located on the back on your ID card.

Specialists

You don't need a referral to see a specialist in your network. To find a specialist in your network, visit FirstCare.com/FindAProvider and select the network name listed on your ID card.

Out-of-Network Coverage

If you seek care from a provider who is not in the FirstCare network, an authorization is required. You may incur additional out-of-network costs. This is explained further in your Certificate of Insurance.

Behavioral Health Providers

There may be times you are upset, worried, blue, or just not feeling like yourself. Or, you may have just lost a loved one, or could be dealing with an addiction. As a FirstCare member, you may call your doctor to get help, or you can call FirstCare at 1-800-327-6943 to talk to someone in complete confidentiality about what's troubling you. You do not need a referral from your PCP to see a mental health provider.

Your Primary Care Physician

When you join a FirstCare PPO plan, you are encouraged to choose a Primary Care Physician, often referred to as a PCP. You can choose a family or general practice doctor, a nurse practitioner, physician assistant, an internist, a OB/GYN, or a pediatrician.

Getting Started

PPO members are encouraged to select a PCP from our network. This doctor can help coordinate and manage your health care needs, including specialty referrals, laboratory services, X-rays, and hospital stays. Your PCP is interested in you as an individual. It is important to give your PCP information about your health history, lifestyle, and current health status. This will help your doctor provide the best possible care they can. Your PCP will treat you when you are sick, but they will also focus on wellness and prevention. This level of care has been shown to reduce the risk of serious chronic conditions like diabetes and high blood pressure. When you choose a PCP, your doctor can help oversee your care. You won't have to figure it out on your own.

Making Appointments

All non-emergency visits to your PCP should be by appointment. When you call your doctor's office to make an appointment, please have your member ID card available.

Be sure to tell them you are a FirstCare member. If you have questions on scheduling an appointment or have difficulty scheduling an appointment within a reasonable time period, contact Customer Service for assistance.

Please note that it may take longer to get an appointment with your doctor for a preventive annual visit.

Selecting or Changing your PCP

To select or change your PCP, go to the FirstCare Member Portal at FirstCare.com or call Customer Service at the phone number on your ID card.

Remember to do the following:

- Carry your member ID card with you at all times. Bring it with you for each doctor visit.
- Obtain a referral from your PCP before making an appointment with a specialist doctor.
- Before your first appointment, be sure to show up early to complete any necessary paperwork.
- Notify your doctor's office at least 24 hours in advance if you need to cancel or reschedule an appointment.
- Write down a list of concerns and questions that you have before the appointment so you don't forget to ask them.
- Write down a list of the medications, supplements, and vitamins that you take. Know what they are for, how much you take (dosage), and how often.

Case Management

When a member is diagnosed with complex health problems, FirstCare has Case Managers available to help.

Case Management Services

Some of the assistance that a Case 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 the member better understand their conditions and how to better manage them.
- Help with learning how to navigate the healthcare system and better understand benefits.

Complex Case Management

Case Management services may be longer term and/or very frequent for members with catastrophic or highly complex problems. In these situations, a FirstCare Case Manager will assist you in understanding your condition and needs for services, and with coordinating the health care services that you and your doctor determine are needed. Your Case Manager stays in touch with your doctor and other caregivers and helps you find needed care within your plan network.

Short-Term Case Management

Case Management services may be short-term, such as when a member is new to our plan and needs help getting existing health care services transferred to doctors or other providers that are in their FirstCare plan network.

Transitional Case Management

It can happen that a FirstCare Member reaches the plan limits on certain types of care. FirstCare Case Managers, who may be nurses or social workers, are available to help you with finding community and other resources when this occurs. Transitional Care Case Managers also assist members by helping with transitions between hospital and home or other care settings and helping members access needed health and support services.

Pediatric-to-Adult Care Case Management

A Case Manager is available to help when you or your child needs help arranging for adult care during a transition from child/adolescent needs to adulthood.

Case Management is available at no extra cost. Enroll by calling the Customer Service number on your FirstCare Member ID card, or through TTY 711. You may choose to participate or opt-out at any time.

The FirstCare.com Provider Search is also available to help find an adult Provider for someone entering adulthood. To contact a Case Manager for help with a transition, call the Customer Service number listed at the front of this booklet or by sending an email to casemgmt@FirstCare.com.

NOTICE TO MEMBER: *Upon receipt of a bill for covered services from any physician or provider, please contact FirstCare Customer Service at the phone number on your ID card.*

Disease Management

FirstCare wants to make sure you have enough accurate and current information on how to manage your health. Our Disease Management programs provide support to help you manage chronic conditions and live your healthiest life. We will reach out and invite you to take part in this program when we notice from your insurance claims that you have asthma, coronary (heart) disease, COPD (emphysema/bronchitis), diabetes, or heart failure.

Disease Management Programs

Participants receive:

- Education about the condition via mailed materials.
- Access to a specially trained nurses to learn to better understand your condition and to discuss preventive and self-care strategies.
- Self-management tools and up-to-date information about the condition online through the member sign-in at FirstCare.com.
- Care reminders for checkups and recommended preventive care.

Programs are provided at no additional cost for the following conditions:

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

You can sign up, get more information, or opt-out of these programs by calling FirstCare Customer Service at the number on your ID card.

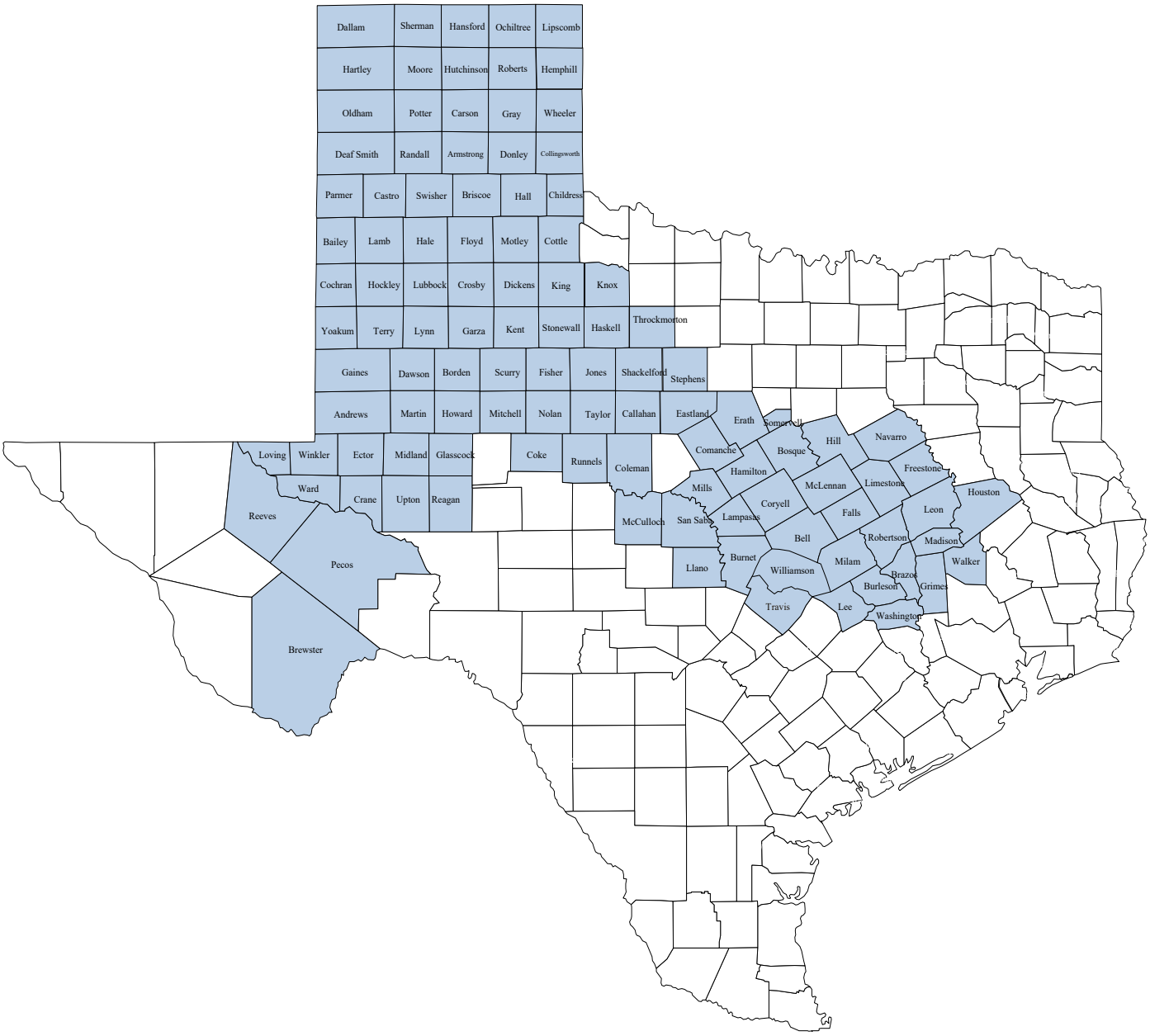
- Wondering if a generic or name brand medication is best?
- Want tips to ease symptoms of a nasty cold?
- Don't know if something is a medical emergency?

Call Nurse24™ at 1-855-828-1013

You can talk with a registered nurse anytime you have questions or need advice about your health—day or night, even on weekends. The call won't cost you a penny and is always confidential. **TTY users call 1-800-562-5259.**

Translation services are available for limited English speakers in your preferred language through the AT&T Language Line Services. ***Y también hablamos español.***

FirstCare PPO Service Area



Viewing the Access Plan

To view or obtain FirstCare's local market access plan, visit https://firstcare.vitalschoice.com and select "FirstCare Provider Access Plan" below the Resources.

Confidentiality

FirstCare Health Plans respects your right to privacy as well as any dependents you have on your plan. It is our policy to maintain confidentiality of all information relating to our members. According to federal law, any person has the right to have their health information protected. Therefore, it may be necessary for you and/or your dependents to authorize access to protected health information. You may call Customer Service to inquire about privacy laws and your rights.

Evaluation of New Technology

FirstCare Health Plans will evaluate new treatments, devices, drugs, procedures, and technologies in coordination with the Texas Department of Insurance (TDI) coverage rules. FirstCare's Medical Technology Assessment Committee, led by our medical directors, uses information from scientific research to decide if these services have been proven to be effective and safe, and FirstCare will follow TDI guidance.

If a new treatment, device, drug, procedure or technology is found to be effective and safe, FirstCare will follow TDI guidelines for the approval of the new technology and will approve for our PPO members if TDI chooses to approve the technology. If a new service is not approved by TDI for general use or is deemed to be experimental, it will usually not be covered. In some cases, your contract may exclude coverage specifically.

Member Notices

Women's Health and Cancer Rights Act (WHCRA) of 1998

As required by the Women's Health and Cancer Rights Act of 1998, this plan provides coverage for:

1. All stages of reconstruction of the breast on which the mastectomy has been performed
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance
3. Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter. Contact Customer Service at the phone number on your ID card for more information.

Self-funded non-federal governmental plans may opt-out of the WHCRA requirements. For more information on WHCRA opt-outs visit www.cms.gov.

Medicaid and the Children's Health Insurance Program (CHIP)

Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in Texas, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office or dial 1-877-KIDS-NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

For more information, please visit www.gethipptexas.com or call 1-800-440-0493.

Member Rights & Responsibilities

As a member of our health plan, you have:

- A right to receive information about your health plan, including the services we offer and our providers and caregivers
- A right to be treated with respect
- A right to have others recognize your dignity
- A right to privacy
- A right to work with providers to make decisions about your health care
- A right to talk openly about appropriate and medically necessary treatment options for your conditions, regardless of cost or benefit coverage
- A right to timely access to your covered services and drugs
- A right to voice complaints or appeals about your health plan, benefit coverage, or your medical care
- A right to information about your rights and responsibilities and a right to make recommendations about our member rights and responsibilities

You are responsible for doing your best to:

- Give your health plan and providers information they need to provide your care; tell your health plan if you move
- Follow plans and instructions for care that you have agreed to with your providers
- Understand your health problems and take part in the treatment plan you and your providers make together

Provider Network Information

- You have the right to an adequate network of preferred providers (also known as "network providers"). If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.
- You have the right, in most cases, to obtain estimates in advance:
  - from out-of-network providers of what they will charge for their services; and
  - from your insurer of what it will pay for the services.
- You may obtain a current directory of preferred providers at the following website: FirstCare.com/Find-a-Provider or by calling the Customer Service phone number on your ID card for assistance in finding available preferred providers.
- If you are treated by a provider or facility that is not a preferred provider, you may be billed for anything not paid by the insurer.
- If the amount you owe to an out-of-network facility-based physician, health care practitioner, or other health care provider, including the amount unpaid by the administrator or insurer, is greater than $500 (not including your copayment, coinsurance, and deductible responsibilities) for services received in a network hospital, you may be entitled to have the parties participate in a teleconference, and, if the result is not to your satisfaction, in a mandatory mediation at no cost to you. You can learn more about mediation at the Texas Department of Insurance website: www.tdi.texas.gov/consumer/cpmmediation.html.
- If directory information is materially inaccurate and you rely on it, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network deductible and out-of-pocket maximum.

HIPAA & Fraud

FirstCare is dedicated to maintaining excellence and integrity in all aspects of its operations and its professional and business conduct. FirstCare is committed to high ethical standards and compliance with all applicable governing laws, rules, and regulations, including the prohibition of misleading sales tactics. FirstCare also recognizes that the detection, investigation, and prevention of fraud, waste, and abuse are vital to maintaining an affordable health care system in this state and country.

Accordingly, FirstCare has developed and implemented a Compliance Program and a Fraud, Waste, and Abuse Plan to effectively articulate and demonstrate the organization's commitment to legal and ethical conduct and to become a function of daily operations. Compliance efforts are designed to establish an organizational culture that promotes prevention, detection, and resolution of instances of conduct that do not conform to federal and state law, federal and state health care program requirements (e.g., the Medicare and Medicaid programs), and FirstCare policies and procedures. These efforts also intend to improve operational quality, to ensure the provision of high quality care, and to reduce fraud, waste, and abuse.

FirstCare has established the following mechanisms for reporting any potential compliance violation, including concerns of suspected fraud, waste and abuse, misleading sales tactics, or inappropriate disclosure of protected health information. Reports of potential violations made by employees, agents, contractors, providers, and enrollees are maintained in a confidential manner. These reporting mechanisms are available 24 hours a day, 7 days a week. Reports may also be made anonymously.

☎	**Compliance Hotline:**	1-866-399-8161
	Compliance Hotline website:	**https://app.mycompliancereport.com/report.aspx?cid=swhp**
	Compliance email:	**SWHPComplianceDepartment@bswhealth.org**
	SIU Email:	**SIUFraudreports@FirstCare.com**

You may also contact the Texas Department of Insurance to report your concerns of suspected fraud, waste, or abuse at 1-800-252-3439 or www.tdi.texas.gov/fraud/index.html.

For more information about reporting fraud, please visit the FirstCare website and refer to www.FirstCare.com/en/Important-Information/Identifying-Reporting-Fraud.

For more information about how FirstCare maintains the privacy of your health information, please visit the FirstCare website and refer to www.FirstCare.com/en/Important-Information.

Notice of Privacy Practices

Para recibir este información en español por favor llame al 1-800-829-6440.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Health Record/Information
We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This Notice of Privacy Practices ("Notice") describes the privacy practices of Baylor Scott & White Health ("BSWH") and its Affiliated Covered Entity ("BSWH ACE") members. An Affiliated Covered Entity ("ACE") is a group of Covered Entities, Health Care Providers and Health Plan under common ownership or control that designates itself as a single entity for purposes of compliance with the Health Insurance Portability and Accountability Act ("HIPAA"). The members of the BSWH ACE will share Protected Health Information ("PHI") with each other for the treatment, payment and health care operations of the BSWH ACE and as permitted by HIPAA and this Notice. As an ACE, BSWH may add or remove Covered Entities as part of the BSWH ACE. For a complete current list of the members of the BSWH ACE, please visit our website at www.BSWHealth.com/PrivacyMatters.The list will also be made available upon request either at our facilities or by contacting us toll-free at 1-866-218-6920. This Notice will tell you about the ways in which we may use and disclose medical information about you and how you can get access to this information. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your records

- You can ask to see or get an electronic or paper copy of your medical records and other health information we have about you by:
  - Contacting the Health Information Management Department at the hospital or the outpatient clinic directly where you received care; or
  - Calling the Scott & White Health Plan ("SWHP") Customer Advocacy line at 844-633-5325 or writing to 1206 West Campus Drive, Temple, TX 76502, ATTN: Customer Advocacy, if you are a member of the health plan.
- We will provide a copy or a summary of your health information in accordance with applicable state and federal requirements. We may charge a reasonable, cost-based fee.
- You may revoke an authorization to use or disclose your health information except to the extent that action has already been taken in reliance on your authorization. To revoke your authorization:
  - Send written notice to the Office of HIPAA Compliance, 2001 Bryan St., Suite 2200, Dallas, TX 75201.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.
- To request an Amendment:
  - Send written notice to the Office of HIPAA Compliance, 2001 Bryan St., Suite 2200, Dallas, TX 75201.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- We will not ask you the reason for your request.
- You may request a confidential communication by:
  - Contacting us in writing at the Office of HIPAA Compliance, 2001 Bryan St., Suite 2200, Dallas, TX 75201.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

- You may request this restriction by:
  - Contacting us in writing at the Office of HIPAA Compliance, 2001 Bryan St., Suite 2200, Dallas, TX 75201.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared your information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why.
- We will include all the disclosures except for those about treatment, payment, health care operations and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- To request a list of those with whom we've shared information:
  - Contact us in writing at the Office of HIPAA Compliance, 2001 Bryan St., Suite 2200, Dallas, TX 75201.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- You may also view a copy of this Notice on our BSWH and SWHP member websites.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your privacy rights have been violated

- You can complain if you feel we have violated your privacy rights by:
  - Contacting us toll-free at 1-866-218-6920, by visiting www.BSWHealth.com/PrivacyMatters or in writing at the Office of HIPAA Compliance, 2001 Bryan St., Suite 2200, Dallas, TX 75201.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling toll-free at 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- For questions or other complaints, you may also contact:
  - The outpatient clinic directly or the Patient Relations Department at the hospital where you received care toll-free at 1-866-218-6919.
- For questions or other complaints relating to Health Plan Coverage:
  - SWHP members contact the Customer Advocacy line at 844-633-5325.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In the following cases, you have both the right and choice to tell us to:

- Share information with your family, close friends or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Fundraising

- We may contact you for fundraising efforts, but you can tell us not to contact you again by letting us know you wish to opt-out of any further fundraising communications.
- Information on how to opt-out will be included in any fundraising communications you may receive.

OUR USES & DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

We can use your health information and share

it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

- We may use your health information to give you information about treatment alternatives or health related benefits/services that may be of interest to you.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.
- We can use and share your health information as necessary to operate and manage our business activities related to providing and managing your health care insurance.

Example: We might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services.

Communications regarding treatment alternatives and appointment reminders

- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Bill for our services

- We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for our services.

For payment

- We can use and share your health information for payment of premiums due to us, to determine your coverage, and for payment of health care services you receive.

Example: We might tell a doctor if you are eligible for coverage and what percentage of the bill might be covered.

For underwriting purposes

- We may use or share your health information for underwriting purposes; however, we will not use or share your genetic information for such purposes.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as the ways mentioned below. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Student immunizations to schools

- We may disclose proof of your child's immunizations to their school based on your verbal or written permission.

Do research

- We can use or share your information for health research.

Food and Drug Administration (FDA)

- We may disclose to the FDA health information relative to adverse events with respect to food, medications, devices, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs or replacement.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services, if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner or funeral director when an individual dies.

Address worker's compensation, law enforcement and other government requests.

We can use or share health information about you:

- For worker's compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral direc-

tor
- We can share health information with a coroner, medical examiner or funeral director when an individual dies.

Address worker's compensation, law enforcement and other government requests
We can use or share health information about you:
- For worker's compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security and presidential protective services

Respond to lawsuits and legal actions
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Electronic Health Information Exchange (HIE)
- We maintain electronic health information about you from other health care providers or entities that are not part of our healthcare system who have treated you or who are treating you and this information is also stored in the HIE.
- Our healthcare system and these other providers can use the HIE to see your electronic health information for the purposes described in this Notice, to coordinate your care and as allowed by law.
- We monitor who can view your information, but the individuals and entities who use the HIE may disclose your information to other providers.
- You may opt-out of the HIE by providing a written request to the Office of HIPAA Compliance, 2001 Bryan St., Suite 2200, Dallas, TX 75201. If you opt-out, your information will still be stored in the HIE, but your information will not be viewable through the HIE.
- You may opt back in to the HIE at any time.
- You do not have to participate in the HIE to receive care.

OUR RESPONSIBILITIES
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this Notice and give you a copy of it.
- We will not use or share your information other than as described here, unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice
We can change the terms of this Notice, and the changes will apply to all information we have about you. The new notice will be available upon request and on our BSWH and SWHP member websites.

Effective Date: December 2018

Your Privacy Rights

You Have the Right to See and Get Copies of Your Records. In most cases, you have the right to get copies of your records. You must make the request in writing by sending a letter to Custodian of Records, FirstCare/SWL&H, 1901 West Loop 289, Suite 9, Lubbock, TX 79407. We require you to include a $10.00 fee for the cost of copying and mailing your records. The records will be a "designated record set", which means we have established a standard set of records for all requests of this nature. If your records are extensive, we may ask you to pay additional copying and postage costs before providing the information. Information about mental health claims or services will not be included: you will need to contact your mental health carrier or mental health providers for that information.

NOTE: FirstCare/SWL&H is a payer of medical health care claims and its "records" consist mostly of claim information. We do not create or maintain "medical records" like those created and maintained by physicians, hospitals, and other medical providers. For those records, you will need to contact your providers. Also, you can obtain many of the same records instantly, and at no charge by using our secure FirstCare/SWL&H Member Web Portals at FirstCare.com.

- Right to Request to Correct or Update Your Records. You may ask FirstCare/SWL&H to change or add missing information to your records if you think there is a mistake. You must make the request in writing, and provide a reason for your request. It is unlikely that we have any records that would require enrollee corrections. We have the right to disagree with any proposed changes and are required to notify you of our action in either regard. Since we are a payer, and not a medical provider, it is unlikely that we would agree to any changes of medical records held by us. We will, or course, make changes to address, phone number, or similar items as appropriate when notified by your employer.

- Right to Get a List of Disclosures. You have the right to ask FirstCare/SWL&H for a list of disclosures of your PHI made after April 14, 2003. You must make the request in writing. This list will not include the times that information was disclosed for routine health plan services which are "treatment, payment, or health care operations" as noted above. The list will not include information provided directly to you or your family, or information that was sent with any previous authorization made by you.

- Right to Request Limits on Uses or Disclosures of PHI. You have the right to ask that FirstCare/SWL&H limit how your information is used or disclosed. You must make the request in writing and tell FirstCare/SWL&H what information you want to limit and to whom you want the limits to apply. FirstCare/SWL&H is not required to agree to the restriction. You can request (in writing or verbally) that the restrictions be terminated.

- Right to Revoke Permission. If you are asked, and agree to sign an authorization to allow FirstCare/SWL&H to use or disclose information, you can cancel that authorization at any time. You must make the request in writing. This will not affect information that has already been shared pursuant to your authorization.

- Right to Choose How We Communicate with you. You have the right to ask that FirstCare/SWL&H share information with you in a certain way or in a certain place. For example, you may ask FirstCare/SWL&H to send information to your work address instead of your home address. You must make this request in writing. You do not have to explain the basis for your request.

- Right to File a Complaint. You have the right to file a complaint if you do not agree with how FirstCare/SWL&H has used or disclosed information about you.

- Right to Get a Paper Copy of this Notice. You have the right to ask for a copy of this notice at any time.

NOTE: WE RESERVE THE RIGHT TO VALIDATE THE IDENTITY OF ANYONE MAKING ANY OF THE REQUESTS ABOVE, AS A FURTHER PROTECTION OF PHI.

How to File a Complaint or Report a Problem
You may contact any of the people listed below if you want to file a complaint or to report a problem with how FirstCare/SWL&H has used or disclosed information about you. Your benefits will not be affected by any complaints you make. FirstCare/SWL&H cannot retaliate against you for filing a complaint, cooperating in an investigation, or refusing to agree to something that you believe to be unlawful.

FirstCare/SWL&H
Custodian of Records
1901 West Loop 289, Suite 9
Lubbock, TX 79407
Phone: 1-800-829-6440
Fax: 1-877-878-8422
Email: CustodianOfRecords@FirstCare.com

Office for Civil Rights, Region VI
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202
Phone: 1-214-767-4056
Fax: 1-214-767-0432
TDD: 1-214-767-8940
Email: www.HHS.gov/ocr

For More Information
If you have any questions about this notice or need more information, please contact the FirstCare/SWL&H Privacy Officer.

Para recibir este documento en español por favor llame al 1-800-829-6440.

FirstCare/SWL&H
Privacy Officer
12940 North Highway 183
Austin, TX 78750
Phone: 1-800-431-7737 | Fax: 1-512-257-6016

In the future, FirstCare/SWL&H may change its Notice of Privacy Practices and make the changes effective on a going-forward basis. A copy of the new notice will be provided to each FirstCare/SWL&H enrollee as required by law. The most current notice will always be posted on our internet web site. You may ask for a copy of the current notice anytime by calling Customer Service at 1-800-829-6440 or get it online at FirstCare.com.

FINANCIAL INFORMATION PRIVACY NOTICE
THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

FirstCare/SWL&H is committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information FirstCare/SWL&H Collects
We collect personal financial information about you from the following sources:
Information we receive from you on applications or other forms, such as name, address, age and Social Security number, information from a consumer report and information collected through an information collecting device from an internet web server; and information about your transactions with us, our affiliates or others, such as account balance information and premium payment history.

Disclosure of Information by FirstCare/SWL&H
FirstCare/SWL&H does not disclose personal financial information about you to any third party, except as required or permitted by law. In the course of our general business practices, FirstCare/SWL&H may disclose personal financial information about you or others without your permission other covered entities, or business associates for treatment, payment and certain health care operational purposes. This may include your premium payment history.

Confidentiality and Security
FirstCare/SWL&H restricts access to personal financial information about you to our employees and service providers who are involved in administering your health care coverage and providing services to you. We maintain physical, electronic and procedural safeguards in compliance with federal standards to guard your personal financial information. We conduct regular audits to guarantee appropriate and secure handling and processing of your information.

Your Right to Access and Correct Personal Information
You may have a right to request access to the personal financial information that we record about you. Your right includes the right to know the source of the information and the identity of the persons, institutions, or types of institutions to whom we have disclosed such information within 2 years prior to your request. Your right includes the right to view such information and copy it in person, or request that a copy of it be sent to you by mail. If requesting FirstCare/SWL&H to copy and mail, we require you to include a $10.00 fee. Your right also includes the right to request corrections, amendments or deletions of any information in our possession. The procedures that you must follow to request access to or an amendment of your information are as follows:

To obtain access to your information: Submit a request in writing that includes your name, address, Social Security number, telephone number, and the recorded information to which you would like access. State in the request whether you would like access in person or a copy of the information sent to you by mail. Upon receipt of your request, we will contact you within 30 business days to arrange providing you with access in person or the copies that you have requested.

To correct, amend, or delete any of your information: Submit a request in writing that includes your name, address, Social Security number, telephone number, the specific information in dispute, and the identity of the document or record that contains the disputed information. Upon receipt of your request, we will contact you within 30 business days to notify you either that we have made the correction, amendment or deletion, or that we refuse to do so and the reasons for the refusal, which you will have an opportunity to challenge.

Send written requests to access, correct, amend, or delete information to:

FirstCare/SWL&H
Custodian of Records
1901 West Loop 289, Suite 9
Lubbock, TX 79407
Phone: 1-800-829-6440 | Fax: 1-877-878-8422
Email: CustodianOfRecords@FirstCare.com

FirstCare™

HEALTH PLANS

PART OF BAYLOR SCOTT & WHITE HEALTH

12940 N Hwy 183, Austin, TX 78750
FirstCare.com