This Evidence of Coverage is not to be used for small employer health plans as covered by the Texas Insurance Code.

This Consumer Choice of Benefits Health Maintenance Organization health care plan, either in whole or part, does not provide state-mandated health benefits normally required in evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you, although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. Please consult with your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage. This Evidence of Coverage is governed by the laws of the state of Texas and applicable federal law.

THIS EVIDENCE OF COVERAGE IS NOT A MEDICARE SUPPLEMENT POLICY

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

Welcome To FirstCare

Dear Employee:

On behalf of FirstCare, I am pleased to welcome You to Our Health Plan.

Please take a few minutes to read this booklet and become familiar with the HMO benefits Your Plan covers and does not cover as explained herein.

If You are new to FirstCare, a representative from Our Customer Service Department will be calling to assist You in understanding Your FirstCare coverage. If You are not new to FirstCare, but would like more information about how to use Your FirstCare Plan, please contact Our Customer Service Department at 1-800-884-4901.

Thank You for selecting FirstCare.

SHA,L.L.C. dba FirstCare
12940 N Highway 183
Austin, Texas 78750
(512) 257-6000
1-800-884-4901
www.FirstCare.com

This Evidence of Coverage is not to be used for small employer health plans as covered by the Texas Insurance Code.

GROUP CONTRACT

EVIDENCE OF COVERAGE

This Group Contract Evidence of Coverage is issued to You (and Your eligible enrolled Dependents), because You have enrolled in the health maintenance organization of SHA, L.L.C. dba FirstCare through Your employer. Your Evidence of Coverage along with any attachments and amendments constitutes Your contract with FirstCare. By completing Your enrollment form, making or having made on Your behalf payment of applicable premiums, and accepting this Evidence of Coverage, You (and Your Dependents if any) agree to abide by and adhere to the provisions, terms and conditions contained in Your Evidence of Coverage.

The effective date of coverage of Your Evidence of Coverage shall be as indicated on Your FirstCare Member ID card.

Note: FirstCare Health Plans does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call FirstCare's toll-free telephone number for information or to make a complaint at:

1-800-884-4901

You may also write to FirstCare at:

SHA, L.L.C. dba FirstCare
ATTN: Complaints and Appeals
12940 N. HWY 183
Austin, TX. 78750

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

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007
Web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

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

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

AVISO IMPORTANTE

Para obtener información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de FirstCare para obtener información o para presentar una queja al:

1-800-884-4901

Usted también puede escribir a FirstCare a:

SHA, L.L.C. dba FirstCare
ATTN: Complaints and Appeals
12940 N. HWY 183
Austin, TX. 78750

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007
Sitio web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES: Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con FirstCare primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas

ADJUNTE ESTE AVISO A SU PÓLIZA: Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

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SECTION 1 – REQUIREMENTS FOR ALL HEALTH CARE SERVICES

To be covered under Your Plan, health care services must meet all of the requirements described in this section.

Medical Necessity

The service must be *medically necessary* as determined by the FirstCare Medical Director. By *medically necessary*, We mean that the service meets *all* of the following conditions:

- The service or item is reasonable and necessary for the diagnosis or treatment of an illness or injury or for a medical condition, such as pregnancy;*
- Is consistent with widely accepted professional standards of medical practice in the United States;
- Is prescribed by a Physician or other healthcare provider
- The service is provided in the most cost-efficient way and at an appropriate duration and intensity, while still giving You a clinically appropriate level of care;
- Is not primarily for the personal comfort of the patient, the Family, Physician, or other provider of care;
- Is not a part of, or associated with, the scholastic, educational, or vocational training of the patient;
- Is neither investigative nor experimental in nature; or
- Is pre-approved, when required by FirstCare.

Not every service that fits this definition is covered under Your Plan. To be covered, a medically necessary service must also be described in *Section 3, What Is Covered. The fact that a Physician or other health care provider has performed, prescribed, or recommended a service does not mean it is medically necessary or that it is covered under Your Plan.* (*Also see Section 5, What Is Not Covered.)*

*The Utilization Review Agent will decide whether a service or supply is Medically Necessary, considering the views of the medical community, guidelines and practices of Medicare and Medicaid, and peer review literature.

Primary Care Physician

All Covered Health Services must be either provided by Your Primary Care Physician (PCP) a Participating Provider or a pre-approved Non-Participating Provider. For more information about who can serve as a PCP, please see the definition of "Primary Care Physician" in *Section 11, Definitions*.

Your Right to Choose an Obstetrician or Gynecologist

You are permitted to designate and visit an obstetrician or gynecologist to obtain direct access to the health care services provided by Your designated obstetrician or gynecologist, without a referral from Your PCP or prior authorization from Us. You are not required to choose an obstetrician or gynecologist, but may decide to have Your PCP provide these services. If You need help choosing a FirstCare obstetrician/gynecologist or to change Your Physician, You may call Our Customer Service Department at 1-800-884-4901. If You prefer, you may also go to the FirstCare website at www.FirstCare.com.

Once You have selected a FirstCare obstetrician/gynecologist, You do not need a referral from Your PCP or pre-approval from Us to make an appointment. You may call Your obstetrician or gynecologist's office directly to schedule Your office visit.

Your FirstCare obstetrician/gynecologist may also refer You for treatment for a disease or condition that is within the scope of an obstetrics and gynecological specialty practice, including treatment of medical conditions concerning the breasts.

Participating Providers

The service must be provided:

- By a Physician or other health care professional who participates in the FirstCare network; and
- At a Hospital, laboratory or other facility that also participates in the FirstCare network.

"Participating Providers" are health care providers in Your community who participate through a contract with FirstCare to provide services to FirstCare Members. The provider must be a Participating Provider at the time the service is rendered. A more detailed definition of Participating Provider appears in *Section 11, Definitions.*

For more information on participating providers, check the FirstCare Provider Directory. Remember that the provider directory is subject to change, so You may want to call Our Customer Service Department at 1-800-884-4901 to request a current Provider Directory or go to the FirstCare website at www.FirstCare.com for current information.

There are special circumstances under which You may obtain Covered Health Services from providers who are not part of the FirstCare network:

- You may have to use Non-Participating Providers for emergency or out-of-area urgent care services described in *Section 4, Emergency and Out-of-Area Urgent Care Services*;
- If We determine medically necessary care cannot be provided by any health care provider participating in the FirstCare network, Your PCP may refer You to an Non-Participating Provider. We will process necessary referrals to out-of-network providers within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation;
- Non-Participating Providers may be used in cases of court-ordered coverage for Dependent children who live outside of FirstCare's Service Area. However, We must approve services that normally require a referral (e.g. inpatient and outpatient procedures, rehabilitation, habilitative services, speech, occupational, or physical therapies) in advance or it will not be covered. Please refer to the specific benefit coverage detailed in *Section 3, What Is Covered*;
- When We agree to continue coverage for the services of a provider who stops participating in the FirstCare network, You may only use an Non-Participating Provider in accordance with the *Continuity of Coverage* provision in this section, when these arrangements have been pre-approved by Us; or
- In all cases, Non-Participating Providers will be reimbursed the Non-Participating Provider Reimbursement (NPPR) Amount for care received or We will arrange to pay those providers directly at rates negotiated with the provider by FirstCare. You will be held harmless for any amounts beyond the copayment or other out-of-pocket amounts that You would have paid had the network included network physicians or providers from whom You could obtain the services.

Ancillary Providers

An Ancillary Provider is a provider with whom a PCP may be required to consult and/or coordinate referrals for certain Covered Health Services on Your behalf. Your PCP may be required to consult with an Ancillary Provider on Your behalf to provide certain services, such as mental health services or chemical dependency services. If You need to obtain information about the health care services that require consultation with an Ancillary Provider, the identity of the Ancillary Providers who coordinate referrals for such health care services in Your area, or a current list of providers of those health care specialty services in Your area, call Our Customer Service Department at 1-800-884-4901.

Continuity of Coverage

You will be notified if You are under the care of a Participating Provider and he or she stops participating in the FirstCare network. Special circumstances may exist where We will continue to provide coverage for that provider's services even though he or she is no longer a Participating Provider with Us. Special circumstances include a person with a disability, an acute condition, a life-threatening illness, undergoing 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 You harm; and
- The provider agrees to continue accepting the same rate of reimbursement that applied when he or she was still a Participating 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.

For Members who have been diagnosed with a terminal illness at the time of the Provider's termination from the plan, coverage will extend no more than a nine-month period after the effective date of the termination.

Other Restrictions

In addition to the general requirements described above, there are specific restrictions on Your coverage for some services. For instance, some services are only covered if We pre-approve them. There are also time limits on Your coverage for some services. These restrictions are described in *Section 3, What is Covered.*

Copayments

Copayments are the amounts You are required to pay to a Participating Provider or other authorized provider in connection with the provision of Covered Health Services. Copayments not subject to the Deductible must continue to be paid even when You have reached Your Deductible. The Copayment amounts are indicated in the Schedule of Copayments.

Embedded Deductible

The amount of Covered Services You are responsible for paying each Plan Year before benefits become payable under this Plan. The Embedded Deductible is the amount of Covered Expenses You must pay for each Member before any benefits are available regardless of provider type. If You have several Members, all charges used to apply toward the "per Member" Embedded Deductible will apply towards the "per Family" Embedded Deductible. When that Family Embedded Deductible amount is reached, no further individual Embedded Deductible will have to be satisfied for the remainder on that Plan Year. No Member will contribute more than the individual Embedded Deductible amount towards the "per Family" Embedded Deductible amount. Copayments not subject to the Embedded Deductible do not apply to the Plan Year Embedded Deductible. Please refer to Your Schedule of Copayments for specified Embedded Deductible amount.

Out-of-Pocket Maximum

The total dollar amount a Member must pay each Calendar Year before We pay benefits at 100%. The Out-of-Pocket Maximum includes deductibles, and [medical] copayments. It does not include premiums, non-covered services and balance billing amounts. Refer to your Schedule of Co-payments for Out-of-Pocket maximum amounts.

FirstCare Review

In making any decision about coverage of Your health care services under the Plan, We may consult with any health care professional or organization that We believe will be helpful, if permitted by law. We also have the right to have health care professionals of Our choice examine Your medical records and physical condition, if

permitted by law. We may use this information to assist in the coordination of Your covered services (such as planning for Your care after You are discharged from the Hospital), to help Us in making decisions about pre-approval of services, and other decisions concerning Your coverage under the Plan.

SECTION 2 – ELIGIBILITY AND ENROLLMENT

Employee Coverage

To be eligible to enroll as a FirstCare Subscriber, You must:

- Live, work, and/or reside in the FirstCare Service Area;
- Work on a full time or full time equivalent basis;
- Usually work at least 30 hours a week, or
- Are another person whose connection with the Enrolling Group meets the eligibility requirements specified by the Application, Plan, Employer Group and Us; and
- Satisfy any probationary or waiting period requirements required by Your Group.

The term does not include:

1. An employee who works on a temporary, seasonal, or substitute basis; or
2. An employee who is covered under:
    - Another health benefit plan;
    - A self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974;
    - The Medicaid program if the employee elects not to be covered by this health plan;
    - Another federal program, including the CHAMPUS program or Medicare program, if the employee elects not to be covered by this health plan; and
    - A benefit plan established in another country if the employee elects not to be covered by this health plan.

Dependent Coverage

To be eligible to enroll as a Dependent, a person must:

- Be an eligible Dependent of an employee or retiree who is enrolled in this Plan;
- Meet all Dependent eligibility criteria determined by Your Group; and
    a. Be Your spouse as defined by Texas law;
    b. Be a child (including a step-child, a legally adopted child or a child who has become the subject of a suit for adoption) of You or Your spouse, who is under age 26;
    c. Be a child for whom You or Your spouse is a court appointed legal guardian. You must provide proof of such guardianship with Your Dependent's enrollment form;
    d. Be a child who is and continues to be both:
        - Unable to maintain self-sufficient employment because of a mental or physical handicap; and
        - Mainly dependent upon You for economic support and maintenance. You must provide proof of Your child's incapacity and dependency (e.g. a Physician's statement) to Us prior to Your child's reaching the age of 26. Afterward, You may be required to show proof of Your child's dependency, but not more often than once per year. ;
    e. Be a newborn child of You or Your spouse. If You wish to add Your newborn to your current coverage (even if You already have dependent coverage) You or Your employer must notify the plan verbally or in writing to enroll Your newborn as a Dependent, within 31 days following Your child's birth, and pay any additional premium charges, if applicable. If we do not receive verbal or written notification from You or Your employer, Your newborn will not be added, and

cannot be added until the next group Open Enrollment Period (even if You already have dependent coverage).

If Your newborn child is born outside the FirstCare Service Area due to an emergency, or is born in an out-of-plan facility to a mother who does not have coverage under this Evidence of Coverage, We may require transfer to a Plan facility and, if applicable, to a Participating Provider. Such transfer must be medically appropriate and approved by the newborn's treating Physician; We will cover expenses associated with transferring a newborn to a Plan facility. Congenital defects are treated the same as any other illness or injury for which coverage is provided;

f. Be an unmarried child of a Dependent (i.e., the Subscriber's grandchild) who is dependent upon You (i.e., grandparent) for support as defined by the United States Internal Revenue Code and applicable federal regulations, and who otherwise meets the requirements for an unmarried child specified above. Coverage may not be terminated solely because the covered child is no longer Your or Your spouse's Dependent for federal income tax purposes; or

g. Be a child who resides inside or outside the FirstCare Service Area and whose coverage under the plan is required by You or Your spouse through a medical support order or dental support order issued under Section 14.061, Texas Family Code. We shall provide coverage that is comparable health or dental coverage to that provided to other dependents under the plan.

Effects of Medicare Eligibility

Medicare eligibility *does not* change eligibility under this Evidence of Coverage. Medicare eligibility *does* affect the way benefits are coordinated. Refer to *Section 8, Coordination of Benefits* for information on primary and secondary coverage.

Enrollment

No person meeting Subscriber or Dependent eligibility requirements will be refused enrollment or re-enrollment because of current health status, age, or requirements for health care services because of a pre-existing physical or mental condition on the effective date of coverage, including pregnancy. No Member's coverage shall be terminated due to a Member's health status or health care needs.

Note: Per Texas Insurance Code, the initial enrollment period for employees meeting the participation criteria for this Plan must be at least 31 days, with at least a 31-day annual Open Enrollment Period.

1. Initial/Annual Open Enrollment Periods

Each eligible employee of the Group shall be permitted to apply for coverage for himself or herself and eligible Dependents during the initial and annual Group Open Enrollment Period. All persons included for coverage must be documented. No proof of insurability shall be required.

2. Group Open Enrollment

A Group Enrollment Period is a time when You and/or Your Dependents (if eligible) may enroll as Members of FirstCare. The Group Open Enrollment will be held at least once a year. No proof of insurability shall be required.

Coverage under this benefit Plan is contingent upon timely receipt by FirstCare of necessary information and initial premium.

3. Newly Eligible Employees

Each new employee of the Group who becomes eligible for coverage at other than the initial or Annual Open Enrollment Period shall be permitted to enroll himself or herself and eligible Dependents within 31 days of becoming eligible.

4. Newly Eligible Dependents

If You wish to enroll a newly eligible Dependent due to marriage, birth, adoption, Your becoming party in an adoption lawsuit, a court order, or Your grandchild becoming Your Dependent for federal income tax purposes, We must receive a signed change request form within 31 days of becoming eligible. No proof of Insurability is required. If a newly eligible Dependent, with the exception of a child subject to a medical support order, is not added within the 31 days of the date establishing eligibility, that Dependent cannot be added to coverage until the next Group Open Enrollment period.

5. Limitation

Persons initially or newly eligible for enrollment who do not enroll within 31 days of the date establishing eligibility cannot be added to coverage until the next Group/Annual Open Enrollment Period.

6. Notice of Ineligibility

It is your responsibility to notify FirstCare and Your employer of any changes that will affect You or Your Dependent's eligibility for services or benefits under this benefit Plan within 31days of the event.

Per Texas Insurance Code, the employer Group is liable for a Member's premiums from the time the Member is no longer eligible for coverage under this Plan until the end of the month in which the Group informs Us in writing that the Member is no longer eligible for coverage. A Member remains covered until the end of that period.

Effective Date of Coverage

FirstCare must receive Your completed enrollment documentation or change request form and payment of any necessary premiums before coverage under this benefit Plan becomes effective. Coverage of medically necessary health services becomes effective on the earliest of the following dates:

1. Initial Enrollment/Annual and Open Enrollment Periods

Coverage shall be effective on the date agreed upon by the Group and FirstCare, usually the first day of the month following the enrollment period.

2. Newly Eligible Employees

Coverage will be effective on the first day of the month following the enrollment, provided appropriate enrollment forms and applicable premium payments are received by FirstCare within 31 days of initial eligibility.

3. Newly Eligible Dependents

Coverage will be effective on the date of the event establishing eligibility, (for example, marriage, adoption, guardianship, or birth). However, the effective date for court-ordered eligible child coverage will be determined by FirstCare in accordance with the provisions of the court order. Appropriate enrollment forms and applicable premium payments must be received by FirstCare within 31 days of the event. Newly eligible Dependents, including newborn children, not added to coverage within 31 days of the event may not be added until the next Group/Annual Open Enrollment Period.

A child for whom You or Your spouse is seeking adoption may be enrolled within either of the following time periods:

- Thirty-one (31) days after You or Your spouse becomes a party in a suit for adoption; or
- Thirty-one (31) days from the date the adoption is final.

Late Enrollees/Special Enrollment Periods/Effective Dates of Coverage

In certain circumstances, eligible individuals may enroll in this health Plan at times other than at the initial or annual Open Enrollment Period. Eligible individuals and Dependents are allowed to enroll in this FirstCare health Plan as a result of the triggering events listed below. As a general rule, the effective date for coverage is the 1st day of the month following the request for enrollment.

A late enrollee is an eligible employee or Dependent who applies for coverage in this Plan after the expiration of the initial enrollment period established through Your employer or after the expiration of the annual Open Enrollment Period. An eligible employee or Dependent requesting enrollment as a late enrollee shall be excluded until the next annual Group Open Enrollment Period.

Who is Not a Late Enrollee (and thus eligible for Special Enrollment)

You must apply for or request a change in coverage within 31 days from the date of the Special Enrollment Events listed below in order to qualify for the enrollment described in this section. Coverage for You and Your eligible Dependents will be effective no later than the 1st day of the calendar month beginning after the date FirstCare receives the request for Special Enrollment.

You or Your Dependent is not a late enrollee if:

You or Your Dependent:

a. Were covered under another health benefit plan or self-funded employer health benefit plan during the time You or Your Dependent were eligible to enroll, and
    - Declined coverage in writing during the time You or Your Dependent were eligible to enroll stating the basis for declining coverage was coverage under another health benefit plan or self-funded employer health benefit plan;
    - Has lost Minimal Essential Coverage under the other health benefit plan or self-funded employer health benefit plan due to termination of the Plan; reduction in the number of hours of employment; termination of employment; termination of contributions toward the premium made by the employer; death of a spouse; or divorce; or COBRA continuation coverage is exhausted; and
    - Requests enrollment within 31 days after the date coverage ends under the other health benefit plan;

b. Is employed by an employer who offers multiple health benefit plans and You elect a different health benefit plan during a Group Open Enrollment Period;

c. Is under a court order to provide coverage for an employee's child and the request for enrollment is made within 31 days from the date Your employer receives notification of the court order;

d. Is under a court order to provide coverage for an employee's spouse and request for enrollment is made within 31 days after issuance of the court order;

e. Is a child of a covered employee who has lost coverage under Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq), other than coverage consisting solely of benefits under Section 1928 of that Act (U.S.C. Section 1396s), or under Chapter 62, Health & Safety Code, and the request for enrollment is made no later than the 60th day after the date on which the child loses coverage; Coverage will be effective the day after the prior coverage.

f. As an eligible employee has a change in family composition due to marriage, birth of a child, adoption of a child or becoming a party in a suit for the adoption of a child and requests enrollment within 31 days of marriage, birth, adoption, or the date the Member becomes a party in a suit for the adoption of a child; and

g. As an individual becomes a Dependent due to marriage, birth of a child, adoption of a child, or an eligible employee becoming a party in a suit for the adoption of a child and requests enrollment within 31 days of marriage, birth, adoption, or becoming a party in a suit for the adoption of a child.

Limitation

Persons initially or newly eligible for enrollment who do not enroll during the special enrollment period may not be enrolled until the next Annual Open Enrollment Period.

FirstCare must receive Your completed enrollment form or change request form and payment of any necessary premiums before coverage under this benefit Plan becomes effective.

Health Insurance Premium Payment (HIPP) Reimbursement Program

An individual who is eligible to enroll and who is a recipient of medical assistance under the state of Texas Medicaid Program or enrolled in CHIP, and who is a participant in the state of Texas HIPP Reimbursement Program may enroll if he or she otherwise meets eligibility requirements for this Plan. If the individual is not eligible unless a family member is enrolled, both the individual and family member may enroll. The Effective Date of Coverage is the first day of the month after FirstCare receives (i) written notice from the Texas Health and Human Services Commission, or (ii) enrollment forms, from You, provided such forms and applicable Premium payments are received by FirstCare within sixty (60) days after the date the individual becomes eligible for participation in the HIPP Reimbursement Program.

SECTION 3 – WHAT IS COVERED

Some services outlined in the section below may require pre-approval in order for the service to be covered. Refer to the pre-authorization list posted at www.FirstCare.com or contact Customer Service at 1-800-884-4901 to determine if a specific service requires pre-approval.

This section describes:

- The health care services covered under Your Plan; and
- Restrictions and limitations related to a specific type of health care service. Your Copayment (if any) can be found in the Schedule of Copayments.

OUTPATIENT SERVICES

Please refer to the Schedule of Copayments for copayment amounts and any benefit limitations that may apply for certain services.

The outpatient services covered by Your Plan are:

1. Physician Office Visits

We cover visits to the Physician's office for diagnosis or treatment of an illness or injury.

The office visit Copayment applies when You have patient contact with the Physician, physician assistant, nurse, or nurse practitioner.

2. Physician Services At Home

We cover Physician services provided to You in Your home, but only if You are unable to leave your home for medical reasons; and the services could not be performed by someone who is not a Physician or if FirstCare deems the home setting to be the most cost-effective and clinically appropriate delivery setting and they are medically necessary.

3. Laboratory Services

We cover medically necessary laboratory services from a participating laboratory provider when the PCP, a Participating Provider, or other authorized Physician prescribes them and they are medically necessary.

4. Radiology Services

We cover x-rays and other radiology services, including therapeutic radiology, needed for diagnosis and/or treatment.

5. Surgical Procedures In Your Physician's Office

We cover surgical procedures performed in Your Physician's office.

If the surgical procedure involves general anesthesia or is performed in a Plan surgical facility, it must meet the requirements for outpatient surgery (including Copayment). Please see *Outpatient Surgery* in this section.

6. Materials Provided In Your Physician's Office

We cover materials and supplies that are generally available in the Physician's office, and are administered or applied during an office visit. Such covered materials or supplies include but are not limited to those necessary for:

- Inhalation therapy and other medically necessary respiratory therapies;
- The administration of medications or Injectable Drugs; and
- Dressings, casts, and splints (where splints are commonly used instead of casts).

7. Medical Injectable Drugs, Defined Hybrid Injectables, Radiation Therapy, Transplant Anti-rejection Therapy, Home Infusion Medications (excluding "self-injectable" drugs), Chemotherapy and Defined Associated Agents

We cover medically injectable drugs, defined hybrid injectable, radiation therapy, specified transplant anti-rejection therapy, home infusion medications (excluding "self-injectable" drugs), specified cancer chemotherapy and defined associated agents, and orally administered anticancer medications. Refer to the Schedule of Copayments for details.

Injectable Medications recognized by the Federal Drug Agency (FDA) as appropriate for self-administration (referred to as "self-injectable" drugs), regardless of the enrollee's ability to self-administer, are not covered, unless Your group has purchased the Prescription Drug Rider or coverage is otherwise specified in this document. Refer to Your Prescription Drug Rider for details.

8. Pre-Natal and Post-Natal Obstetrical Care

We cover Physician services for pre-natal and post-natal office visits. We also cover amniocentesis and chorionic villus sampling when medically indicated.

9. Rehabilitation, Habilitation, Speech, Occupational, and Physical Therapy Services

We cover medically necessary outpatient rehabilitation including, habilitation, speech, cardiac rehabilitation, occupational and physical therapy services that meet these conditions:

- Your PCP or participating specialist, orders such rehabilitation or therapy services; and
- The services can be expected to meet or exceed the treatment goals established for You by Your Physician.

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

10. Therapies for Children with Developmental Delays

Covered Services include treatment for "Developmental Delays", which means a significant variation in normal development as measured by appropriate diagnostic instruments and procedures in one or more of the following areas:

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

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

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

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

11. Acquired Brain Injury

We provide coverage for certain benefits related to acquired brain injury. Coverage includes the following services:

- Cognitive rehabilitation therapy;
- Cognitive communication therapy;
- Neurocognitive therapy and rehabilitation;
- Neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing and treatment;
- Neurofeedback therapy;
- Remediation required for and related to treatment of an acquired brain injury
- Post-acute transition services;
- Post-acute treatment services; or
- Community reintegration services, including outpatient day treatment services, or other post-acute care treatment services necessary as a result of and related to an acquired brain injury.

Coverage is also provided for reasonable expenses related to periodic reevaluation of the care of an enrollee who:

- Has incurred an acquired brain injury;
- Has been unresponsive to treatment; and
- Becomes responsive to treatment at a later date.

A determination of whether expenses are reasonable may include consideration of:

- Cost
- Time that has expired since the previous evaluation
- Differences in the expertise of the provider performing the evaluation;
- Changes in technology; and
- Advances in medicine.

As required by the Texas Insurance Code Chapter §1352, We will not refuse required covered services for and related to treatment of an acquired brain injury solely because they are provided by an assisted living facility

12. Outpatient Surgery

We cover outpatient surgery performed in an outpatient surgery facility and same-day surgery performed in a Hospital, including invasive diagnostic procedures such as endoscopic examinations, if Your PCP or in plan specialist orders or arranges the surgery;

13. Pain Management Services

We cover medically necessary pain management treatment and related services. All covered services must meet these conditions:

- Your PCP or participating specialist orders such pain management services;
- Services can be expected to meet or exceed treatment goals established for You by Your Physician;

Services are scientifically proven and evidence-based to improve Your medical condition;

14. Allergy Testing and Injections

We cover medically necessary allergy testing performed to evaluate and determine the cause of allergy. We also cover appropriate allergy treatments including injections and serum.

15. Short-Term Mental Health Services

Short-term outpatient evaluation and treatment for mental illnesses and disorders are covered when all of these conditions are met:

- The mental illness or disorder being treated is listed in the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, at the time services are provided;
- There must be clear evidence of interference with developmentally appropriate social, academic, or occupational functioning manifesting itself predominately in at least two settings, for example, at home and at school or work;
- The services must be for evaluation or crisis intervention;

The initial evaluation, diagnosis, medical management and ongoing medication management of attention deficit disorder (ADD) and attention deficit hyperactivity disorder (ADHD) are also covered.

Treatment for certain mental illnesses is not covered. Refer to *Section 5, What is Not Covered.*

16. Serious Mental Illness Services

Treatment of serious mental illness is covered if the mental illness or disorder being treated is one of the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

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

Coverage is provided for serious mental illness, including group and individual outpatient treatment.

17. Autism Spectrum Disorder

We provide the following Autism coverage:

a. For screening a child for autism spectrum disorder at the ages of 18 and 24 months.
b. For the treatment of autism spectrum disorder as provided to a Member who is diagnosed with autism spectrum disorder from the date of diagnosis.
c. All generally recognized services prescribed in relation to autism spectrum disorder by the Member's primary care physician in the treatment plan recommended by that physician. An individual providing treatment prescribed must be;
    1. A health care practitioner:
        - Who is licensed, certified, or registered by an appropriate agency of this state;
        - Whose professional credential is recognized and accepted by an appropriate agency of the United States; or
        - Who is certified as a provider under the TRICARE military health system; or
    2. An individual acting under the supervision of a health care practitioner

Generally recognized services may include services such as:

- Evaluation and assessment services;
- Applied behavior analysis;
- Behavior training and behavior management;
- Speech therapy;
- Occupational therapy;
- Physical therapy; or
- Medications or nutritional supplements used to address symptoms of autism spectrum disorder.

18. Chemical Dependency Treatment

Medically necessary outpatient treatment for chemical dependency (abuse of, psychological or physical dependence on, or addiction to alcohol or a controlled substance) and detoxification are covered. A series of treatments is a planned, structured, and organized program to promote chemical free status. The series may include different facilities or modalities and is complete when the Member:

- Is discharged on medical advice from inpatient detoxification, inpatient rehabilitation/ treatment, partial Hospitalization, or intensive outpatient;
- Completes a series of these levels of treatment without a lapse in treatment; or
- Fails to materially comply with the treatment program for 30 days.

PREVENTIVE HEALTH CARE SERVICES

Please refer to the Schedule of Copayments for copayment amounts and any benefit limitations that may apply for certain services.

The preventive health care services covered by Your Plan are:

1. Routine Physical Examinations

We cover routine examinations by Your PCP for Plan Members. Your PCP decides how often and extensive these examinations should be, based on national and regional medical standards of care.

2. Well-Baby And Well-Child Care

We cover well-baby and well-child preventive care by Your PCP for Plan Members. Your PCP decides how frequent and extensive this care should be, based on national and regional medical standards of care.

3. Routine Immunizations

We cover routine adult and children immunizations recommended by the American Academy of Pediatrics and U.S. Public Health Service for people in the United States, including immunizations for travel outside the United States. However, We do not cover immunizations for employment, school sports or extracurricular activities, or recreation activities. We cover routine immunizations for children and adolescents as recommended or approved by the Food and Drug Administration (FDA) and the Center for Disease Control (CDC). Immunizations must be properly ordered and directed by Your PCP.

4. Well-Woman Examinations

For women who are Plan Members, We cover well-woman gynecological examinations. You may choose to have Your PCP or Your designated obstetrician/gynecologist perform the well-woman examination.

For women who are Plan Members we cover one annual ovarian cancer screening blood test CA 125 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. A screening test required under this section must be 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.

5. Screening Mammogram

We cover annual screening mammograms 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). Mammograms may be obtained by referral from Your PCP or Plan obstetrician/gynecologist, whether or not a well-woman examination is performed at the same time.

6. Bone Mass Measurement

These 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. Examination for Detection of Prostate Cancer

We cover an annual prostate examination to detect prostate cancer, including a physical examination and a prostate-specific antigen (PSA) test.

8. Screening for Detection of Colorectal Cancer

We cover screening examinations and procedures for Plan Members at a normal risk for developing colon cancer. These examinations include fecal occult blood tests, a flexible sigmoidoscopy, or a colonoscopy.

9. Cardiovascular Disease Testing

We cover one noninvasive screening test for men older than 45 years of age and younger than 76 years of age and for women older than 55 years of age and younger than 76 years of age who are covered under this Plan, have diabetes or have a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm, that is intermediate or higher. We cover one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five years. These tests include computed tomography (CT) scanning measuring coronary artery calcification or an ultrasonography measuring carotid intima-media thickness and plaque.

10. Routine Sight, Speech and, Hearing Screening

We cover routine screenings of vision, speech, and hearing for all Plan Members, including newborns. We also cover one hearing screening every Plan Year for all Members.

We *do not* cover eye exams to prescribe glasses or contact lenses, even after vision surgery (except for Keratoconus).

11. All Other Preventive Services

We cover the following services that are required by Section 2713 of the Patient Protection & Affordable Care Act (PPACA):

- Evidence−based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC");
- Evidenced−informed preventive care and screenings provided in Health Resources and Services Administration ("HRSA") guidelines for infants, children, adolescents and women; and
- Current recommendations of the United States Preventive Services Task Force ("USPSTF") regarding breast cancer screening, mammography, and prevention.

The preventive care services described in items above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, you may contact Our customer service department at 1-800-884-4901.

Examples of covered services included are routine annual physicals, immunizations, well−child care, cancer screening mammograms, bone density test, screening for prostate cancer and colorectal cancer, smoking cessation counseling services and healthy diet counseling and obesity screening and counseling.

Examples of covered immunizations included are Diphtheria, Haemophilus influenzae type b, Hepatitis B, Measles, Mumps, Pertussis, Polio, Rubella, Tetanus, Varicella, Rotavirus and any other immunization that is required by law for a child.

FAMILY PLANNING SERVICES

Please refer to the Schedule of Copayments for copayment amounts and any benefit limitations that may apply for certain services.

We cover these family planning services when Your PCP or Your designated obstetrician/gynecologist provides them:

- Physical examinations, related laboratory tests, and medical supervision; and
- Information and counseling on contraception.

Coverage is provided for the following contraceptive materials and services:

Insertion or removal of an intrauterine device (IUD);

- Fitting of a diaphragm contraceptive;
- Insertion or removal of a birth control device implanted under the skin (such as Norplant); and
- Vasectomies and tubal ligations.
- Depo-Provera™ Injections

Coverage for all other prescription contraceptives, including but not limited to oral medications, and patches are provided. Refer to Your Prescription Drug Rider for details.

INPATIENT SERVICES

Please refer to the Schedule of Copayments for copayment amounts and any benefit limitations that may apply for certain services.

To be covered, all admissions must be to a Plan Hospital, skilled nursing facility, or other inpatient facility. The only exceptions to this requirement are admissions covered under *Section 4, Emergency and Out-of-Area Urgent Care Services***.** Inpatient services must be prescribed, directed or arranged by Your PCP or in plan specialist. If We determine that medically necessary services cannot be performed at one of Our participating inpatient facilities, We will approve admissions to out-of-plan facilities.

1. Obstetrical Services

We will approve inpatient admissions for obstetrical services in accordance with the standards described below.

We cover inpatient care following childbirth for You and Your newborn child for a minimum of 48 hours following an uncomplicated vaginal delivery, and 96 hours following an uncomplicated delivery by cesarean section. If additional time is required, it must be pre-approved by Us.

Note: *If your Newborn requires confinement in neonatal intensive care unit (NICU), then any applicable deductible / copayment will be applied separately to Your newborn, for any covered charges associated with that confinement. This is in addition to any applicable Mother deductible / copayment.*

In the event that You or Your newborn is discharged from inpatient care before the expiration of the minimum hours of coverage described above, We will cover post-delivery outpatient care. Post-delivery care may take place at Your provider's office or in Your home. Post-delivery care services include maternal and neonatal physical assessments (physical evaluations for both You and Your newborn); parent education, assistance and training in breast-feeding and bottle-feeding; and the performance of any appropriate clinical tests. A Physician, registered nurse, or other licensed health care professional may provide the services. This visit is in addition to Your coverage for outpatient post-natal obstetrical care. See Pre-Natal and Post-Natal Obstetrical Care in this section.

2. Mastectomy or Related Procedures

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.

We do not cover prophylactic mastectomy procedures as described in *Section 5, What Is Not Covered*.

3. Room, Meals, and General Nursing Care

Hospital room and board, including regular daily medical services and supplies, will be payable as shown in the Schedule of Copayments. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.

We cover special diets during inpatient care, if they are medically necessary and prescribed by a Physician.

4. Medical, Surgical and Obstetrical Services

We cover these medical, surgical, and obstetrical services:

- Physician services;
- Operating room and related facilities;
- Anesthesia and oxygen services;
- Intensive care and other special care units and services;
- X-ray, laboratory, and other diagnostic tests;
- Prescription medications and biologicals for use while You are an inpatient;
- Radiation and inhalation therapies; and
- Whole blood including cost of blood, blood plasma, and blood plasma expanders, that are not replaced by or for the enrollee; administration of whole blood and blood plasma.

5. Observation Unit Admission

We cover admissions to the observation unit of a Hospital, or other approved facility if admission for observation is ordered by Your PCP or in plan specialist.

6. Rehabilitation, Habilitation, Speech, Occupational, and Physical Therapy Services

We cover inpatient rehabilitation, habilitation, speech, occupational, and physical therapy services, including cardiac rehabilitation services that meet all of these conditions:

- Your PCP or participating provider specialist orders such rehabilitation or therapy services;
- The services can be expected to meet or exceed the treatment goals established for You by Your Physician.

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

7. Skilled Nursing Facility

We cover inpatient care in a skilled nursing facility if it meets all of these conditions:

- If You were not admitted to a skilled nursing facility, You would need acute care hospitalization;
- The skilled nursing services are of a temporary nature and will lead to rehabilitation and increased ability to function;
- Your PCP or attending participating provider specialist refers You.

We *do not* cover custodial care as described in *Section 5, What Is Not Covered.*

8. Short-Term Mental Health Services

Short-term evaluation and crisis intervention is covered for Members who are demonstrating an acute psychiatric crisis of severe proportions, which substantially impairs thoughts, perception of reality, judgment or grossly impairs behavior.

Treatment for certain mental illnesses is not covered. Refer to *Section 5, What is Not Covered.*

9. Serious Mental Illness Services

Treatment for serious mental illness is covered if the mental illness or disorder being treated is one of the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

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

10. Chemical Dependency Treatment

Inpatient treatment for chemical dependency (abuse of, psychological or physical dependence on, or addiction to alcohol or a controlled substance) is covered.

A series of treatments is a planned, structured, and organized program to promote chemical free status. Treatment is considered complete when the Member is discharged on medical advice from inpatient detoxification, inpatient rehabilitation/treatment, partial hospitalization or intensive outpatient, or a series of these levels of treatments without a lapse in treatment. Treatment may also be considered complete or terminated when a Member does not comply with the treatment program for a period of 30 days.

11. Blood and Blood Products

We provide coverage for:

- Whole blood including cost of blood, blood plasma, and blood plasma expanders that are not replaced by or You.
- Administration of whole blood and blood plasma.

OTHER HEALTH CARE SERVICES

Please refer to the Schedule of Copayments for copayment amounts and any benefit limitations that may apply for certain services.

1. Home Health Care

Health Services include:

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

Home Health Agency means a business that:

- Provides home health services; and
- Is licensed by the Texas Department of Human Services under Chapter 142, Health and Safety Code.

Home health services means the provision of health services for payment or other consideration in a patient's residence under a plan of care that is:

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

Home health services are provided unless the attending physician certifies that hospitalization or confinement in a skilled facility would be required if a treatment plan for home health care were not provided. The Home Health Care visit limitation can be extended in the event that it would result in not having to admit the Member to a Facility for continued Medical Care.

We cover skilled care services within the home care benefit from:

1. A licensed home health agency; or

2. Private duty nursing, when pre-approved in the following limited set of circumstances:

- Skilled care that exceeds the capacity of periodic home care from a licensed home health agency AND
- Member's care can be safely managed in the home setting AND
- Member's Primary care provider is willing and able to follow the patient during private duty nursing service AND
- Not being used for the purpose of providing custodial care or for the reason of member/family convenience.

2. Home Infusion Therapy

Home Infusion Therapy is the administration of medication (including chemotherapy), fluids or nutrition by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the Member's home. Home infusion therapy medications are covered under "Medical Injectable Drugs". These benefits include Home Infusion Therapy:

- Equipment and supplies needed to administer the therapy;
- Delivery services;

- Related nursing services; and
- Patient and Family education.

Injectable Medications recognized by the FDA as appropriate for self-administration (referred to as "self-injectable" drugs), regardless of the enrollee's ability to self-administer, are not covered, unless Your group has purchased the Prescription Drug Rider or coverage is otherwise specified in this document. Refer to Your Prescription Drug Rider for details.

3. Non-Emergency Ambulance Transport Service

We cover non-emergency ambulance transport (for example, a Member is discharged from an inpatient facility and needs to be moved to a skilled nursing facility). Non-emergency ambulance transport must be medically necessary.

Ambulance transport services for convenience are not covered.

For emergency ambulance services, see *Section 4, Emergency and Out-of-Area Urgent Care.*

4. Reconstructive Surgery Services

Covered Health Services provided by or under the direction of a Physician in a Physician's office, Hospital, or other Health Care Facility or program and are necessary to:

- Correct a defect resulting from a congenital anomaly that was present at birth;
- Restore normal physiological functioning following an accident, injury or disease;
- Perform breast reconstruction necessitated by a partial or complete removal of breast for cancer. Reconstruction of the unaffected breast will be covered when necessary to achieve symmetry and prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy. Initial breast reconstruction resulting from a mastectomy that occurred prior to the Effective Date of coverage is a covered benefit.
- Conduct Surgery for craniofacial abnormalities to improve the function of, or to attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infection or disease.

5. Spinal Manipulation

Your plan includes coverage for spinal manipulation services. Services may be rendered by a participating in Participating Provider. Refer to the Schedule of Copayments (SOC) for benefit details.

6. Prosthetics and Orthotics

We cover standard external, non-cosmetic prosthetic or orthotic devices. Examples of covered devices include artificial arms, legs, hands, feet, eyes, breast prostheses, and surgical brassieres after mastectomy for breast cancer. See *Section 11, Definitions* for more information.

We cover repair or replacement of any external prosthetic or orthotic device, unless the repair is needed due to misuse of the device(s) or the replacement is due to loss by the Member. We also cover professional services related to the fitting and use of those devices that equal coverage provided under federal law.

Orthopedic/corrective shoes, shoe inserts, arch supports, orthotic inserts and other supportive devices for the feet are not covered, except when pre-approved and medically necessary for individuals with foot complications from diabetes. We do not cover ankle braces with the exception of braces required for recovery after surgery, and for certain illness and injury.

7. Internal Implantable Devices

We cover internal, non-cosmetic prosthetic and orthotic devices, including permanent aids and supports for defective parts of the body, except for those described in *Section 5, What is Not Covered.*

Examples of covered devices include: cochlear implants, joint replacements, cardiac valves, internal cardiac pacemakers, lumbar spinal cord stimulators, sacral nerve stimulators, and intra-ocular implantable lenses following cataract surgery or to replace an organic lens missing because of congenital absence. Benefits are provided for standard implantable lenses in connection with surgery for cataracts or other diseases of the eye or to replace an organic lens missing because of congenital absence. Contact lenses are covered for the treatment of Keratoconus only.

NOTE: Only certain brands/types of internal implantable devices are covered and some implantable devices require pre-approval from FirstCare.

8. Dorsal Column Stimulators

Dorsal column stimulation (spinal cord stimulation) is a covered benefit for neurogenic pain. Medical necessity guidelines must be met and authorized by Us.

9. Durable Medical Equipment

The following durable medical equipment is covered as a basic Plan benefit:

Durable Medical Equipment (DME) is medical equipment that in the absence of illness or injury is of no medical or other value to You, which is able to withstand repeated use by more than one person and is not disposable. Examples of such equipment include but are not limited to: crutches, hospital beds, and wheelchairs, walkers, lymphedema pumps, traction devices, canes, Continuous Passive Motion (CPM) devices, infusion pumps, phototherapy light, alternating pressure pads and pumps.

Coverage is provided for the medically necessary DME meeting the following conditions:

- DME must be ordered or prescribed by a health care provider and provided by a contracted supplier;
- DME must be medically necessary as determined by the Medical Director;
- DME may be purchased or rented, whichever is most cost effective, as determined by the Medical Director;
- Coverage is provided for the initial equipment only; and
- Only the standard equipment is covered. Special features that are not part of the basic equipment are not covered, such as electric beds and motorized or customized wheelchairs.

In the event it is determined to be more cost effective to purchase or when the rental payments equal the purchase price of any DME, then that DME becomes the property of the company. You are responsible for any replacement, repair, adjustment or routine maintenance of Your equipment.

The following items are not included in the DME limitation:

- Oxygen and mechanical equipment necessary for treatment of chronic or acute respiratory failure;
- Durable medical equipment used for the treatment of diabetes; and
- Monitoring devices, such as apnea monitors, glucose monitors and uterine monitors, for use in the home when prescribed and directed by a health care provider and approved by FirstCare.

10. Medical Supplies

The following medical supplies are covered.

- Medical supplies used for the treatment of diabetes are covered. Examples of these supplies include test strips, lancets, and lancet devices. For a more complete listing of these supplies, see the definition of *Diabetes Supplies in Section 11 Definitions.*
- Standard ostomy supplies, sterile dressing kits, such as tracheostomy and central line dressing kits, as well as those medical supplies requiring a Physician's order to purchase, when purchased through a Participating Provider. Supplies that can be purchased over-the-counter without a Physician order are not covered. See *Section 5, What is Not Covered.*
- Disposable Home Infusion Therapy supplies
- Allergy syringes.

11. Diabetes Services

For those Members diagnosed with diabetes, elevated blood glucose levels induced by pregnancy or other medical conditions associated with elevated blood glucose levels, diabetes supplies, equipment, medications, and self-management education for the treatment of diabetes are covered. Eye examinations are also covered for Members with diabetes.

Diabetes Equipment and Supplies

See *Durable Medical Equipment and Supplies* in this section. Insulin Pump Supplies can be obtained in 30-day amounts through this Durable Medical Supply benefit or in a 90-day amount through a Participating Mail Service Pharmacy. Call the FirstCare Customer Service Department at 1-800-884-4901 for more information.

Diabetes Medications

The following medications for the treatment of diabetes are covered:

- Insulin;
- Insulin analog preparations;
- Prescriptive and non-prescriptive medications for controlling blood sugar levels; and
- Glucagon emergency kits.

Medications are limited to a 30-day supply when purchased through a retail Plan pharmacy or a 90-day supply when purchased through a Participating Mail Service Pharmacy. For information on participating pharmacies, see the Provider Directory or call the FirstCare Customer Service Department at 1-800-884-4901 or go to the FirstCare website at www.FirstCare.com.

You pay a Copayment for each medication. For a detailed list of Copayments please refer to the *Schedule of Copayments.*

Diabetes Self-Management Education

Diabetes self-management individual and group training programs are covered when ordered by Your Physician and provided by a licensed Participating Provider or a certified diabetes educator or dietician under the following circumstances:

- After the initial diagnosis, including nutritional counseling and proper use of Diabetes Equipment and Supplies;

- When the provider diagnoses a significant change in the condition which requires a change in Your self-management regimen; or
- When the provider prescribes, orders, or recommends such additional training in order to teach the Member about new techniques and treatments for diabetes.

12. Hearing Aids and Cochlear Implants

We provide coverage for a hearing aid or cochlear implant and related services and supplies for a covered individual who is 18 years of age or younger when determined to be medically necessary by a Plan Physician and obtained from a Participating Provider. Refer to the Schedule of Copayments (SOC) for details.

Coverage includes:

- fitting and dispensing services and the provision of ear molds as necessary to maintain optimal fit of hearing aids;
- any treatment related to hearing aids and cochlear implants, including coverage for habilitation and rehabilitation as necessary for educational gain; and
- for a cochlear implant, an external speech processor and controller with necessary components replacement every three years; and

Limitations:

- one hearing aid in each ear every three years; and
- hearing aid prescription must be written by:
    a. a physician certified as an otolaryngologist or otologist; or
    b. an audiologist who (1) is legally qualified in audiology; or (2) holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements; and who performs the exam at the written direction of a legally qualified otolaryngologist or otologist.
- When alternate hearing aids can be used, the plan's coverage may be limited to the cost of the least expensive device that is:
    a. Customarily used nationwide for treatment, and
    b. Deemed by the medical profession to be appropriate for treatment of the condition in question. The device must meet broadly accepted standards of medical practice, taking into account your physical condition. You should review the differences in the cost of alternate treatment with your physician. You and Your physician may still choose the more costly treatment method however You are responsible for any charges in excess of what the plan will cover.
- one cochlear implant in each ear with internal replacement as medically or audiologically necessary.

Coverage required under this section is subject to any provision that applies generally to coverage provided for durable medical equipment benefits under the plan, including a provision relating to deductibles, copayments, or prior authorization.

13. Limited Accidental Dental-Related Services

a. We provide limited coverage for dental services that would be excluded from coverage but are determined by the Medical Director to be medically necessary and incident to and an integral part of a covered medical procedure. Examples could include the following:

- Removal of broken teeth as necessary to reduce a fractured jaw.
- Reconstruction of a dental ridge resulting from removal of a malignant tumor.
- Extraction of teeth prior to radiation therapy of the head and neck.

b. We provide limited coverage for initial restoration and correction of damage caused by external violent accidental injury to natural teeth and/or jaw if:

- The fracture, dislocation or damage results from an accidental injury;
- Restoration or replacement is completed within 6 months of the date of the injury.

c. Removal of cysts of the mouth (except for cysts directly related to the teeth and their supporting structures).

d. Certain Oral surgeries including maxillofacial surgical procedures that are limited to:

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

e. Medically necessary services performed in a Plan outpatient facility and are required for the delivery of necessary and appropriate dental services when the dental services cannot be safely provided in a dentist's office due to the Member's physical, mental, or medical condition.

The services described above are the only dental-related services covered under Your Plan. See *Section 5, What is Not Covered.*

14. Temporomandibular Joint Syndrome (TMJ) Services

We provide coverage for the diagnosis and surgical treatment of disorders of, and conditions affecting the temporomandibular joint, which includes the jaw and the cranio-mandibular joint resulting from an accident, trauma, congenital defect, developmental defect, or a pathology.

We do not cover medical treatment or oral appliances and devices used to treat temporomandibular pain disorders and dysfunction of the joint and related structures, such as the jaw, jaw muscles, and nerves. See *Section 5, What is Not Covered.*

15. Dialysis Services

Dialysis Services are covered. Pre-approval is not required if the services are received by a contracted provider. Pre-approval is required for these services if they are received by a Non-Participating Provider and is granted only when medically necessary to see a Non-Participating Provider.

16. Organ and Stem Cell Transplants

Preauthorization is required for any organ, tissue, or United States Food and Drug Administration (FDA) approved artificial device transplant, even if the member is already in a treatment facility under another preauthorization.

The covered transplants or device must meet all of the following conditions or they will not be covered:

- The recipient is a Member.
- The Member meets all of the criteria used by FirstCare to determine medical necessity for the transplant.
- The member meets all of the protocols established by the facility in which the transplant is performed.
- A contracted medical facility designated and approved by FirstCare as being in Our transplant network is authorized to evaluate the Member's case, has determined that the proposed

transplant is appropriate for treatment of the Member's condition and has agreed to perform the transplant;

- The proposed transplant is not experimental or investigational for treatment of the Member's condition, and is not to be performed in connection with a drug, device, or medical treatment or procedure that is experimental or investigational.
- Donated human organs or tissues or an FDA approved artificial device are used.

Covered services and supplies related to an organ or tissue transplant or FDA approved artificial device include, but are not limited to, imaging studies (e.g. x-rays, CT scan, MRI, scan), laboratory testing, chemotherapy, radiation therapy, prescription drugs, procurement of organs or tissues from a living or deceased donor, and complications arising from such transplant.

Note: *Denials for experimental/investigational treatments or procedures are eligible for review by an Independent Review Organization (IRO). See Section 9 for information on complaints and appeal procedures.*

Limitations & Non-covered Services

Coverage of each type of solid organ transplant listed above is limited to one (1) initial transplant and one (1) subsequent re-transplant due to rejection.

For a covered transplant to a Plan Member, medical costs for the removal of organs, tissues, or bone marrow from a live donor will be covered, but only to the extent that such costs are not covered by the donor's group or individual health plan, benefit contract, prepayment plan, or other arrangement for coverage of medical costs, whether on an covered or uncovered basis. If the donor is also a Member of FirstCare, coverage is subject to all procedures, limitations, exclusions, Copayments, and deductibles that apply under the donor-Member's plan only if all the above conditions are met. We do not cover any other donor expenses, including any transportation costs.

17. Chemotherapy

We cover chemotherapy services.

18. Radiation Therapy

We cover radiation therapy services.

19. Amino Acid-Based Elemental Formulas

We provide coverage for amino acid-based elemental formulas, regardless of the formula delivery method, that are used for the diagnosis/treatment of the following:

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

Coverage for these services is provided in no less of a favorable manner than the basis on which prescription drugs and other medications and related services are covered by this Plan.

20. Clinical Trials – Routine Patient Care

In regards to this benefit, routine patient care entails the costs of any medically necessary health care service for which benefits are provided under a health benefit plan, without regard to whether You are participating in a clinical trial.

Routine patient care costs DO NOT include:

- Costs of investigational new drugs or devices that are not approved for any indication by the United States Food and Drug Administration, including drugs or devices that are the subject of clinical trials;
- Costs of services that are not health care services, regardless of whether the service is required in connection with participation in clinical trials;
- Costs of services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; or
- Costs of health care services that are specifically excluded from this Plan. See *Section 5, What is Not Covered* for further details.

This benefit is provided for routine patient care for a Member in connection with a Phase I, II, III, or IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of a life-threatening disease or condition or cancer.

21. Hospice Services

We cover the care and treatment of a Member by a participating hospice if these conditions are met:

- The services are provided by a participating hospice provider licensed by the State of Texas;
- Your Plan Physician has certified that You have a limited life expectancy of 6 months or less due to a terminal illness.

Covered services include the provision of pain relief, symptom management and supportive services to terminally ill Members and their immediate families on both an outpatient and inpatient basis.

22. Nutritional Counseling

Your plan includes coverage for nutritional counseling services. Services may be rendered by a Participating Provider. Refer to the Schedule of Copayments (SOC) for benefit details.

23. Telemedicine and Telehealth Services

Your plan includes coverage for telemedicine and telehealth services. Services may be rendered by a Participating Provider. Refer to the Schedule of Copayments (SOC) for benefit details.

SECTION 4 – EMERGENCY AND OUT-OF-AREA URGENT CARE SERVICES

Please refer to the Schedule of Copayments for copayment amounts and any benefit limitations that may apply for certain services.

There are special circumstances for health care services that We will cover, even though those services are not provided by a Participating Provider. These are:

Emergency Care

1. What is Emergency Care

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

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

Heart attacks, cardiovascular accidents, poisoning, loss of consciousness or breathing, convulsions, severe bleeding, and broken bones are examples of medical emergencies for which emergency care would be covered.

Emergency care includes the following services:

- An initial medical screening examination by the facility providing the emergency care or other evaluation required by state or federal law that is necessary to determine whether an emergency medical condition exists;
- Services for the treatment and stabilization of an emergency condition; and
- Post-stabilization care originating in a Hospital emergency room, Freestanding Emergency Medical Care Facility, or comparable emergency facility, if approved by Us, provided that We must approve or deny coverage within the time appropriate to the circumstances relating to the delivery of the services but in no case to exceed one hour of a request for approval by the treating Physician or the Hospital emergency room.

Emergency services, including inpatient services, are covered regardless of the providing facility's location.

2. Requirements for All Emergency Care

To be covered, emergency care must meet all of these conditions:

- You must obtain the services immediately, or as soon as possible, after the emergency condition occurs;
- As soon as possible after the emergency occurs and You seek treatment, You (or someone acting for You) must contact Your PCP for advice and instructions. In any event, You must contact the Plan within 24 hours, unless it is impossible to do so; and

- You must be transferred to the care of Participating Providers as soon as this can be done without harming Your condition. We do not cover services provided by Non-Participating Providers after the point at which You can be safely transferred to the care of a Participating Provider.

FirstCare has the right to review the services and circumstances in which You received them. We will cover the initial medical screening evaluation necessary to determine whether an emergency medical condition exists. After an emergency condition has been stabilized, Your Physician must preauthorize continued treatment or it may not be covered.

Out-of-Area Urgent Care

1. What is Out-of-Area Urgent Care

Out-of-area urgent care means medical services that:

- Do not meet the requirements necessary to be considered "Emergency Care" described in this section;
- You urgently need while You are outside of FirstCare's Service Area;
- You could not reasonably have anticipated needing before You left the FirstCare Service Area; and
- Cannot safely be delayed until You are able to come back to the Service Area to obtain care through Your PCP.

In determining whether services provided to You will be covered as out-of-area urgent care, We have the right to review the services and the circumstances in which You received them. If We decide that some or all of the services do not meet the coverage requirements of this section, You will have to pay all charges for the non-covered services.

2. *Requirements for All Out-of-Area Urgent Care*

To be covered, out-of-area urgent care must meet all of these conditions:

- Before receiving treatment for urgent care, You should try to contact Your PCP and explain Your medical circumstances to him or her;
- You must obtain the services immediately after the urgent condition occurs, or as soon as possible afterward. In any event, You (or someone acting for You) must contact Us within 24 hours, unless it is impossible to do so; and
- If You were unable to contact Your PCP before seeking treatment, You (or someone acting for You) must contact Your PCP for advice and instructions as soon as possible after the urgent condition occurs. In any event, You (or someone acting for You) must contact Us within 24 hours, unless it is impossible to do so.

Additionally, You must be transferred to the care of Participating Providers as soon as this can be done without harming Your condition. We do not cover services provided by Non-Participating Providers after the point at which You can be safely transferred to the care of a Participating Provider.

FOR IN-AREA URGENT CARE: If You urgently need services while inside the FirstCare Service Area, but Your condition is not serious enough to be a medical emergency, You should first seek care through Your PCP, as You would for Your regular covered care. Please remember that We will not cover urgent care inside the Service Area from an Non-Participating Provider**.**

Services and Copayments

As long as the requirements described above are satisfied, We will cover the following services:

- Hospital emergency room services, including an initial medical screening examination;
- Services in an outpatient emergency, Freestanding Emergency Medical Care Facility, or urgent care center. We will also cover emergency services in a comparable facility;
- Emergency ambulance service to the nearest medical facility able to provide appropriate care. For non-emergency ambulance transport services, see *Section 3, What is Covered*; and
- Any other covered health care services detailed in *Section 3, What Is Covered*. However, the services must meet all of the conditions described above under this section. Your specific Copayments for these services are outlined in the *Schedule of Copayments.*

If possible, You should make these Copayments to the provider of services at the time the service is rendered, even if the provider is an Non-Participating Provider.

Payment Procedures

Payment for emergency care received from Non-Participating Providers, inside or outside Our Service Area, and out-of-area urgent care is provided in one of two ways:

- We will pay Non-Participating Provider Reimbursement Amount for care received from Non-Participating Providers
- You will be held harmless for any amounts beyond the copayment or other out-of-pocket amounts that You would have paid had the network included network physicians or providers from whom You could obtain the services.
- You should contact Us at www.FirstCare.com or Customer Service at 1-855-572-7238 if the Non-Participating Provider bills You for amounts beyond the amount paid by Us.

You may contact ConsumerProtection@tdi.texas.gov or 1-800-252-3439 for complaints regarding payment.

Medically Necessary Services

If medically necessary covered services are not available through network physicians or providers, We will, on the request of a network physician or provider, within a period not to exceed five business days, shall allow referral to a non-network physician or provider and shall fully reimburse the non-network physician or provider for emergency care services at the Non-Participating Provider Reimbursement (NPPR) amount until You can reasonably be expected to transfer to a network physician or provider. You will be held harmless for any amounts beyond the copayment or other out-of-pocket amounts that You would have paid had the network included network physicians or providers from whom You could obtain services. We must provide for a review by a specialist of the same specialty or a similar specialty as the type of physician or provider to whom a referral is requested before We may deny a referral.

FirstCare Review

We will cover the initial medical screening evaluation necessary to determine whether an emergency medical condition exists; however, We have the right to review all other services that were provided to You to determine whether they satisfy all the conditions for coverage of emergency or Out-of-Area urgent care specified above, if permitted by law. If We decide that they did not satisfy one or more of these conditions, We will require You to pay for the services. An initial medical screening will be a covered service subject to the applicable Copayment described above. If You disagree with Our decision, You can appeal Our decision by using the procedures described in *Section 9, Member Complaint and Appeal Procedure.*

SECTION 5 – WHAT IS NOT COVERED

It is important that You understand what services are not covered. There are two general rules to remember:

- We cover only the health care services described in Sections 3 and 4 of this document. If a service is not listed in either of those sections, it is not covered.
- You must always meet the conditions for coverage described in Sections 1 through Section 4 of this document. Please make sure You meet all of these conditions and follow all of the required procedures. If You do not, We will not pay for the service.

We will not pay for the following services:

1. **Additional expenses** incurred as a result of Your failure to follow a Participating Provider's medical orders.

2. The following types of **Alternative Services,** therapy, counseling and related services or supplies:
    - Acupuncture, naturopathy, hypnotherapy or hypnotic anesthesia, Christian Science Practitioner Services or biofeedback;
    - For or in connection with marriage, child, career, social adjustment, finances, or medical social services;
    - Psychiatric therapy on Court Order or as a condition of parole or probation.
    - Lifestyle Eating and Performance (LEAP) program.

3. **Amniocentesis,** except when Medically Necessary.

4. **Assistant Surgeons**, unless determined to be Medically Necessary.

5. **Biofeedback** services, except for the treatment of acquired brain injury and for rehabilitation of acquired brain injury.

6. **Circumcision** in any male other than a newborn (age 30 days or less), unless Medically Necessary.

7. Services that are supplied by a person who ordinarily resides in the Member's home or is a Family member or **close relative** of the Member.

8. Televisions, telephones, guest beds, and other items for Your **comfort or convenience** in a Hospital or other inpatient facility. Admission kits, maternity kits, and newborn kits provided to You by a Hospital or other inpatient facility.

9. 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 related prostheses, except breast prosthesis following mastectomy), unless specifically provided in *Section 3, What Is Covered*. Among the procedures 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 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.

10. **Cryotherapy** devices such as PolarCare™.

11. Respite or Domiciliary care and Inpatient or outpatient **custodial care**. Custodial care is care that:

- Primarily helps with or supports daily living activities (such as, cooking, eating, dressing, and eliminating body wastes); or
- Can be given by people other than trained medical personnel.

Care can be custodial even if it is prescribed by a Physician or given by trained medical personnel, and even if it involves artificial methods such as feeding tubes or catheters. This includes custodial care for conditions such as, but not limited to, Alzheimer's disease, senile deterioration, persistent vegetative state, mental retardation, mental deficiency, or any other persistent illness or disorder.

12. 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 for Members , 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.

The only dental-related coverage We provide is described in *Section 3, What Is Covered, Limited Dental Care Service.*

This Plan must remain in effect during the entire time the corrective treatment of an Injury to natural teeth is being completed.

13. Charges for the normal **delivery of a baby** (vaginal or cesarean section) outside Our Plan's Service Area if the delivery is within thirty days of Your due date specified by Your participating Physician, or Your Physician has advised against travel outside Our Service Area, except in case of emergency as specified in *Section 4, Emergency and Out-of-Area Urgent Care Services.* Complication of a pregnancy or delivery is treated as any other illness.

14. The following **devices**, **equipment, and supplies** are excluded:

- Corrective shoes, shoe inserts, arch supports, and orthotic inserts, except as provided for under *Section 3, What is Covered* and for the treatment of diabetes ;
- Equipment and appliances considered disposable or convenient for use in the home, such as over-the counter bandages and dressings;

- Comfort or convenience items, such as bathtub chairs, whirlpool tubs, safety grab bars, stair gliders or elevators, over-the-bed tables, bed boards, saunas, and exercise equipment;
- Environmental control equipment, such as air conditioners, purifiers, humidifiers, dehumidifiers, electrostatic machines, and heat lamps;
- Consumable medical supplies, such as over-the-counter bandages, dressings, and other disposable supplies, skin preparations, surgical leggings, elastic stockings, TED stockings, stump socks and compression garments.
- Foam cervical collars;
- Stethoscopes, sphygmomanometers, and recording or hand-held pulse oximeters;
- Hygienic or self-help items or equipment; and
- Electric, deluxe, and custom wheelchairs or auto tilt chairs.
- Sequential lymphedema compression devices, except for treatment after a mastectomy.

15. The following **drugs, equipment, and supplies**, except immunizations and prescribed treatment of Phenylketonuria (PKU) and diabetes:

- 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

16. Educational testing and therapy, motor or language skills, 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 as described in *Section 3, What Is Covered*.

17. Electron Beam Tomography (EBT).

18. Treatments, services or supplies for **non-Emergency Care** at an emergency room.

19. Weekend admission charges for **non-Emergency Care** services, unless medically necessary.

20. Non-**Emergency** confinement, treatment, services, or supplies received outside the United States.

21. Equine or Hippo therapy.

22. 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 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.

Denials for Experimental & Investigational drugs, devices, treatments or procedures are eligible for review by an Independent Review Organization (IRO). See Section 9 for information on complaints and appeal procedures.

23. 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. We do not cover ankle braces, with the exception of those listed under *Section 3, What is Covered.*

24. **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.

25. **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.

26. All charges for a **Hospital** admission for procedures to diagnose or evaluate or treat, unless determined to be Medically Necessary.

27. All charges for inpatient **Hospital** days that exceed the medically recommended length of stay for the diagnosis, unless medically necessary.

28. **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.

29. 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 while You are in the custody of any government authority, and any care that is required by law to be given in a public facility.

30. Appearance at court hearings and other **legal proceedings.**

31. **Massage therapy**, unless associated with a physical therapy modality provided by a licensed physical therapist.

32. **Mastectomy** for relief of pain, prophylactic mastectomy to reduce the risk of breast cancer occurrence (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.

33. 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.

Denials for Experimental & Investigational drugs, devices, treatments or procedures are eligible for review by an Independent Review Organization (IRO). See Section 9 for information on complaints and appeal procedures.

34. **Medications** prescribed for non-FDA approved indications are not covered. This includes experimental, investigational, and any disease or condition that is excluded from coverage under this Evidence of Coverage; or that the FDA has determined to be contraindicated for treatment of the current indication.

Denials for Experimental & Investigational drugs, devices, treatments or procedures are eligible for review by an Independent Review Organization (IRO). See Section 9 for information on complaints and appeal procedures.

35. **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.

Denials for Experimental & Investigational drugs, devices, treatments or procedures are eligible for review by an Independent Review Organization (IRO). See Section 9 for information on complaints and appeal procedures.

36. **Mental health** services for the treatment of 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 covered health service.

37. Charges for **missed appointments** and charges for completion of a Claim form.

38. Implanted **neurological stimulators**, including but not limited to spinal or dorsal column stimulators for Parkinson's, movement disorders, or seizures, except for stimulators implanted for relief or neurogenic pain when meeting established clinical criteria; and except for neurogenic bladder.

39. Charges that exceed the **Non-Participating Provider Reimbursement (NPPR)**. Refer to *Section 1, Requirements for All Healthcare Services*, for clarification on out-of-network services and services received from non-participating providers.

40. If a service is **not covered** under the Plan, 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.
- Complications from non-covered service
- All care related to services that are not covered, including direct complications and pre or post care.

For example, if a Member undergoes non-covered cosmetic surgery, We will not cover pre-operative care, post-operative care, or hospitalization related to the non-covered surgery. Even if the service was covered by another health plan, it will be considered non-covered under this Plan.

41. **Obesity:** Services intended primarily to treat obesity, such as gastric bypasses and balloons, vertical sleeve gastrectomy, bileo-pancreatic diversion (duodenal switch),stomach stapling, jaw wiring, vertical banding, 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 or if 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 Plan.

42. Prophylactic **oophorectomy:** removal of one or both ovaries in the absence of malignant disease to reduce the risk of ovarian cancer occurrence.

43. **Orthotic** devices, except for the treatment of diabetes and those described in *Section 3, What is Covered.*

44. **Orthotripsy** and related procedures.

45. **Outpatient services** received in federal facilities or any items or services provided in any institutions operated by a state government or agency when a Member has no legal obligation to pay for such items or services, except for treatment provided in a tax supported mental health institution or by Medicaid.

46. Intradiscal Electrothermal Annuloplasty (IDET) procedures for **pain management**.

47. **Physical Exams,** Treatments and evaluations required by employers, insurers, schools, camps, courts, licensing authorities, flight clearance and other third parties.

48. All internal and external **prosthetic items and devices**, except for those specified in *Section 3, What is Covered*. We do not cover splints unless they are needed for urgent or emergency treatment and/or in lieu of castings or surgery.

49. **Reduction mammoplasty**, except for surgical reconstruction related to treatment of breast or unless medically necessary.

50. Long-term **rehabilitative services**. Long term is defined as more than two months.

51. **Reports:** Special medical reports not directly related to treatment.

52. **Self-Injectable Medications** recognized by the FDA as appropriate for self-administration, regardless of the enrollee's ability to self-administer, are not covered, except as covered in the Prescription Drug Rider or coverage is otherwise specified in this document. Refer to Your prescription drug Rider for details.

53. **Services** not completed in accordance with the prescribing Physician's orders.

54. **Services** required as a result of Experimental/Investigational drug testing done voluntarily by You without Our approval.

    Denials for Experimental/Investigational drugs, devices, treatments or procedures are eligible for review by an Independent Review Organization (IRO). See Section 9 for information on complaints and appeal procedures.

55. **Services** provided and independently billed by interns, residents or other employees of Hospitals, laboratories or other medical Facilities; unless the Member is hospitalized due to an emergency (or an approved admission), hospital-based providers must be paid at NPPR or agreed rate.

56. **Services** that are provided, paid for, or required by state or federal law where this Evidence of Coverage is delivered, except under Medicaid, when in the absence of insurance, there is no charge for that service.

57. Volunteer **services**, which would normally be provided at no charge to You.

58. **Services** associated with autopsy or post-mortem examination unless requested by Us.

59. Any **services or supplie**s furnished at a facility, which is primarily a place of rest, a place for the aged, a nursing home or similar institution.

60. All **services or supplies** provided while You are not covered under this Plan; either before the effective date of coverage or after this Evidence of Coverage ended.

61. Treatment, implanted devices or prosthetics, or surgery related to **sexual dysfunction** or inadequacies including, but not limited to impotency, regardless of Medical Necessity, unless related to prior surgical treatment or a result of treatment for a covered condition.

62. Sports cords and transcutaneous electrical nerve stimulation (TENS) units.

63. **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.

64. Infertility testing and treatment, infertility drugs, reversal of voluntary **sterilization**; gamete intra-fallopian transfer (GIFT); zygote intra-fallopian transfer (ZIFT); in vitro fertilization (IVF), unless an additional rider has been purchased; any costs related to surrogate parenting; sperm banking for future uses, medical services for artificial insemination; or any assisted reproductive technology or related treatment.

65. 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 any such items or supplies specified in *Section 3, What is Covered*.

66. Medical treatment and oral appliances and devices for **temporomandibular joint** (TMJ) syndrome.

67. 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.

68. **Transportation**, except for ambulance or air ambulance used for transport in a medical emergency or when We have pre-approved services for medical transport purposes only (e.g. from a Hospital to a skilled nursing facility).

69. **Treatment** a school system is required to provide under any law.

70. **Vision Care Services:** Vision exams, eye exercises, training, orthoptics, multiphase testing, eyeglasses (including eyeglasses and contact lenses prescribed following vision surgery) contact lenses, except for treatment of Keratoconus, and any other items or services for the correction of Your eyesight, including but not limited to: orthoptics, vision training, vision therapy, radial keratotomy (RK), automated lamellar keratoplasty (ALK or LK), astigmatic keratotomy (AK), laser vision corrective surgery and photo refractive keratectomy (PRK-laser) unless specifically provided in *Section 3, What Is Covered,* or provided by a Rider.

71. Health care services for any **work-related** injury or illness.

72. Illness or injury incurred as a result of **war** or any act of war, whether declared or undeclared, whether or not You served in the military.

Limitations Due To Certain Conditions

In the event that due to circumstances not within the control of FirstCare, including but not limited to a major disaster, epidemic, the complete or partial destruction of facilities, war, riot, civil insurrection, disability of a significant number of Participating Providers and their personnel, or similar causes, the rendering of Covered Health Services provided under this Evidence of Coverage is delayed or rendered impractical, FirstCare shall make a good faith effort to arrange for an alternative method of providing coverage. In such an event, FirstCare and its Participating Providers shall render Covered Health Services insofar as practical, and according to their best judgment; but FirstCare and Participating Providers shall incur no liability or obligation for delay or failure to provide or arrange for services if such failure or delay is caused by any such event.

SECTION 6 – UTILIZATION REVIEW (U.R.) PROGRAM

The following provisions apply to Your coverage under the FirstCare Evidence of Coverage. .

Definitions

Preauthorization, Pre-Approval, Authorization, and Authorize - the review and confirmation of the Medical Necessity of an admission or Covered Health Service that is subject to the U.R. Program Requirements.

Scheduled - a medical procedure, treatment, surgery, or service, which has been planned in advance by Your Health Care Provider.

Effect on Benefits

We will pay for Covered Health Services described in the Schedule of Copayments and subject to all provisions of this Evidence of Coverage, when the Utilization Review requirements are properly followed and the applicable Medical Care is Pre-authorized. You are responsible for obtaining Pre-authorization. .

In the event of an Adverse Determination, the Utilization Review Agent will provide a written notification to You and Your Health Care Provider. The Utilization Review Agent will provide notification to the provider of record within 24 hours by telephone or electronic transmission if You are an inpatient or by mail within three calendar days if You are not an inpatient. If the health care service involves post-stabilization treatment or a Life-Threatening condition, the Utilization Review Agent will provide notification within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case to exceed one hour of a request made during normal business hours or within one hour of opening for business the next day if the request is received after hours. The determination will be provided to the treating physician or health care provider. You can request an appeal if You or Your Health Care Provider does not agree with an Adverse Determination made by Our Utilization Review Agent.

A Utilization Review Agent will also provide notice not later than 30 days prior to the discontinuance of concurrent prescription drug or intravenous infusions for which You are receiving health benefits under the Evidence of Coverage. You are entitled to an immediate appeal to an Independent Review Organization for the denial of prescription drugs or intravenous infusions.

You, a person acting on Your behalf, Your Health Care Provider, or other Health Care Provider may appeal the Adverse Determination and contact the Utilization Review Agent. The URA will provide a list of documents that You or the appealing party needs to submit. In a circumstance involving a Life-Threatening condition, You are entitled to an immediate appeal to an Independent Review Organization. Please see Section 9 for more information on appeals for Adverse Determinations.

Utilization Review Program Requirements

You must notify Us before Covered Health Services, which require Preauthorization, are provided. You may either telephone Us, or have the attending Physician, a relative, or any other person contact Us on Your behalf.

Preauthorization must be obtained to receive maximum benefits provided for in this Evidence of Coverage. Any instances of material misrepresentation or failure to perform the proposed service(s) in order to obtain preauthorization may adversely affect payment of those services.

Pre-Authorization Requirements

We require that certain medical services, care, or treatments be preauthorized before We will pay for all related Covered Health Services. Preauthorization means that We review and confirm that proposed services, care, or treatments are Medically Necessary. You are responsible for ensuring that Your Physician obtains preauthorization for any proposed services at least five (5) days before You receive them. For a listing of the

services requiring preauthorization, please go to www.FirstCare.com or contact Customer Service at 1-800-884-4901. A paper copy is available upon request. This listing is subject to change.

If you fail to get proper authorization on the services, care or treatment that require preauthorization, they will not be covered.

Additionally, if You fail to get proper authorization, You may be charged additional amounts, which will not count toward Your Deductibles or Out-of-Pocket Maximums. These amounts are shown on the Schedule of Copayments.

We will 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.

Case Management Program

FirstCare's Case Management Program is included as part of Your benefit for when you have a serious medical or behavioral health condition or have experienced a significant change in Your health status. The program is voluntary and You may opt in or out at any time. FirstCare accepts referrals for Case Management from members or their caregivers, providers or other FirstCare staff. FirstCare also monitors claims and other information to help locate members who may benefit from services. FirstCare has doctors, nurses, social workers, pharmacists and behavioral health practitioners on the case management team so that a multi-disciplinary approach can be used to meet the needs of each member individually.

Once You are referred or identified, a member of the team reaches out to contact You and collect some additional health information if You agree to participate. This information is used to work with You or Your health care provider to decide the right level of case management and to develop a plan of care specific to You. Providing this information will not affect Your benefits. Some of the ways a case manager can provide include:

- Help with finding medical or behavioral health providers that can meet Your needs;
- Help with getting community resources that may be available to You;
- Information and resources to help You better understand Your conditions and how to better manage them;
- Help with learning how to navigate the healthcare system and better understand benefits.

Referrals for Case Management can be made by calling FirstCare Customer Service at 1-800-884-4901, or can be made by email sent to casemgmt@firstcare.com.

Disease Management Program

FirstCare Plus is a special disease management program offered to You at no additional cost. FirstCare Plus is a program that helps members with certain conditions to learn more about how to manage them. These conditions include:

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

- Heart Failure

Participation in disease management is completely voluntary and members may opt in or out at any time without affecting their benefits. Members who agree to participate receive phone calls from specially trained nurses and other staff, as well as helpful information in the mail. You can sign up or get more information by calling FirstCare Customer Service at 1-800-884-4901.

SECTION 7 – TERMINATION OF COVERAGE

Termination of Coverage

Your coverage may be terminated for any of the following reasons:

1. For a Member, in the case of:

- Nonpayment of amounts due, under this Evidence of Coverage may be canceled after not less than 30 days written notice; except that no written notice will be required for failure to pay premiums;
- Fraud or intentional material misrepresentation, coverage may be canceled after not less than 30 days written notice; subject to the incontestability provisions outlined in *Section 10, Miscellaneous Provisions;*
- Fraud in the use of services or facilities, coverage may be canceled after not less than 30 days written notice;
- Failure to meet eligibility requirements, coverage will be canceled immediately, subject to continuation of coverage privileges, if applicable;
- Failure of the Subscriber to live. work, and/or reside in the Service Area, coverage may be canceled through written notice 30 days before the termination date. This notice is required per 28 TAC §11.506(3)(A)(vii). This provision only applies if coverage is terminated uniformly without regard to any health status-related factor of Members. Coverage for a child who is the subject of a medical support order cannot be canceled solely because the child does not live, work, and/or reside in the Service Area.

2. For a Group, in the case of:

- Nonpayment of premium, subject to the Grace Period provision described in *Section 11, Definitions.* In this case, Your coverage will terminate at the end of the last period for which a premium payment has been made to FirstCare. If the payment is not received within the Grace Period, coverage may be canceled and the terminated Members may be held liable for the cost of services received during the Grace Period;
- Fraud on the part of the Group, coverage may be terminated after 30 days written notice;
- Violation of participation requirements. Coverage may be canceled if a Group fails to meet the participation requirement for a period of at least six consecutive months. FirstCare may terminate coverage upon the first renewal date following the end of the six month consecutive period;
- No enrollees from Your Group live, work, and/or reside in the Service Area; and
- Membership of an employer in an association ceases. If coverage is terminated uniformly without regard to the health status of a covered Member, coverage may be canceled after 30 days written notice. This provision applies only if coverage is terminated uniformly without regard to the health status of a covered Member.

Cancellation by a Group or individual Subscriber in the case of a material change by FirstCare to any provisions required to be disclosed to the Group or to the Subscribers pursuant to Title 28, Texas Administrative Code Chapter 11 or other law. Under such circumstances, the contract (or individual Subscriber's enrollment) may be canceled after not less than 30 days written notice to the Plan.

Termination of Benefits

Upon the effective date of a termination of coverage, the Member or Group shall not be entitled to any further benefits hereunder after such effective date. Neither FirstCare nor any Participating Provider shall have any further obligation to provide services or facilities pursuant to this benefit Plan. Members whose Group has not been terminated may be eligible for continuation of coverage benefits as described below.

Continuation of Coverage

Upon termination of coverage, You may be eligible for continuation coverage, if either of the following provisions applies.

1. COBRA

Under the provisions of Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, Public Law 99-272), You may have the right to continue coverage under the health Plan beyond the date it would otherwise terminate.

2. State Continuation of Coverage

Upon completion of coverage under COBRA or if Your Group is not required to offer COBRA, You have the option to elect State Continuation of Coverage. If You no longer meet eligibility requirements, have been continuously covered under the Group contract for at least three consecutive months prior to the contract ending, and have not been terminated for cause, then You may elect State Continuation of Coverage. You must submit a completed application to Us within 60 days following the later of:

- The effective date of termination of Group coverage;
- The effective date of termination of COBRA coverage; or
- The date You are given notice of the right of continuation by the employer.

You must submit the premium payments applicable for such continuation membership within the 45-day period. After that, there will be a 30-day grace period for subsequent premium payments. If You fail to meet any of these conditions for continuation, then You shall not be eligible to elect continuation any time after the 31-day period.

The effective date of such continuation coverage shall be the date of termination of Group coverage. . The premium rate will be 102% of the Group premium charged to the employer. The premium must be paid in advance to the employer on a monthly basis.

Continuation of the coverage may not terminate until the earliest of:

- Six months after the date continuation of coverage is effective, if you were previously covered by COBRA;
- Nine months after the date continuation of coverage is effective, if you were not previously covered by COBRA;
- The date You fail to make timely premium payments;
- The date on which You are covered for similar benefits under another group or individual health plan;
- The date on which the Group coverage terminates in its entirety; or

Thirty days prior to the end of the six or nine months of continuation contract, We will notify You that You may be eligible for coverage under the Health Insurance Risk Pool, as provided under Texas Insurance Code.

This continuation of coverage will be to the extent necessary to comply with provisions of the applicable statute. Contact Your employer for verification of eligibility and procedures to follow.

Continuation of Coverage for Certain Dependents

If coverage under this Evidence of Coverage ends as the result of a Subscriber's death, retirement, or divorce, a Dependent's coverage can continue. The Dependent must have been covered under the Plan for at least

one year, unless the Dependent is an infant less than one year of age. You must apply for this continuation coverage within 60 days of the event establishing eligibility for continuation.

Continuation is not available when coverage terminates due to any of these circumstances:

- The Evidence of Coverage is canceled; or
- The Dependent fails to make timely premium payments.

Continuation ends at the earliest of:

- Three years after the date that the coverage would have ended;
- The Dependent fails to make timely premium payments;
- The Dependent becomes eligible for coverage under any other group plan providing similar benefits; or
- The coverage is canceled.

The premium rate will be the Group premium charged to the employer and may include a five-dollar administrative fee. The premium must be paid in advance to Your employer on a monthly basis.

Refunds

As required by Texas Statute, if Your coverage is terminated, premium payments received on Your behalf that apply to periods after the effective date of termination of coverage shall be pro rata refunded to Your Group within 30 days after We have actual knowledge of Your termination. Upon the making of such refund to the Group, neither FirstCare nor any Participating Provider shall have any further liability under this benefit Plan with respect to the refunded amount. Any claims for refunds must be made within 60 days from the effective date of termination of a Member's coverage, or such right to a refund shall be deemed to have been waived by the Member and the applicable Group.

Rescissions

As outlined in Section 2712 of H.R. 3590 (Patient Protection & Affordable Care Act):

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be cancelled except with 30 day prior written notice to the enrollee, and only as permitted under section 2702(c) or 2742(b).

SECTION 8 – COORDINATION OF BENEFITS AND SUBROGATION

If any benefits to which a Member is entitled under this Evidence of Coverage are also covered under any other plan as described below in subparagraph A(1), the benefits payable under another plan include the benefits that would have been payable had claim been duly made therefore.

Coordination of Benefits (COB)

For purposes of this section only, the following words have the following definitions:

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

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

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

2. **Allowable Expense** means a health care expense, including deductibles, coinsurance, and copayments, that is covered at least in part by any Plan covering the person for whom claim is made. When a Plan (including this Health Care Plan) provides benefits in the form of services, the reasonable cash value of each service rendered is considered to be both an Allowable expense and a benefit paid. In addition, any expense that a health care provider or Physician by law or in accord with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

3. **Allowed amount** is the amount of a billed charge that a carrier determines to be covered for services provided by a non-participating health care provider or physician. The allowed amount includes both the carrier's payment and any applicable deductible, copayment, or coinsurance amounts for which the Member is responsible.

4. **Custodial parent** is the parent with the right to designate the primary residence of a child by a court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child's resides more than one-half of the calendar year, excluding any temporary visitation.

If a Member is eligible to receive benefits under another plan that duplicates benefits provided under this Evidence of Coverage, FirstCare will coordinate Our benefits with the plan(s) according to the Coordination of Benefits rules outlined below. FirstCare may seek reimbursement from any plan(s) for the cost of services provided. However, We will not seek reimbursement that exceeds this Plan's financial responsibility. It is the Member's responsibility to ensure that all procedures are properly authorized in advance by FirstCare and to provide FirstCare with information that will assist Us in determining Coordination of Benefit obligations.

The rules establishing the order of benefit determination between FirstCare and any other plan covering the Member on whose behalf a claim is made are as follows:

- Whenever a plan does not contain a Coordination of Benefits provision, that plan must be primary. The primary plan pays benefits before the secondary plan pays. When FirstCare is determined to be the secondary plan based on the Coordination of Benefits rules described in this section, then FirstCare will be liable only for the amount due under the secondary plan rules, regardless of whether or not payment is actually made by the primary plan.
- Whenever a plan contains a Coordination of Benefits provision, benefits will be determined according to the Rules of Coordination below.
- When a FirstCare Member has other coverage that is primary, FirstCare will provide secondary coverage only when those services are preauthorized through Our Medical Services Department. It is the Member's responsibility to contact the Customer Service Department to assure prior authorization has been obtained for any referral to a Physician, a professional, or a facility.
- Whenever a plan is not a closed panel plan , that plan must pay or provide benefits as if it were the primary when a Member uses a noncontract provider or physician, except for emergency services or authorized referrals that are paid or provided by the primary plan. A "Closed Panel plan" is a plan that provides benefits to covered persons primarily in the form of services through a panel of providers and physicians that have contracted with or are employed by the plan and that excludes coverage for services provided by other providers and physicians, except in cases of emergency or referral by a panel member.
- When multiple plans providing coordinated coverage are treated as a single plan, this section applies only to the plan as a whole, and coordination among the component plans is governed by the terms of the plans. If more than one plan pays or provides benefits under the plan, the plan designated as primary within the plan must be responsible for the plan's compliance with this section
- If a Member is covered by more than one secondary plan, the order of benefit determination rules of this section decide the order in which secondary plans' benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan that, under the rules of this section, has its benefits determined before those of that secondary plan.
- If the rules described in this section do not determine the order of benefits, the allowable amounts must be shared equally between other plans. In addition, this Plan will not pay more than it would have paid had it been the primary plan.
- Coverage that is obtained by virtue of membership in a group that is designed to Supplement a part of a basic package of benefits and provides that this supplementary coverage must be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverage that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out of network benefits.

Rules of Coordination

Rules establishing the order of benefit determination as to a Member's claim for the purposes of this section are as follows:

1. Non-Dependent/Dependent

The benefits of the plan which covers the Member as a Subscriber are determined before those of the plan which covers the Member as a Dependent except, if the Member is also a Medicare beneficiary and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

- Secondary to the plan covering the Member as a Dependent; and
- Primary to the plan covering the Member as other than a Dependent (for example, a retired employee)`, then the benefits of the plan covering the Member as a Dependent are determined before those of the plan covering that Member as other than a Dependent.

2. Dependent Child Covered Under More Than One Plan

Unless there is a court order stating otherwise, plans covering a dependent child must determine the order of benefits using the following rules that apply:

a. For a dependent child whose parents are married or living together, whether or not they have ever been married:
   - The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
   - If both parents have the same birthday, the benefits of the plan that covered one parent longer are determined before those of the plan that covered the other parent for a shorter period of time.

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

   - If a court order states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, and that parent's spouse does, then the spouse's plan is the primary plan. This clause must not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court order provision.
   - If a court order states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of (B)(2)(a) must determine the order of benefits.

   - If a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of (B)(2)(a) must determine the order of benefits.

   - If there is no court order allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

     1. First, the plan covering the custodial parent;
     2. Then, the plan covering the spouse of the custodial parent;
     3. Then, the plan covering the noncustodial parent;

4. Finally the plan covering the spouse of the noncustodial parent

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

- For a dependent child who has coverage under either or both parents 'plans and has his or her own coverage as a dependent under a spouse's plan (B)(5) applies.

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

- In the event none of the provisions listed above determines the order of benefits, the allowable expenses must be shared equally between plans.

3. Active/Retired or Laid-off Employee

The benefits of a plan which covers a Member as an employee, who is neither laid off nor retired, are determined before those of a plan which covers that Member as a laid off or retired employee. The same would hold true if a Member is a dependent of an active employee and that same Member is a dependent of a retired or laid-off employee, If the other plan does not have this rule, and if as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if (B) (1) of this section can determine the order of benefits

4. COBRA or State Continuation Coverage

If a Member whose coverage is provided under a right of continuation pursuant to federal or state law and is also covered under another plan, the following shall be the order of benefit determination:

- The benefits of a plan covering the Member as a Subscriber (or as that Subscriber's Dependent); and
- The benefits under the continuation coverage.

If the other plan does not have the rule described above, and if as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if (B) (1) of this section can determine the order of benefits

5. Longer/Shorter Length of Coverage

If none of the above rules determine the order of benefits, the benefits of the plan that covered a Subscriber or Member longer are determined before those of the plan that covered that Member for the shorter term.

To determine the length of time a Member has been covered under a plan, two successive plans must be treated as one if the Member was eligible under the second plan within 24 hours after the first plan ended.

The start of a new plan does not include:

- a change in the amount or scope of a plan's benefits;
- a change in the entity that pays, provides, or administers the plan's benefits; or
- a change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

The Member's length of time covered under a plan is measured from the Member's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group must be used as the date from which to determine the length of time the claimant's coverage under the present plan has been in force.

6. Rules of Coordination for Medicare

Medicare Part A – (Hospital Insurance)

- If you have been diagnosed with end stage-renal disease, benefits will be determined in accordance with Medicare guidelines for members with end-stage renal disease.
- When Medicare benefits are primary, claims must be filed with Medicare first. You are responsible for sending the Medicare explanation of benefits form to us for determination of FirstCare benefits.
- In general, if you are an active, working employee, FirstCare is the primary payer for you and your dependents; however, if your Employer has less than 20 employees, Medicare will be the primary payer for you and your dependents.
- If you are a retiree enrolled in Medicare Part A, Medicare is the primary payer, FirstCare will pay the Medicare Part A deductible, and you will be responsible for any copayments.
- If you are a retiree not enrolled in Medicare Part A, FirstCare will be the primary payer.

Medicare Part B – (Supplemental Medical Insurance)

- In general, if you are an active, working employee, FirstCare is the primary payer for you and your dependents; however, if your Employer has less than 20 employees, Medicare will be the primary payer for you and your dependents.
- If you are Medicare-eligible due to retirement, disability or other reasons, regardless of your Medicare Part B status, FirstCare will provide benefits secondary to Medicare Part B.

If you choose not to enroll in Medicare Part B, you may have greater out-of-pocket expenses after FirstCare pays secondary benefits than an individual who is enrolled in Medicare Part B.

7. Employer Providers

Benefits which are provided directly through a specified provider of an employer, shall in all cases be primary before the benefits of this Evidence of Coverage.

8. Military Providers

Services and benefits for military personnel for which a Member is legally entitled and for which facilities are reasonably available, shall in all cases be primary before the benefits of this Evidence of Coverage, if We approve such services in advance. Otherwise, no benefits will be payable.

9. Release of Information

For purposes of this Evidence of Coverage, FirstCare may, subject to applicable confidentiality requirements set forth in this Evidence of Coverage, release to or obtain from any insurance company or other organization necessary information to implement these Coordination of Benefit provisions. Any Member claiming benefits under this Evidence of Coverage must furnish to FirstCare all information deemed necessary by it to implement these Coordination of Benefits provisions.

10. Recovery of Payments

Whenever payments have been made by FirstCare with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment required in accordance with the Coordination of Benefits provisions of this section, then FirstCare shall have the right to recover such payment to the extent of such excess from among one or more of the following as FirstCare shall determine:

- Any person or persons to, or for, or with respect to whom such payments were made; and
- Any insurance company or companies (or any other organization or organizations) to which such payments were made, including, but not limited to Personal Injury Protection (PIP) benefits, No-fault benefits, Medical Payment (Med Pay), Uninsured Motorist, Liability and Umbrella coverage.

11. On-The-Job Injury/Illness

In the event services are provided or payments are made by FirstCare for work-related injuries or illnesses sustained by a Member or such services are determined to be covered by a Workers' Compensation System or any other insurance, FirstCare shall have the right to recover the Non-Participating Provider Reimbursement (NPPR) Amounts for such services provided or the payments made by FirstCare from the third party payer. It is understood that coverage under this Evidence of Coverage is not in lieu of, and shall not affect, any benefits or requirements for coverage under an applicable Workers' Compensation System(s) or under any other applicable insurance coverage.

Subrogation, Reimbursement and/or Third Party Responsibility

1. Subrogation

If the Plan pays or provides benefits for you or your dependents, the Plan is subrogated to all rights of recovery which you or your dependent have in contract, tort, or otherwise against any person, organization, or insurer for the amount of benefits the plan has paid or provided. That means the Plan may use your rights to recover money through judgment, settlement, or otherwise from any person, organization, or insurer. For the purposes of this provision, subrogation means the substitution of one person or entity (the Plan) in the place of another (you or your dependent) with reference to a lawful claim, demand or right, so that he or she who is substituted succeeds to the rights of the other in relation to the debt or claim, and its rights or remedies.

Except where subrogation rights are precluded by factual circumstances, the plan will have a right of reimbursement. If you or your dependent recover money from any person, organization, or insurer for an injury or condition for which the Plan paid benefits, you or your dependent agree to reimburse the Plan from the recovered money for the amount of benefits paid or provided by the plan. That means, subject to Title 6, Chapter 140 of the Texas Civil Practice and Remedies Code that you or your dependent will pay to the Plan the amount of money recovered by you through judgment, settlement or otherwise from the third party or their insurer, as well as from any person, organization or insurer, up to the amount of benefits paid or provided by the plan.

You or your dependent agree to promptly furnish to the Plan all information which you have concerning your rights of recovery from any person, organization, or insurer and to fully assist and cooperate with the plan in protecting and obtaining its reimbursement and subrogation rights. You, Your dependent or your attorney will notify the Plan before settling any claim or suit so as to enable us to enforce our rights by participating in the settlement of the claim or suit. You or your dependent further agree not to allow the reimbursement and subrogation rights of the plan to be limited or harmed by any acts or failure to act on your part.

2. Right of Reimbursement

a. If We pay benefits and you recover or are entitled to recover benefits from other coverage or from any legally responsible party, We have the right to recover from you the amount We have paid.

b. You must notify Us, in writing, within 31 days of any benefit payment, settlement, compromise or judgment. If you waive or impair our right to reimbursement, We will suspend payment of past or future services until all outstanding lien(s) are resolved

c. If You recover payment from and release any legally responsible party for future medical expenses relating to an illness or bodily injury, We shall have a continuing right to seek reimbursement from you. This right, however, shall apply only to the extent allowed by law.

d. This reimbursement obligation exists in full regardless of whether the settlement, compromise, or judgment designates the recovery as including or excluding medical expenses.

3. Our Right of Subrogation

To the extent allowed by Texas law, We have the right to recover payments acquired by you against any person or organization for negligence or any willful act resulting in illness or bodily injury to the extent we have paid for services. As a condition of receiving benefits from Us, you agree to assign to us any rights you may have to make a claim, take legal action or recover any expenses paid for benefits covered under this Contract.

If We are precluded from exercising our right of subrogation, We may exercise our right of reimbursement.

4. Excess Insurance

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

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

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

5. Wrongful Death

In the event that You die as a result of Your injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan’s subrogation and reimbursement rights shall still apply.

6. Obligations

a. It is Your obligation at all times, both prior to and after payment of medical benefits by the Plan, to a reasonable extent:

- to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan’s rights;
- to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;

- to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
- to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
- to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
- to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Beneficiary may have against any responsible party or Coverage.

b. If You and/or Your attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, You will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from You.

c. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon Your cooperation or adherence to these terms.

7. Minor Status

In the event You are a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate to a reasonable extent in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

8. Severability

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

SECTION 9 – MEMBER COMPLAINT AND APPEAL PROCEDURE

A *Complaint* means any dissatisfaction expressed by You, or anyone acting on Your behalf, orally or in writing to Us with any aspect of Our operation, including but not limited to, dissatisfaction with plan administration, procedures related to review or appeal of an Adverse Determination, the denial, reduction or termination of a service for reasons not related to medical necessity (Adverse Benefit Determination), the way a service is provided, or disenrollment decisions. The term does not include a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to Your satisfaction and does not include a Participating Provider's or Your oral or written dissatisfaction or disagreement with an Adverse Determination. A Complaint filed concerning dissatisfaction or disagreement with an Adverse Determination constitutes an appeal of that Adverse Determination. You will have 180 days from the original paid date of the claim to appeal.

Complaint Procedure

If You notify Us orally or in writing of a Complaint, We will not later than the fifth business day after the date of the receipt of the Complaint, send to You a letter acknowledging the date We received Your Complaint. If the Complaint was received orally, We will enclose a one-page Complaint form clearly stating that the Complaint form must be returned to Us for prompt resolution.

Complaints should be directed to the Customer Service Department at 1-800-884-4901 or in writing to:

SHA, L.L.C. dba FirstCare
ATTN: Coordinator of Complaints & Appeals
1901 West Loop 289
Suite 9
Lubbock, Texas 79407

After receipt of the written Complaint or one-page Complaint form from You, We will investigate and send You a letter with Our resolution. The total time for acknowledging, investigating and resolving Your Complaint will not exceed 30 calendar days after the date We receive Your 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. The investigation and resolution shall be concluded in accordance with the medical immediacy of the case.

You may use the Appeals Process to resolve a dispute regarding the resolution of Your Complaint.

Complaint Appeal Procedure

If the Complaint is not resolved to Your satisfaction, You have the right either to appear in person before a Complaint Appeal Panel where You normally receive health care services, unless another site is agreed to by You, or to address a written appeal to the Complaint Appeal Panel.

We shall send an acknowledgment letter to You not later than the fifth business day after the date of receipt of the request for appeal.

We shall appoint Members to the Complaint Appeal Panel, which shall advise Us on the resolution of the dispute. The Complaint Appeal Panel shall be composed of an equal number of Our staff, Physicians or other providers, and Members.

Not later than the fifth business day before the scheduled meeting of the panel, unless You agree otherwise, We shall provide to You or Your designated representative:

- Any documentation to be presented to the panel by Our staff;

- The specialization of any Physicians or providers consulted during the investigation; and
- The name and affiliation of each of Our representatives on the panel.

You or a designated representative is entitled to:

- Appear in person before the Complaint Appeal Panel;
- Present alternative expert testimony; and
- Request the presence of and question any person responsible for making the prior decision that resulted in the appeal.

Once the appeal panel has heard the complaint's case, they will make a recommendation. If their recommendation is to overturn the complaint decision, then the case and the panel's recommendation is forwarded to the Executive Appeal Panel for review and a final decision to ensure that policies and procedures are being followed and considered in the final decision.

Written notification of Our final decision on the appeal will be provided no later than the 30th calendar day after the date We received the appeal. However, You may waive the 30th calendar day requirement if You are unable to schedule a timely appeal panel. If the appeal is denied, the written notification shall include a clear and concise statement of:

- The clinical basis for the appeal's denial;
- The contractual criteria used;
- Notice of Your right to seek review of the denial by an Independent Review Organization (IRO), and the procedures for obtaining that review; and
- The notice will also include the toll-free telephone number and address of the Texas Department of Insurance.

Adverse Determination Appeal Procedure

In the event of an Adverse Determination, notification will include:

- The principal reasons for the Adverse Determination.
- The clinical basis for the Adverse Determination.
- A description or source of the screening criteria that were utilized as guidelines in making the determination.
- Notification of the right to appeal an Adverse Determination internally to FirstCare and externally to an Independent Review Organization.
- Notification of the procedures for appealing an Adverse Determination internally and/or to an Independent Review Organization.
- Notification to the Member who has a Life-Threatening condition of the Member's right to an immediate review by an Independent Review Organization and the procedure to obtain that review.
- Immediate appeal to an Independent Review Organization for denial of prescription drugs or intravenous infusions. Notwithstanding any other law, in a circumstance involving the provision of prescription drugs or intravenous infusions for which the patient is receiving benefits, the enrollee is:
    - Entitled to an immediate appeal to an independent review organization as provided by Subchapter I; and
    - Not required to comply with procedures for an internal review of the utilization review agent's adverse determination.
- Information about the availability of, and contact information for the Consumer Assistance desk at the Texas Department of Insurance.
- Statement that You are entitled to receive reasonable access to/copies of documents, records and other information relevant to the Adverse Determination.

You, a person acting on Your behalf, Your Physician, or Participating Provider may appeal an Adverse Determination orally or in writing.

We shall send an acknowledgment letter to You not later than the fifth business day after the date of receipt of the request for appeal. We will outline a list of documents that You must submit for review by the utilization review agent.

Investigation and resolution of appeals relating to denials of ongoing emergency care, continued hospitalization, prescription drugs or intravenous infusions for which the patient is receiving benefits, shall be conducted in accordance with the medical immediacy of the case but in no event to exceed one business day after Your request for appeal.

Due to the ongoing emergency care, continued hospitalization, prescription drugs or intravenous infusions for which the patient is receiving benefits, and upon Your Appeal, We shall provide a review by a Physician or provider who has not previously reviewed the case and is of the same or similar specialty as typically manages the medical condition, procedure, or treatment under discussion for review of the appeal.

The Physician or provider reviewing the appeal may interview You or Your designated representative and shall render a decision on the appeal. Initial notice of the decision may be delivered orally if followed by written notice of the determination within three days.

Written notification of Our final decision on the appeal will be provided no later than the 30th calendar day after the date We received the appeal. If the appeal is denied the written notification shall include a clear and concise statement of:

- The clinical basis for the appeal's denial.
- The specialty of the Physician making the denial.
- Notice of Your right to seek review of the denial by an Independent Review Organization and the procedures for obtaining that review.

Filing Complaints with the Texas Department of Insurance

Any person, including persons who have attempted to resolve Complaints through Our Complaint system process and who are dissatisfied with the resolution, may report an alleged violation to:

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104

The commissioner shall investigate a Complaint against Us to determine compliance within 60 days after the Texas Department of Insurance's receipt of the Complaint and all information necessary for the Department to determine compliance. The commissioner may extend the time necessary to complete an investigation in the event any of the following circumstances occur:

- Additional information is needed;
- An on-site review is necessary;
- We, the Physician or provider, or You do not provide all documentation necessary to complete the investigation; or
- Other circumstances beyond the control of the Texas Department of Insurance occur.

Appeals to an Independent Review Organization (IRO)

In a circumstance involving a Life-Threatening condition, You are entitled to an immediate appeal to an Independent Review Organization and are not required to comply with procedures for an internal review of Our Adverse Determination.

We shall permit any party whose appeal of an Adverse Determination is denied by Us to seek review of that determination by an Independent Review Organization assigned to the appeal as follows:

- We shall provide to You, Your designated representative, and/or Your provider of record, information on how to appeal the denial of an Adverse Determination to an Independent Review Organization.
- We must provide such information to You, Your designated representative, and/or Your provider of record at the time of the denial of the appeal.
- We shall provide to You, Your designated representative, and/or Your provider of record the prescribed form.
- You, Your designated representative, and/or Your provider of record must complete the form and return it to Us to begin the independent review process.
- In Life-Threatening situations, You, Your designated representative, and/or Your provider of record may contact Us by telephone to request the review and provide the required information.

The appeal process does not prohibit You from pursuing other appropriate remedies including injunctive relief, a declaratory judgment, or relief available under law, if the requirement of exhausting the process for appeal and review places Your health in serious jeopardy.

FirstCare will not take any retaliatory action, such as refusing to renew or canceling coverage, against You or Your Group because You, the Group, or any person acting on Your or Your Group's behalf, has filed a Complaint against FirstCare or appealed a decision made by FirstCare.

SECTION 10 – MISCELLANEOUS PROVISIONS

Entire Evidence of Coverage

This booklet, the applicable Employer Group Contract of Your Group, any attachments and amendments, and Your (including Your Dependents, if any) enrollment form(s) constitute the entire contract between FirstCare and You (and Your covered Dependents), as well as Your Group, and as of the effective date of Your coverage, this Evidence of Coverage supersedes all other agreements.

Change in Premium Upon Notice

We reserve the right to adjust the premium on each anniversary date of this Evidence of Coverage upon 60 days' notice to You.

Cancellation

Except as otherwise provided herein, FirstCare will not have the right to cancel Your coverage if the following requirements are met:

- The Employer Group Contract of Your Group remains in full force and effect;
- You and Your Dependents, if any, remain eligible for coverage in accordance with this Evidence of Coverage and the applicable requirements of Your Group; and
- All applicable premiums have been paid in accordance with this Contract.

Authority

No agent or employee of FirstCare is authorized to change the form or content of this Contract other than to make necessary and proper insertions in blank spaces. Any changes to the form or content of this Evidence of Coverage may only be made through proper endorsement signed by an authorized officer of FirstCare. No agent, employee, or other person, except an authorized officer of FirstCare, has the authority to waive any terms, provisions, conditions, or restrictions of this Evidence of Coverage.

Authorization to Examine Health Records

You and Your Dependents, if any, expressly consent to and expressly authorize, to the fullest extent permitted by applicable law, any and all Physicians and health care providers who provide care to any of You to permit the examination and copying of any portion of such provider's medical and other records pertaining to any of You by FirstCare, upon request by FirstCare without need of further authorization from any of You.

Notice of Claim

It is not expected that You will make payment for Covered Health Services, other than required Copayments. However, if You pay for Covered Health Services in addition to the required Copayment(s), You must file a claim with Us within 180 days from the date You incurred Covered Health Services, unless You can document as soon as reasonably possible after the 180-day period, to Our satisfaction, good cause why such claim could not be filed within such 180-day period. Provided, however, reimbursement shall not be allowed if a claim is made beyond one year from the date such Covered Health Services were first incurred. We will provide forms for the submission of written proof of payment. You may contact Our Customer Service Department at 1-800-884-4901.

Payment of Claims

Payment of claims to You will be handled as follows:

Not later than the 15th day after We receive a claim from You, We will:

- Acknowledge receipt of the claim;
- Commence any investigation of the claim; and
- Request information, statements, and forms from You as deemed necessary. Additional requests may be made during the course of the investigation.

Not later than the 15th day after receipt of all requested items and information, FirstCare will:

- Notify You of the acceptance or rejection of the claim and the reason if rejected; or
- Notify You that additional time is needed and state the reason. Not later than the 45th day after the date of notification of the additional time requirement, We shall accept or reject the claim.

Claims will be paid no later than the fifth day after notification of acceptance of the claim.

Legal Action

No action at law or in equity shall be brought to recover under this Evidence of Coverage prior to the expiration of 60 days after proof of loss has been filed in accordance with the requirements of this Evidence of Coverage, nor shall such action be brought at all, unless brought within three years from the expiration of the time within which notice of claim is required by this Evidence of Coverage.

Notice

Any notice required by or given involving this Evidence of Coverage may be given by personal delivery, telephone facsimile transmission, overnight delivery service or United States mail, first class, or postage prepaid, addressed as follows:

FirstCare
SHA, L.L.C.
12940 N Highway 183
Austin, Texas 78750

And if to a Member, at the last address specified in the corporate records of FirstCare.

Interpretation of this Evidence of Coverage

"Evidence of coverage" means any certificate, agreement, or contract, including attachments and amendments, and to include a blended contract, that: (A) is issued to You; and (B) states the coverage to which You are entitled. Texas Health Maintenance Organization Act Sec. 843.002(9).

The laws of the State of Texas shall be applied to the interpretation and construction of this Evidence of Coverage. Any provision contained in this Evidence of Coverage not in conformity with the Texas Health Maintenance Organization Act, or other applicable Texas laws shall not be rendered invalid but shall be construed and applied as if it were in full compliance with the Act and such other applicable Texas laws.

Assignment

This Evidence of Coverage is not assignable by You, Your Dependents, if any, or Your Group without the written consent of FirstCare. Likewise, the coverage and benefits provided by this Evidence of Coverage are not assignable without the written consent of FirstCare.

Gender

The use of any gender in this Evidence of Coverage shall be deemed to include and reference the other genders, and likewise, use of the singular tense shall be deemed to include the plural and vice versa.

Modifications

This Evidence of Coverage shall be subject to amendment, modification, or termination as required by law or regulatory order without the consent of the Group or any Member; otherwise, this Evidence of Coverage can be amended, modified, or terminated by the mutual written agreement of FirstCare and the Group without the consent of any Member. In all cases, We will provide 60 days advance written notice to You before the effective date of any material modification to this Evidence of Coverage, including changes in preventive care. You must provide Us 30 days' prior written notice in the case of cancellation resulting from a material change to the Evidence of Coverage/Group Contract.

Clerical Error

Clerical error, whether made by the Group or FirstCare, in keeping records pertaining to the coverage of Members under this Evidence of Coverage, will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

Headings and Captions

The headings and captions used in this Evidence of Coverage are provided for purposes of reference and convenience only and shall not be used in continuing or interpreting this Evidence of Coverage.

Incontestability

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

- It is in a written enrollment application signed by the Subscriber; and
- A signed copy of the enrollment application is or has been furnished to the Subscriber or the Subscriber's personal representative.

We may only contest an individual contract because of fraud or intentional misrepresentation of material fact made on the enrollment application

SECTION 11 – DEFINITIONS

This section provides definitions for some of the terms used in this document.

Acquired Brain Injury: A neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

Adverse Determination: A determination by a health maintenance organization or a utilization review agent that health care services provided or proposed to be provided to an enrollee are not medically necessary or appropriate, or are experimental or investigational. The term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review.

Ancillary Provider: A provider with whom a PCP may be required to consult and/or coordinate regarding certain Covered Health Services on behalf of a Member.

Annual Maximum: The annual maximum amount for Non-Essential Health Benefits that We will pay for any Member under all health plans issued by Us providing Covered Health Services for the Plan Year span of any Member. When this maximum is reached, coverage for such Member will end with respect to such Non-Essential Health Benefits. See the Schedule of Copayments for details as to if Your Plan is administered on a Contract Year or Calendar Year basis.

Autism Spectrum Disorder: Means a neurobiological disorder that includes autism, Asperger's syndrome, or Pervasive Development Disorder – Not Otherwise Specified.

Calendar Year: The calendar year starting on January 1st and continuing through December 31st.

Cancer Chemotherapy: Any medication used to directly treat cancer. Medications used as supportive therapy (i.e. anti-nausea, etc.) are not included in this definition. A list of these medications will be maintained by the FirstCare Pharmacy and Therapeutics Committee.

Chemotherapy Associated Agents: Any medication used as supportive therapy for Cancer Chemotherapy administered at the time of chemotherapy administration. Medications used as supportive therapy not administrated at the time of chemotherapy infusion will be covered on a Pharmacy Rider benefit only.

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

Cognitive Rehabilitation Therapy: Services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.

Community Reintegration Services: Services that facilitate the continuum of care as an affected individual transitions into the community.

Complaint: See *Section 9, Member Complaint and Appeal Procedure* for a complete definition and description.

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, including but not limited to:

- Acute nephritis;
- Nephrosis;
- Cardiac decompensation;
- Missed abortion;
- Termination of pregnancy by non-elective cesarean section;

- Termination of ectopic pregnancy;
- Spontaneous termination of pregnancy when a viable birth is not possible; and
- Similar medical and surgical conditions of comparable severity.

The following conditions are not considered Complications of Pregnancy:

- False labor;
- Occasional spotting;
- Health Care Provider prescribed rest during pregnancy; and
- Morning sickness.

Complications of pregnancy are treated as any other Illness.

Contract Month: The period of each succeeding month beginning on the Plan effective date.

Contract Year: A 12 month period beginning with the effective date of coverage for a Group, and each succeeding 12 month period thereafter that the Employer Group Contract is effective.

Copayment: The amount You are required to pay to a Participating Provider or other authorized provider in connection with the provision of Covered Health Services. The Copayment amounts are indicated in the Schedule of Copayments. Copayments not subject to the Deductible must continue to be paid even when You have reached Your Deductible.

Covered Health Services: Those medical and health care services and items specified and defined in the Schedule of Copayments as being covered services but only when such services and items are medically necessary and when they are performed, prescribed, directed, or authorized in accordance with FirstCare's policies and procedures and this Evidence of Coverage.

Crisis Intervention: A short-term process which provides intensive supervision and highly structured activities to the Member who is demonstrating an acute psychiatric crisis of severe proportions, which substantially impairs the Member's thoughts, perception of reality, and judgment, or which grossly impairs behavior.

Crisis Stabilization Unit: A 24-hour residential program that is usually short-term in nature and provides intensive supervision and highly structured activities to persons who are demonstrating an acute psychiatric crisis of moderate to severe proportions.

Cryotherapy: Also known as cold therapy, cryotherapy is the treatment of pain and/or inflammation by lowering the temperature of the skin over the affected area.

Custodial Care: Care not given primarily for therapeutic value in the treatment of an Illness or Injury and is provided primarily for the maintenance of the Member, and is essentially designed to assist in the activities of daily living. We and/or an independent medical review board will decide if a service or treatment is Custodial Care.

Deductible: The amount of Covered Health Services You are responsible for paying each Plan Year before benefits become payable under this Plan. The *Deductible* is the amount of Covered Expenses You must pay for each Member before any benefits are available regardless of provider type. Copayments not subject to the Deductible do not apply to the Deductible. Refer to your Schedule of Copayments for the Deductible amount.

Dependent: A Member of a Subscriber's family who meets the eligibility requirements specified in *Section 2, Eligibility and Enrollment,* and who has become enrolled as a Member of FirstCare through the Subscriber's Group.

Diabetes Supplies and Equipment: Equipment and supplies for the treatment of diabetes for which a physician or practitioner has written an order, including blood glucose monitors, including those designed to be used by or adapted for the legally blind; test strips specified for use with a corresponding glucose monitor; lancets and lancet devices; visual reading strips and urine testing strips and tablets which test for glucose, ketones and protein; insulin and insulin analog preparations; injection aids, including devices used to assist

with insulin injection and needleless systems; insulin syringes; biohazard disposal containers; insulin pumps, both external and implantable, and associated appurtenances, which include insulin infusion devices; batteries; skin preparation items; adhesive supplies; infusion sets; insulin cartridges; durable and disposable devices to assist in the injection of insulin; and other required disposable supplies; repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer's warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump; prescription medications and medications available without a prescription for controlling the blood sugar level; podiatric appliances, including up to two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes; glucagon emergency kits.

As new or improved treatment and monitoring equipment or supplies become available and are approved by the United States Food and Drug Administration, such equipment or supplies shall be covered if determined to be medically necessary and appropriate by a treating physician or other practitioner through a written order. All supplies, including medications, and equipment for the control of diabetes shall be dispensed as written, including brand name products, unless substitution is approved by the physician or practitioner who issues the written order for the supplies or equipment.

Diabetes Self-Management Training: Includes (i) Training provided after the initial diagnosis of diabetes, including nutritional counseling and proper use of Diabetes Equipment and Supplies; (ii) additional training authorized on the diagnosis of a significant change in Your symptoms or condition that requires changes to Your self-management regime; and (iii) periodic or episodic continuing education training as warranted by the development of new techniques and treatments for diabetes.

Drug Coverage List: A listing of prescription drugs that are approved by the FirstCare Pharmacy and Therapeutics Committee to be dispensed through participating pharmacies and which will be a covered benefit pending any utilization management approvals.

Eligible Person: An employee of the Enrolling Group who works on a full-time basis (usually at least 30 hours a week) or full time equivalent, or other person whose connection with the Enrolling Group meets the eligibility requirements specified by the Application, Plan, Employer Group and Us. The term also includes a sole proprietor, a partner, and an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of an Employer. The term does not include:

1. An employee who works on a part-time, temporary, seasonal, or substitute basis; or
2. An employee who is covered under:
    - Another health benefit plan;
    - A self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the employee retirement income security act of 1974;
    - The Medicaid program if the employee elects not to be covered;
    - Another federal program, including the CHAMPUS program or Medicare program, if the employee elects not to be covered; or
    - A benefit plan established in another country if the employee elects not to be covered.

Embedded Deductible: The amount of Covered Services You are responsible for paying each Calendar Year before benefits become payable under this Plan. The Embedded Deductible is the amount of Covered Expenses You must pay for each Member before any benefits are available regardless of provider type. If you have several Members, all charges used to apply toward the “per Member” Embedded Deductible will apply towards the “per Family” Embedded Deductible. When that Family Embedded Deductible amount is reached, no further individual Embedded Deductible will have to be satisfied for the remainder on that Calendar Year. No Member will contribute more than the individual Embedded Deductible amount towards the “per Family” Embedded Deductible amount. Copayments not subject to the Embedded Deductible do not apply to the Calendar Year Embedded Deductible. Please refer to Your Schedule of Copayments for specified Embedded Deductible amount.

Emergency Services: As required by the Insurance Code §1271.155 (concerning Emergency Care), includes emergency transport in an emergency medical services vehicle licensed under Health and Safety Code Chapter 773 (concerning Emergency Medical Services), which is considered emergency care if it is provided as part of the evaluation and stabilization of medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the individual's condition, sickness, or injury is of such a nature that failure to get immediate care through emergency transport could place the individual's health in serious jeopardy, result in serious impairment to bodily functions, result in serious dysfunction of a bodily organ or part, result in serious disfigurement, or for a pregnant woman, result in serious jeopardy to the health of the fetus.

Employer Group Contract: The agreement between FirstCare and a Group providing for the provision of Covered Health Services in accordance with the terms, provisions, and conditions of the Evidence of Coverage to Members of Your Group. This Evidence of Coverage is a part of the Employer Group Contract, and will be provided to each member of the group. Any direct conflict between the Employer Group Contract and this Evidence of Coverage will be resolved according to the terms which are more favorable to the Member.

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

Evidence of Coverage: The term used to describe this document along with any attachments and amendments and Your Enrollment Form, which constitute Your contract with FirstCare.

Facility: A health care or residential treatment center licensed by the state in which it operates to provide medical inpatient, residential, day treatment, partial hospitalization, or outpatient care. Facility also means a treatment center for the diagnosis and/or treatment of chemical dependency or mental illness.

Family: You and Your Dependents who are covered under this Evidence of Coverage.

FirstCare: The registered service mark and trade name of the health Plan.

Freestanding Emergency Medical Care Facility: A facility, licensed under Health and Safety Code Chapter 254 (Concerning Freestanding Emergency Medical Care Facilities), structurally separate and distinct from a hospital that receives an individual and provides emergency care, as defined in Insurance Code §843.002 .

Full Time Employee: The term full-time employee means, with respect to a calendar month, an employee who is employed an average of at least 30 hours of service per week with an employer. For this purpose, 130 hours of service in a calendar month is treated as the monthly equivalent of at least 30 hours of service per week, provided the employer applies this equivalency rule on a reasonable and consistent basis. For rules on the determination of whether an employee is a full-time employee, including the look-back measurement method for purposes of determining and computing liability under section 4980H (but not for the purpose of determining status as an applicable large employer), see §54.4980H-3.

Full-time equivalent employee (FTE): The term full-time equivalent employee, or FTE, means a combination of employees, each of whom individually is not treated as a full-time employee because he or she is not employed on average at least 30 hours of service per week with an employer, who, in combination, are counted as the equivalent of a full-time employee solely for purposes of determining whether the employer is an applicable large employer. For rules on the method for determining the number of an employer's full-time equivalent employees, or FTEs, see §54.4980H-2(c).

Grace Period: A period of 31 days after a Premium Due Date, during which premiums may be paid to FirstCare without lapse of Your coverage and that of Your Dependents, if any, under an Evidence of Coverage. If payment is not received within the 31 days, coverage will be canceled and You will be responsible for any cost of services received during the Grace Period.

Group: An employer or other party that has entered into an Employer Group Contract with FirstCare, and through which You and Your Dependents, if any, have enrolled in the health Plan.

Group Open Enrollment Period: A 31-day period established by a Group and FirstCare from time to time, but not less frequently than once in any Plan Year, during which Eligible Persons in the Group may enroll in FirstCare.

Hospital: An acute care institution licensed by the State of Texas as a Hospital, which is primarily engaged, on an inpatient basis, in providing medical care and treatment of sick and injured persons through medical, diagnostic, and major surgical facilities, under supervision of a staff of Physicians and with 24-hour a day nursing and Physician service; provided, however, it does not include a nursing home or any institution or part thereof which is used principally as a custodial facility.

Hybrid Injectables: Any injectable defined as a Pharmacy Injectable required to be administered at the time of dialysis or cancer chemotherapy infusion. If these medications are not administered at the point of service, and they are Pharmacy Injectables, they are covered on a Pharmacy Rider only. These drugs will be defined by the Pharmacy and Therapeutics Committee

Independent Review Organization (IRO): An organization selected as provided under the Texas Insurance Code.

Life-Threatening: A disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Lifetime Maximum: The lifetime maximum benefit amount for Non-Essential Health Benefits that We will pay for any Member under all health plans issued by Us providing Covered Health Services for the lifetime of any Member. When this maximum is reached, coverage for those Non-Essential Health Benefits will end for the non-Essential Health Benefits.

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

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

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

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

Medical Director: A Physician designated by FirstCare to monitor appropriate provision of medically necessary Covered Health Services to Members in accordance with their applicable Evidences of Coverage.

Medical Injectables: Any medication that is infused via intravenous infusion (IV), injected intramuscularly (IM), where medical supervision is required, or has to be administered at the point of care (i.e.: Dialysis Centers). These drugs will be defined by the FirstCare Pharmacy and Therapeutics Committee.

Medically Necessary or Medical Necessity: The service meets all of the following conditions:

- The service or item is reasonable and necessary for the diagnosis or treatment of an illness or injury or for a medical condition, such as pregnancy.*
- Is consistent with widely accepted professional standards of medical practice in the United States;
- Is prescribed by a Physician;
- The service is provided in the most cost-efficient way and at an appropriate duration and intensity, while still giving You a clinically appropriate level of care;
- Is not primarily for the personal comfort of the patient, the Family, Physician, or other provider of care;
- Is not a part of, or associated with, the scholastic, educational, or vocational training of the patient;

- Is neither investigative nor experimental in nature; or
- Is pre-approved, when required by FirstCare.

Not every service that fits this definition is covered under Your Plan. To be covered, a medically necessary service must also be described in *Section 3, What Is Covered. The fact that a Physician or other health care provider has performed, prescribed, or recommended a service does not mean it is medically necessary or that it is covered under Your Plan.* (*Also see Section 5, What Is Not Covered.)*

*The Utilization Review Agent will decide whether a service or supply is Medically Necessary, considering the views of the medical community, guidelines and practices of Medicare and Medicaid, and peer review literature.

Medicare: Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or subsequently amended.

Member: A person who has enrolled in FirstCare as a Subscriber or Dependent and is eligible to receive Covered Health Services.

Minimum Essential Coverage means health insurance coverage that is recognized as coverage that meets substantially all requirements under federal law pertaining to adequate individual, Group or government health insurance coverage. For additional information on whether particular coverage is recognized as "Minimum Essential Coverage", please call the customer service telephone number shown on the back of Your identification card or visit www.cms.gov.

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

Neurobehavioral Testing: An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.

Neurobehavioral Treatment: Interventions that focus on behavior and the variables that control behavior.

Neurobiological disorder: Means an illness of the nervous system caused by genetic, metabolic or other biological factors.

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

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

Neurofeedback Therapy: Services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.

Neurophysiological Testing: An evaluation of the functions of the nervous system.

Neurophysiological Treatment: Interventions that focus on the functions of the nervous system**.**

Neuropsychological Testing: The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

Neuropsychological treatment: Interventions designed to improve or minimize deficits in behavioral and cognitive processes.

Non-Essential Health Benefits: These are benefits that are comprised of benefits and services other than those defined by Section 1302(b) of the Patient Protection & Affordable Care Act (PPACA).

Non-Participating Provider: Any Hospital, Facility, Home Health Agency, or Health Care Provider who is not contracted with Us at the time services are rendered.

Non-Participating Provider Reimbursement (NPPR): The amount we will fully reimburse at the usual and customary rate or at an agreed rate. We determine this amount based on the payment methodology established by Medicare. This is also referred to as the Usual, Customary and Reasonable (UCR) amount.

Open Enrollment Period: A 31-day period occurring at least once a year, as specified in the Group Application and decided periodically by Group and FirstCare, during which Eligible Persons may enroll in the Plan.

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

Orthotics: Custom-fitted or custom-fabricated medical devices that are applied to a part of the human body to correct a deformity, improve function, or relieve symptoms of a disease.

Out-of-Pocket Maximum: The total dollar amount a Member must pay each Calendar Year before We pay benefits at 100%. The Out-of-Pocket Maximum includes deductibles, and [medical] copayments. It does not include premiums, non-covered services and balance billing amounts.

Participating Provider: A Physician, medical group, Hospital or other health care provider who has contracted with FirstCare to provide Covered Health Services to Members of Your Plan. For more information on the network of Participating Providers available to You, check the provider directory We give to You, ask Your PCP or call Us. Please remember that the list of Participating Providers in the directory is subject to change, so You may want to call Our Customer Service Department at 1-800-884-4901 for the most current provider information or go to the FirstCare website at www.FirstCare.com.

Pharmacy Injectables: Any medication that is injected subcutaneously or specifically designed and generally accepted to be self-injected and does no-t require direct medical professional oversight. These drugs will be defined by the FirstCare Pharmacy and Therapeutics Committee.

Physician: Any person who is duly licensed and qualified to practice within the scope of a medical practice license issued under the laws of the State of Texas or in which state treatment is received.

Plan, Your Plan, The Plan: The coverage of health care services available to You under the terms of this Evidence of Coverage.

Plan Year: The annual period that begins on the anniversary of this Plan's Effective Date. See the Schedule of Copayments for details as to if Your Plan is administered on a Contract Year or Calendar Year basis.

Post-Acute Transition Services: Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

Post-Acute-Care Treatment Services: Services provided after acute-care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral, or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or reestablishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.

Premium Due Date: The first day of each calendar month during a Plan Year.

Primary Care Physician (PCP): The Physician who is responsible for coordinating the health care services You receive under Your Plan, including referring You to specialists and other services. At the time of enrollment, if Your Plan requires it, You must select a PCP, or one will be assigned for You. You may change your PCP by calling Our Customer Service Department and will be limited to no more than four changes in in a 12-month period. Usually PCPs are general practitioners, family practitioners, internists, or pediatricians. Sometimes Physicians who practice in a particular office of a participating medical group, rather than an individual Physician, may serve as Your PCP. However, if You suffer from a chronic, disabling or life-threatening illness, You may apply to the Plan Medical Director to have a participating specialist Physician designated as Your PCP. Your application to the Medical Director must include the following:

- A written certification of medical need signed by You and the participating specialist who would serve as Your PCP;
- Any additional information specified by the Medical Director; and
- A written statement from the participating specialist indicating that he or she is willing to accept responsibility for the coordination of all Your health care needs.

If Your request is denied, that denial may be appealed through Our Member appeal process. If Your request is approved, the effective date for the participating specialist to be Your PCP is the first day of the month following the approval. Under state law, such designations cannot be made retroactively.

For the names of PCPs, please see Your Provider Directory or contact Our Customer Service Department at 1-800-884-4901. You may also go to the FirstCare website at www.FirstCare.com.

Prosthetics: Devices meant to replace, wholly or partly, a lost limb or body part, such as an arm or a leg.

Psychiatric Day Treatment Facility: A facility that provides treatment for not more than eight hours in any 24-hour period after which the Member is allowed to leave. Similar to a Residential Treatment Center for adults. The Joint Commission on Accreditation of Healthcare Organizations must accredit such facility.

Psychophysiological Testing: An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

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

Remediation: The process(es) of restoring or improving a specific function.

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

Rider: A supplement to Your Plan that describes any additional benefits or changes in Your benefits or the terms of Your coverage under the Plan. We may provide Riders to You at the time You enroll in the Plan or at other times after that.

Self-Injectable Medications: Medications recognized by the FDA as appropriate for self-administration (referred to as “self-injectable” drugs).

Service Area: The geographical area that FirstCare is authorized by law to serve. FirstCare’s Service Area map is provided in this booklet.

Skilled Nursing Facility or Extended Care Facility: An institution which:

- Is accredited under one program of the Joint Commission on Accreditation of Health Care Organizations as a Skilled Nursing Facility or is recognized by Medicare as an Extended Care Facility;
- Furnishes room and board and 24 hour-a-day skilled nursing care by, or under the supervision of a registered nurse (RN); and
- Is not a clinic, rest Facility, home for the aged, place for drug addicts or alcoholics, or a place for Custodial Care.

Subscriber: A covered employee of a Group who meets all applicable eligibility requirements of *Section 2, Eligibility and Enrollment* and whose enrollment form and applicable premium payment have been received in accordance with the enrollment requirements of this Evidence of Coverage.

Telehealth: A health service, other than a telemedicine medical service, delivered by a health professional licensed, certified, or otherwise entitled to practice in Texas, and acting within the scope of the health professional's license, certification, or entitlement, to a patient at a different physical location than the health professional using telecommunications or information technology.

Telemedicine: A health care service delivered by a physician licensed in Texas, or a health professional acting under the delegation and supervision of a physician licensed in Texas and acting within the scope of the physician's or health professional's license, to a patient at a different physical location than the physician or health professional using telecommunications or information technology.

Toxic Inhalant: A volatile chemical under Chapter 484, Texas Health and Safety Code, or abusable glue or aerosol paints under Section 485.001, Texas Health and Safety Code.

Ultrasound, Breast: Procedure that may be used to determine whether a lump is a cyst or a solid mass.

Us, We or Our: FirstCare.

Utilization Review: A system for prospective and/or concurrent review of the Medical Necessity and appropriateness of Covered Health Services Your provider is currently providing or proposes to provide to You. Utilization Review does not include elective requests by You for clarification of coverage.

Utilization Review Agent (URA): An entity designated by Us to perform Utilization Review of Medically Necessary treatment. The URA also determines Totally Disabled and Total Disability.

Utilization Review Plan: The screening criteria and Utilization Review procedures of a Utilization Review Agent. The program provides:

- Pre-treatment Review;
- Concurrent Review; and
- Discharge Planning

You or Your: A covered Member.

SECTION 12 – REQUIRED DISCLOSURES

NOTICE OF SPECIAL TOLL-FREE COMPLAINT NUMBER

TO MAKE A COMPLAINT ABOUT A PRIVATE PSYCHIATRIC HOSPITAL, CHEMICAL DEPENDENCY TREATMENT CENTER, OR PSYCHIATRIC OR CHEMICAL DEPENDENCY SERVICES AT A GENERAL HOSPITAL, CALL:

1-800-832-9623

Your complaint will be referred to the state agency that regulates the hospital or chemical dependency treatment center.

NOTICE OF OUT-OF-NETWORK COVERAGE

28 TAC §11.1612(c)

A health maintenance organization (HMO) plan provides no benefits for services you receive from out-of-network physicians or providers, with specific exceptions as described in your evidence of coverage and below.

You have the right to an adequate network of in-network physicians and providers (known as network physicians and providers).

If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance at: www.tdi.texas.gov/consumer/complfrm.html.

If your HMO approves a referral for out-of-network services because no network physician or provider is available, or if you have received out-of-network emergency care, the HMO must, in most cases, resolve the out-of-network physician's or provider's bill so that you only have to pay any applicable in-network copayment, coinsurance, and deductible amounts.

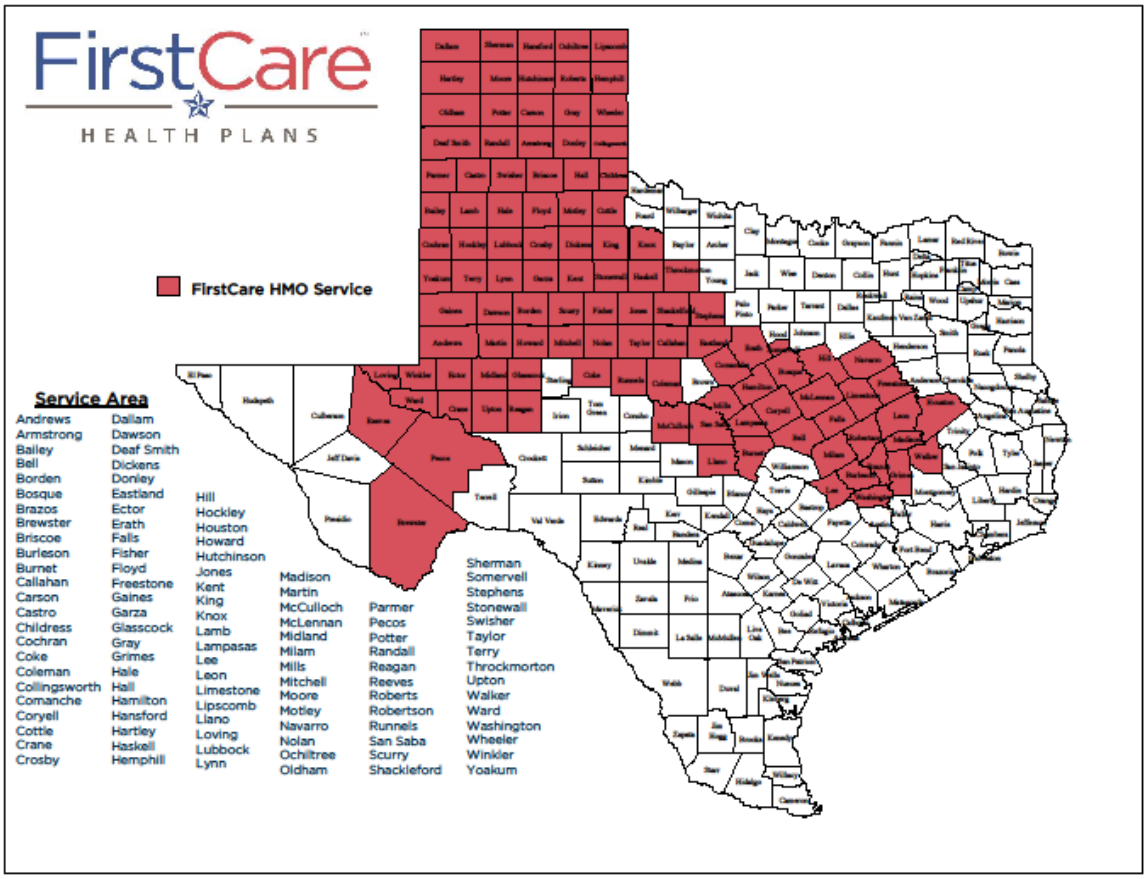
You may obtain a current directory of network physicians and providers at the following website: www.firstcare.com/FindAProvider or by calling 1-800-884-4901 for assistance in finding available network physicians and providers. If you relied on materially inaccurate directory information, you may be entitled to have a claim by an out-of-network physician or provider paid as if it were from a network physician or provider, if you present a copy of the inaccurate directory information to the HMO, dated not more than 30 days before you received the service.

BALANCE BILLING NOTICE

28 TAC §1456.003

A facility-based physician or other health care practitioner may not be included in FirstCare's provider network. The non-network facility-based physician or other health care practitioner may balance bill FirstCare HMO members for amounts not paid by FirstCare due to the provider being out-of-network. If the member receives a balance bill from a facility-based physician or other health care practitioner, contact FirstCare Customer Service at 1-800-884-4901.

SERVICE AREA MAP



FirstCare™

HEALTH PLANS

If you, or someone you're helping, has questions about FirstCare Health Plans, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-855-572-7238 (TTY/TDD 1.800.562.5259).

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de FirstCare Health Plans, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-855-572-7238 (TTY/TDD 1-800-562-5259).

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về FirstCare Health Plans, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-855-572-7238 (TTY/TDD 1-800-562-5259).

Chinese: 如果您或您正在帮助的人士对第一救护健康计划 (FirstCare Health Plans) 有疑问，您有权免费获取对应您母语的帮助及信息。联系口译员请拨打1-855-572-7238 (TTY/TDD 1-800-562-5259)。

Korean: 귀하 또는 귀하가 돕는 있는 사람이 FirstCare Health Plans에 문의할 사항이 있는 경우, 귀하의 언어도 무료 지원 및 정보를 받을 권리가 있습니다. 통역사와 통화하시려면 1-855-572-7238 (TTY/TDD 1-800-562-5259) 번으로 전화해 주십시오.

Arabic:
لك الحق، أو لدى اي شخص آخر تساعده، في الحصول على المساعدة والمعلومات أو اي أسئلة بخصوص FirstCare Health Plans. للتحدث مع مترجم بلغتك بدون تكلفة اتصل بالرقم 1-855-572-7238 (TTY/TDD 1-800-562-5259)

Urdu:
اگر آپ یا آپ کسی کی مدد کر رہے ہیں, اور سوالات ہیں" FirstCare Health Plans " کے بارے میں, تو یہ آپ کا حق ہے مدد حاصل کرنا اور معلومات حاصل کرنا اپنی زبان میں بغیر کسی قیمت کے. کسی ترجمان سے بات کرنے کے لئے کال کریں. 1-855-572-7238 (TTY/TDD 1-800-562-5259)

Tagalog: Kung mayroon kang, o sinumang tinutulungan mo, mga katanungan tungkol sa FirstCare Health Plans, mayroon kang karapatang humingi ng tulong at impormasyon nang walang bayad. Upang makipag-usap sa isang tagapagsalin, tumawag sa 1-855-572-7238 (TTY/TDD 1-800-562-5259)

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de FirstCare Health Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-855-572-7238 (TTY/TDD 1-800-562-5259).

Hindi: यदि आपके, या आप जिन्हें सहायता कर रहे हैं उनके पास FirstCare Health Plans से संबंधित कोई प्रश्न हैं तो आपको अपनी भाषा में बिना किसी शुल्क के सहायता और जानकारी पाने का अधिकार है। किसी अनुवादक से बात करने के लिए यहां कॉल करें 1-855-572-7238 (TTY/TDD 1-800-562-5259)

Persian-Farsi:
اگر شما یا شخصی که به او کمک می‌کنید سوالی درباره FirstCare Health Plans داشتید، این حق را دارید تا کمک و اطلاعات را به زبان خود و بدون هیچ هزینه‌ای دریافت کنید. برای صحبت با یک مترجم با شماره 1-855-572-7238 (TTY/TDD 1-800-562-5259) تماس حاصل فرمایید.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zu FirstCare Health Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-855-572-7238 (TTY/TDD 1-800-562-5259) an.

Gujarati: જો તમને, અથવા કોઈકને તમે મદદ કરી રહ્યાં છો, તેને FirstCare Health Plans વિશે પ્રશ્નો હોય તો, તમને નિશુલ્ક તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા કોલ કરો: 1-855-572-7238 (TTY/TDD 1-800-562-5259).

Russian: Если вам или лицу, которому вы помогаете, возникнет вопросы по FirstCare Health Plans, то вы имеете право на бесплатную помощь и информацию на вашем языке. Для разговора с переводчиком позвоните по телефону 1-855-572-7238 (TTY/TDD 1-800-562-5259).

Japanese: FirstCare Health Plan についてご質問の場合は、無料でご自分の言語のサポートと情報を得ることができます。1-855-572-7238 （テレタイプライター/聴覚障害者用通信機器 1-800-562-5259） にお電話いただき、通訳者とお話しください。

Laotian: ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ ມີຄຳຖາມກ່ຽວກັບ FirstCare Health Plans, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໂອ້ລົມກັບລ່າມແປພາສາ, ກະລຸນາໂທ 1-855-572-7238 (TTY/TDD 1-800-562-5259).

Non-Discrimination Notice

FirstCare Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. FirstCare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We provide free communication aids and services to people with disabilities. We also provide language assistance to people whose primary language is not English.

To receive language or communication assistance please call 1-855-572-7238.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, please contact us to file a grievance:

SHA, LLC dba FirstCare
ATTN: Complaints and Appeals
12940 N. HWY 183
Austin, TX 78750
Phone: 1-855-572-7238 *(Mon. - Fri., 8 a.m. - 5 p.m. CT)*
TTY /TDD: 1-800-562-5259

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

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F
HHH Building, Washington, DC 20201
Phone: 1-800-368-1019
TTY/TDD: 1-800-537-7697

Complaint forms are available at: http://www.hhs.gov/ocr/filing-with-ocr/index.html

Language/Non-Discrimination_Notice
Last Updated: 08182017

Amendment to Evidence of Coverage

Section 3 – What is Covered is amended as follows:

Hearing Aids and Cochlear Implants

We provide coverage for a hearing aid or cochlear implant and related services and supplies for a covered individual when determined to be medically necessary by a Plan Physician and obtained from a Participating Provider. Refer to the Schedule of Copayments (SOC) for details.

Coverage includes:

- fitting and dispensing services and the provision of ear molds as necessary to maintain optimal fit of hearing aids;
- any treatment related to hearing aids and cochlear implants, including coverage for habilitation and rehabilitation as necessary for educational gain; and
- for a cochlear implant, an external speech processor and controller with necessary components replacement every three years; and

Limitations:

- one hearing aid in each ear every three years; and
- hearing aid prescription must be written by:
    a. a physician certified as an otolaryngologist or otologist; or
    b. an audiologist who (1) is legally qualified in audiology; or (2) holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements; and who performs the exam at the written direction of a legally qualified otolaryngologist or otologist.
- When alternate hearing aids can be used, the plan's coverage may be limited to the cost of the least expensive device that is:
    a. Customarily used nationwide for treatment, and
    b. Deemed by the medical profession to be appropriate for treatment of the condition in question. The device must meet broadly accepted standards of medical practice, taking into account your physical condition. You should review the differences in the cost of alternate treatment with your physician. You and Your physician may still choose the more costly treatment method however You are responsible for any charges in excess of what the plan will cover.
- one cochlear implant in each ear with internal replacement as medically or audiologically necessary.

Coverage required under this section is subject to any provision that applies generally to coverage provided for durable medical equipment benefits under the plan, including a provision relating to deductibles, copayments, or prior authorization.

Section 3 – What is Covered is amended as follows:

Limited Accidental Dental-Related Services

We provide limited coverage for dental services that would be excluded from coverage but are determined by the Medical Director to be medically necessary and incident to and an integral part of a covered medical procedure. Examples could include the following:

- Removal of broken teeth as necessary to reduce a fractured jaw.
- Reconstruction of a dental ridge resulting from removal of a malignant tumor.

- Extraction of teeth prior to radiation therapy of the head and neck.

We provide limited coverage for initial restoration and correction of damage caused by external violent accidental injury to natural teeth and/or jaw if:

- The fracture, dislocation or damage results from an accidental injury;
- You seek treatment within 48 hours of the time of the accident or upon the effective date of coverage, whichever comes later;
- Restoration or replacement is completed within 6 months of the date of the injury or upon the effective date of coverage, whichever comes later.

Removal of cysts of the mouth (except for cysts directly related to the teeth and their supporting structures).

Certain Oral surgeries including maxillofacial surgical procedures that are limited to:

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

Medically necessary services performed in a Plan outpatient facility and are required for the delivery of necessary and appropriate dental services when the dental services cannot be safely provided in a dentist's office due to the Member's physical, mental, or medical condition.

The services described above are the only dental-related services covered under Your Plan. See *Section 5, What is Not Covered.*

Section 9 – Member Complaint and Appeal Procedure is amended as follows:

Appeals to an Independent Review Organization (IRO)

Medical Appeals

In a circumstance involving a Life-Threatening condition, You are entitled to an immediate appeal to an Independent Review Organization and are not required to comply with procedures for an internal review of Our Adverse Determination.

Any party whose appeal of an Adverse Determination is denied by Us, may seek review of that determination by an Independent Review Organization assigned to the appeal as follows:

- We shall provide to You, Your designated representative, and/or Your provider of record, information on how to appeal the denial of an Adverse Determination to an Independent Review Organization.
- We must provide such information to You, Your designated representative, and/or Your provider of record at the time of the denial of the appeal.
- We shall provide to You, Your designated representative, and/or Your provider of record the prescribed form.
- You, Your designated representative, and/or Your provider of record must complete the form and return it to Us to begin the independent review process.

The Independent Review Organization must issue a decision to the health plan and the claimant (enrollee) within four business days or less from the Independent Review Organization's receipt of the request for review and provide written notice of its decision within 48 hours of the oral notification.

The appeal process does not prohibit You from pursuing other appropriate remedies including injunctive relief, a declaratory judgment, or relief available under law, if the requirement of exhausting the process for appeal and review places Your health in serious jeopardy.

FirstCare will not take any retaliatory action, such as refusing to renew or canceling coverage, against You because You, or any person acting on Your behalf, has filed a Complaint against FirstCare or appealed a decision made by FirstCare.

Pharmacy Appeals

Where a medication is not covered on the formulary or awaiting formulary review, an Exception Prior Authorization allows clinical review for medical necessity and coverage.

Exigent circumstances exist when a Member is suffering from a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when a Member is undergoing a course of treatment using a non-formulary drug.

If We deny a request for a standard exception or for an expedited exception, the Member, the Member's designee, or the Member's prescribing physician (or other prescriber) may submit a request that the original exception request and subsequent denial of such request be reviewed by an Independent Review Organization.

The Independent Review Organization will make a determination on the external exception request and notify the Member, the Member's designee, or the Member's prescribing physician (or other prescriber, as appropriate) of the coverage determination no later than 72 hours following the receipt of the request, if the original request was a standard exception request and no later than 24 hours following the receipt of the request if the original request was an expedited exception request.

If We grant an external exception review of a standard exception request, We will provide coverage of the non-formulary drug for the duration of the prescription. If We grant an external exception review of an expedited exception request, We will provide coverage of the non-formulary drug for the duration of the exigency.