FirstCare™ HEALTH PLANS

FirstCare *mySeries*

Benefits Summary
ChoicePlus II

This chart only summarizes covered benefits.
Please refer to the Policy for coverage details including exclusions and limitations.

COVERED SERVICE	PREFERRED PROVIDER (In-Network Benefits)	NON-PREFERRED PROVIDER (Out-of-Network Benefits)
POLICY YEAR: CALENDAR		
DEDUCTIBLE (Does not apply toward Out-of-Pocket Maximum)	$3,000 per Insured $6,000 per Family	$6,000 per Insured $12,000 per Family
OUT-OF-POCKET MAXIMUM[1]	$3,000 per Insured $6,000 per Family	$6,000 per Insured $12,000 per Family
AGGREGATE LIFETIME MAXIMUM	$2,000,000	
PRE-AUTHORIZATION PENALTY	Failure to Pre-authorize reduces benefits by 50% or $500, whichever is less.	
INPATIENT SERVICES Inpatient Services include: • Semi-Private Room and Board Charges • Surgical Procedures • Pre-Admission Testing • Physician Hospital Visits • Intensive Care & Coronary Care Units • Operating/Recovering Room • Acquired Brain Injury • Laboratory Tests and X-ray • Reconstructive Surgery • Observation Unit • Physician Services • Skilled Nursing Facility - *Limited to a combined 30 In-/Out-of-Network days per Policy Year*	100% after Deductible	70% after Deductible
OUTPATIENT SERVICES Outpatient Services/Surgery include: • Facility Charges • Surgical Procedures • Physician Services	100% after Deductible	70% after Deductible
Laboratory Tests and X-ray in an Outpatient Setting	100% after Deductible	70% after Deductible
MRI, CT Scans, Sleep Study, Nuclear Stress Tests and PET Scan	100% after Deductible	70% after Deductible

[1] ***Out-of-Pocket Maximum*** *is the total amount that must be paid each Policy Year before benefits are covered at 100%, up to the Usual, Customary and Reasonable (UCR) amount. Coinsurance amounts count towards the Out-of-Pocket Maximum. Deductibles do not count towards the Out-of-Pocket Maximum. Copayments that are not subject to the Deductible do not apply to the Out-of-Pocket Maximum and must continue to be paid, even though the Insured has reached the Out-of-Pocket Maximum.*

FirstCare PPO is a product of Southwest Life & Health Insurance Company
which is a wholly owned subsidiary of SHA, L.L.C.
ChoicePlus II – PP09I002 (Jan. 09)

COVERED SERVICE	PREFERRED PROVIDER (In-Network Benefits)	NON-PREFERRED PROVIDER (Out-of-Network Benefits)
PHYSICIAN OFFICE SERVICES		
Physician Office Services Include: • Physician Office Visits • Medications, supplies and materials administered in the office • Second Surgical Opinion	$30 office visit Copayment	70% after Deductible
Laboratory Tests and X-Ray	100% after Deductible	70% after Deductible
MRI, CT Scans, Sleep Study, Nuclear Stress Tests and PET Scan performed in the Physician's office	100% after Deductible	70% after Deductible
Allergy Services: • Office Visit • Allergy Testing • Serum • Injection Administration	$30 office visit Copayment 100% after Deductible 100% after Deductible 100% after Deductible	70% after Deductible
Surgical Procedures performed in the Physician's Office	100% after Deductible	70% after Deductible
PREVENTIVE SERVICES ****Limited to a combined $500 In-/Out-of-Network benefit per Insured per Policy Year.***		
Preventive Services include*: • Annual Routine Physicals* • Well Baby and Well Child Care* • Routine Eye, Speech and Hearing Screenings for Children when performed during an office visit* • Routine Labs and X-Rays* • Routine Immunizations (ages 6 and older)* • Examinations and testing for the detection of Prostate Cancer* • Well Woman Exam including Routine Annual Physicals*	$30 office visit Copayment	70% after Deductible
Immunizations for Newborns (birth to 6-years of age)	Covered in full	Covered in full
Newborn Child Hearing Screenings (birth to 30-days old)	$30 office visit Copayment	70% after Deductible
Preventive Diagnostics and Testing: • Screening mammograms including Digital, X-ray and Ultrasound • Screening for the detection of Colorectal Cancer *(If other procedures are done during screening, additional copays, deductibles, and/or coinsurance will apply)* • Bone Mass Measurement	100% after Deductible	70% after Deductible

COVERED SERVICE	PREFERRED PROVIDER (In-Network Benefits)	NON-PREFERRED PROVIDER (Out-of-Network Benefits)
FAMILY PLANNING		
Family Planning and Counseling	$30 office visit Copayment	70% after Deductible
Contraceptive Devices, Implants and Injections including: • Diaphragm • IUD • Subdermal Contraceptive Implants & Removal • Depo-Provera™ Injections	100% after Deductible	70% after Deductible
Sterilization Procedures: (Vasectomy & Tubal Ligation) • When performed in an Outpatient Facility • When performed in the Physician's Office • When performed in an Inpatient Facility	100% after Deductible	70% after Deductible
DIABETIC SERVICES		
Diabetic Self-Management Education	$30 office visit Copayment	70% after Deductible
Insulin and Diabetic Medication: • 30-day Supply o 1st tier – Generic Drugs o 2nd tier – Brand name drugs on drug list o 3rd tier – Brand name drugs not on drug list	$20 per prescription – after Deductible $50 per prescription – after Deductible $100 per prescription – after Deductible	The claim is paid at 70%, after Deductible, of the actual charges, after they are first reduced by the sum of the applicable In-Network pharmacy charges and any required difference in the cost between a Brand Name medication and a Generic medication.
• Mail Order (up to 90-day supply) o 1st tier – Generic Drugs o 2nd tier – Brand name drugs on drug list o 3rd tier – Brand name drugs not on drug list	$60 per prescription – after Deductible $150 per prescription – after Deductible $300 per prescription – after Deductible	
Test Strips: • Level 1 Strips • Level 2 Strips	100% after Deductible	70% after Deductible
Other Diabetic Supplies and Equipment (30-day Supply)	100% after Deductible	70% after Deductible
SPECIALTY SERVICES/PHARMACY		
Specialty Services/Pharmacy includes: • Medical Injectable Drugs *(excluding Depo-Provera™ injectables)* • Defined Hybrid Injectables • Radiation Therapy • Transplant Anti-Rejection Therapy • Specified Cancer Chemotherapy • Defined Associated Agents	• When Covered Service cost is $500 or less: No additional Coinsurance taken after Deductible. *See the office visit, outpatient surgery or inpatient hospital section(s) for applicable charges.* • When Covered Service cost is more than $500: 30% coinsurance after Deductible, not	70% after Deductible 70% after Deductible

COVERED SERVICE	PREFERRED PROVIDER (In-Network Benefits)	NON-PREFERRED PROVIDER (Out-of-Network Benefits)
	to exceed $3,000 Out-of-Pocket Maximum for these specific services. *See Section 3 - How Benefits Are Paid in Your Certificate of Insurance.*	
Home Infusion Therapy *(excluding "self-injectable" drugs)*	100% after Deductible	70% after Deductible
EMERGENCY ROOM SERVICES		
Emergency Room	100% after Deductible	
Minor Emergency/Urgent Care Facilities	100% after Deductible	70% after Deductible
Ambulance	100% after Deductible	70% after Deductible
OTHER HEALTH CARE SERVCES		
Limited Accidental Dental Care and Medically Related Oral Surgeries – *Limited to a combined $1,000 In-/Out-of Network Maximum Benefit per Policy Year.*	100% after Deductible	70% after Deductible
Therapy Services: • Rehabilitation Therapy, Occupational Therapy, & Physical Therapy *(Limited to a combined 20 In-/Out-of-Network visits per Policy Year)* • Speech Therapy *(Limited to 20 In-/Out-of-Network visits per Policy Year)*	100% after Deductible	70% after Deductible
Hospice Care – *Limited to a combined $10,000 In-/Out-of-Network Lifetime Maximum Benefit.*	100% after Deductible	70% after Deductible
Spinal Manipulation – *Limited to a combined 10 In-/Out-of-Network visits per Policy Year.*	100% after Deductible	70% after Deductible
Pain Management Services	100% after Deductible	70% after Deductible
Durable Medical Equipment (DME) – *Limited to a combined $2,000 In-/Out-of-Network Maximum Benefit per Policy Year. This limit applies to both Outpatient & Home Health Care services. DME used in the treatment of diabetes, oxygen and monitoring devices are not included in the $2,000 maximum.*	100% after Deductible	70% after Deductible
Medical Supplies	100% after Deductible	70% after Deductible
Prosthetics: External Devices: *Combined In-/Out-of-Network Lifetime Maximum of $4,000 per Device/Limb*	100% after Deductible	70% after Deductible
Orthotics	100% after Deductible	70% after Deductible
Internal Implantable Devices	100% after Deductible	70% after Deductible
Dialysis Services *(Inpatient & Outpatient)*	100% after Deductible	70% after Deductible

COVERED SERVICE	PREFERRED PROVIDER (In-Network Benefits)	NON-PREFERRED PROVIDER (Out-of-Network Benefits)
Organ Transplant Services *(Inpatient & Outpatient) – Limited to a combined $300,000 In-/-Out of Network Lifetime Maximum*	100% after Deductible	70% after Deductible
Home Health Care Services include: *Limited to a combined 20 In-/Out-of-Network visits per Covered Service per Policy Year* • Skilled nursing services provided by a registered nurse or vocational nurse; supervised by one registered nurse and one physician • Home health aide services; supervised by a registered nurse • Medical equipment/supplies other than drugs and medicines: *Limited to the combined dollar amount listed under Durable Medical Equipment (DME) for both Outpatient & Home Health DME services.*	100% after Deductible	70% after Deductible
ALL OTHER COVERED SERVICES	100% after Deductible	70% after Deductible

FirstCare™ HEALTH PLANS

Prescription Drug Rider PX09I1EL

CALENDAR YEAR MAXIMUM BENEFIT **$4,000 per Insured**

CALENDAR YEAR DEDUCTIBLE **$100 per Insured**

This Rider is issued to You in connection with and amends Your Southwest Life & Health Insurance Individual Contract Certificate of Insurance. This Rider is effective as of the date of Your Individual Contract Certificate of Insurance. Capitalized terms used in this Rider that are not defined herein shall have the meanings ascribed to such terms in Your Certificate of Insurance.

	PARTICIPATING RETAIL PHARMACY Standard Drugs 30-day supply	PARTICIPATING RETAIL PHARMACY Maintenance Drugs* 30-day supply	 90-day supply	PARTICIPATING HOME DELIVERY PHARMACY Maintenance Drugs* 90-day supply
Tier I	$10 per Prescription	$13 per Prescription	$39 per Prescription	$30 per Prescription
Tier II	$35 per Prescription	$45 per Prescription	$135 per Prescription	$105 per Prescription
Tier III	$50 per Prescription	$65 per Prescription	$195 per Prescription	$150 per Prescription
****Tier IV**	25% per Prescription	38% per Prescription – 30 or 90 day supply		25% per Prescription
Tier V	50% per Prescription	65% per Prescription – 30 or 90 day supply		50% per Prescription

*Plan provides two fills of maintenance medications through Participating Retail Pharmacies at the standard drug copayment level. After that, maintenance medications can be procured through the Home Delivery Pharmacy or through the Participating Retail Pharmacy at the applicable maintenance drug copayments.

** If drugs covered under the Tier IV benefit level are also covered through Your medical benefit plan; then the benefit coverage is provided through this Prescription Drug Rider and is non-duplicative. Refer to Your Schedule of Benefits for details

OUT-OF-NETWORK RETAIL PHARMACY (30-Day Supply)

The claim is paid at 70% of the actual charges, after they are first reduced by the sum of the applicable In-Network pharmacy Copayment and any required difference in the cost between a Brand Name medication and a Generic medication. When submitting a claim, You must submit a completed claim form and an itemized prescription receipt from the pharmacy. The receipt must include the National Drug Code for the prescription medication dispensed. Call Customer Service at (800) 240-3270 or visit www.FirstCare.com to obtain a claim form for pharmacy reimbursement.

WHAT THIS RIDER COVERS:

This Rider covers the following Prescription Drugs included in the approved FirstCare Drug Coverage List (DCL) when they are prescribed by a Primary Care Physician (PCP) or other authorized referral Prescribers:

- Medically Necessary Prescription Drugs including Generic drugs and drugs listed in the FirstCare DCL. When a Generic Drug is available and the Brand Name is dispensed, You will be responsible for the Generic Drug Copayment plus the difference between the cost of the Generic Drug and the cost of the Brand Name Drug, even if Your Physician prescribes a name brand drug.
- Compound medications must contain at least one covered Legend Drug.

- Legend Pre-natal vitamins.
- Growth hormone therapy for the treatment of documented growth hormone deficiency in children for which epiphyseal closure has not occurred.
- Formulas necessary for the treatment of Phenylketonuria (PKU) or other Heritable Disease.
- Contraceptive legend drugs and devices.
- Injectable medications recognized by the FDA as appropriate for self-administration (referred to as "Self-Injectable" drugs), regardless of the Insured's ability to self-administer.

LIMITATIONS:

- Certain medications are subject to dispensing limitations based upon generally accepted medical practice, including but not limited to, medications, contained in the FirstCare DCL.
- Certain medications are subject to prior authorization, including but not limited to, medications contained in the FirstCare DCL. Failure to pre-authorize these medications will reduce the benefit by 50% or $500 whichever is less.
- New FDA approved medications (unique chemical entities) will require prior authorization until they have been reviewed by the FirstCare P&T committee, and their coverage status is determined.
- Medications covered under this Rider are limited to a 30-day supply. Maintenance medications may be filled up to a 90-day supply through Participating Retail Pharmacies or through the Home Delivery Pharmacy program.
- Prescriptions will not be refilled until 75% percent of the prescription has been used.
- Medications prescribed for non-FDA approved indications, referred to as off-label drug use, *are not covered*. This includes experimental and investigational drugs, used to treat any disease or condition that is excluded from coverage under this Rider, or that the FDA has determined to be contraindicated for treatment of the current indication. Off-label drug use may be covered if the drug is approved by the FDA for at least one indication, and is recognized by reproducible studies for treatment of the indication for which the drug is prescribed in substantially accepted peer-reviewed national medical professional journals and a nationally recognized medical technology evaluation service.
- One vacation override is allowed each policy year.

WHAT IS NOT COVERED:

- Medications not listed on the DCL.
- Drugs that by law do not require a prescription unless listed in the DCL.
- Prescriptions written in connection with any treatment or service that is not a covered benefit unless listed in the DCL.
- Devices of any kind, even those requiring a prescription, including but not limited to therapeutic devices, health appliances, hypodermic needles or similar items, unless used in the treatment of diabetes.
- Any medication that is not Medically Necessary. Denials for medications that are not medically necessary are subject to the Insured Complaint and Appeal Procedures outlined in Section 9 of your Certificate of Insurance.
- Over-the-counter vitamins and mineral supplements.
- Appetite suppressants, anti-smoking aids (e.g. Nicorette gum and nicotine patches), medications used for any cosmetic improvement, including wrinkles, uncomplicated nail fungus regardless of ambulation or pain, hair loss, growth or removal, idiopathic non-growth hormone deficiency short stature, and DESI Drugs.
- Growth hormone drugs for persons 18 years of age or older. However, growth hormone therapy for the treatment of documented growth hormone deficiency in children for which epiphyseal closure has not occurred, are covered when services are pre-authorized.
- Prescriptions or refills that replace lost, stolen, spoiled, expired, spilled or are otherwise misplaced or mishandled by the Insured.
- Prescriptions written for the treatment of infertility.
- Any medication covered under Your medical plan.

FirstCare HEALTH PLANS

Prescription Drug Rider PX09I1EL

GENERAL PROVISIONS:

- The Insured Person(s) will give their FirstCare Identification Card to the Pharmacist when presenting a Prescription Order to an In-Network Pharmacy.
- If We request, the Insured Person will authorize and direct an Out-of-Network Pharmacy to provide to Us all information, copies or other records relating to all Prescription Orders concerning the Insured Person, to the extent permitted by state or federal law. We will maintain the confidentiality of all the information.
- We are not liable for any claims, injury, demand or judgment based on tort or other grounds (including warranty of drugs), arising out of or in connection with the sale, compounding, dispensing, manufacturing or use of any Prescription Drug whether or not covered under this Rider.
- For High Deductible Health Plans (HDHP), the deductible and out-of-pocket maximum of the Plan will apply to this Rider. Also, copayments under this Rider will count toward the HDHP Plan's deductible and out-of-pocket maximum.

DEFINITIONS

Brand Name Drug means a drug that has no Generic Equivalent or a drug that is the innovator or original formulation for which the Generic Equivalent forms exist.

Contract Year Deductible is the amount of Covered Prescription Drug Expenses You must pay for each Insured before any benefits are available.

Copayment means the amount that will be charged to the Insured Person by the In-Network Pharmacy or Home delivery Pharmacy for dispensing or refilling any Prescription Order.

Covered Drugs means those medications prescribed by a Physician that, under state or federal law, may be dispensed only by a Prescription Order or is a compounded prescription that contains at least one legend ingredient or insulin. The maximum amount dispensed will not exceed an amount required for 30 consecutive days. Medications for chronic conditions may be filled up to a 90-day supply.

DESI Drugs: Any drug targeted in the FDA's Drug Efficacy Study Implementation (DESI) which demonstrates a lack of evidence supporting the drug's efficacy.

Drug Coverage List or DCL means a comprehensive list of medications consisting of Generic Equivalent drugs and single source (sometimes referred to as Brand Name) drugs. The FirstCare DCL is the list of medications authorized by the FirstCare Pharmacy and Therapeutics Committee to be dispensed through Participating Pharmacies. The DCL may be revised from time to time.

Experimental or Investigational means 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; or
- 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; or
- 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.

Facility means 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.

Generic Equivalent Prescription Drug means a Prescription Drug that is pharmaceutically and therapeutically equivalent to a Brand Name Drug as classified by First Data Bank® or other nationally recognized drug classification service.

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

In-Network Pharmacy means a pharmacy with whom We have contracted to provide Prescription Drugs to Insured Persons.

Insured Person means either the Policyholder or his eligible Dependents covered under the Policy.

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

Maintenance Drug means medication prescribed for a chronic long term condition and is taken on a regular recurring basis. Conditions that may require maintenance drugs are high blood pressure and diabetes.

Out-of-Network Pharmacy means a pharmacy that has not contracted with Us to provide Prescription Drugs.

Participating Home Delivery Pharmacy means a pharmacy providing prescription service by mail which has contracted with FirstCare to provide such services.

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

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

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

Standard Drug means a FDA approved medication that requires a written prescription by a licensed physician.

For more information and to view the DCL, please visit www.FirstCare.com.

Southwest Life & Health Insurance Company

President

IN CONSIDERATION OF THE PAYMENT OF PREMIUMS IN ACCORDANCE WITH THE PROVISIONS CONTAINED IN THIS POLICY, WE AGREE TO PROVIDE BENEFITS TO EACH INSURED UNDER THE TERMS OF THIS POLICY FROM THE EFFECTIVE DATE OF THIS POLICY AND FOR CONSECUTIVE PREMIUM PAYMENT PERIODS THEREAFTER, UNLESS THIS POLICY IS TERMINATED AS PROVIDED IN *SECTION 9 - TERMINATION OF COVERAGE*.

This Policy is subject to (1) maximum lifetime benefits; (2) premium increases as described in Section 10; (3) termination of coverage in accordance with Section 9 and (4) Pre-authorization requirements detailed in Section 6

GUARANTEED RENEWAL EXCEPT FOR THE STATED REASONS

We can refuse to renew this Policy only: (1) for non-payment of premium; (2) for fraudulent or intentional material misstatements; (3) if all Policies with the same form number are non-renewed in the state in which Your Policy was issued or the state in which you presently reside; (4) ceasing to be a Covered Dependent; or (5) if you no longer reside, live, or work in an area in which We are authorized to provide coverage, but only if all Policies are not renewed or not continued.

NOTICE OF 10-DAY RIGHT TO EXAMINE POLICY

PLEASE READ YOUR POLICY CAREFULLY. You have 10 days to examine this Policy after You receive it. If after examining it, You are not satisfied for any reason, You may return it to Us within the 10-day period and the premium You have paid will be returned to You. However, if You receive any services prior to returning this Policy, You will be responsible for those charges.

SOUTHWEST LIFE & HEALTH INSURANCE COMPANY
(Herein Called We, Our, or Us)

Has issued this

PREFERRED PROVIDER OPTION
INDIVIDUAL ACCIDENT AND HEALTH MAJOR MEDICAL PLAN
POLICY

providing

Comprehensive Major Medical Expense Coverage

to

POLICYHOLDER:

EFFECTIVE DATE:

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYEE IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS THAT WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO THE NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND

POSTED. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

Southwest Life & Health Insurance Company

SOUTHWEST LIFE & HEALTH INSURANCE COMPANY
FirstCare Individual PPO

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Southwest Life & Health Insurance Company's toll free telephone number for information or to make a complaint at:

(800) 240-3270

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

(800) 252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
FAX: (512) 475-1771
Web: http//www.tdi.state.tx.us
E-mail: ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES: Should You have a dispute concerning Your premium or about a claim, You should contact Southwest Life & Health Insurance Company first. If the dispute is not resolved, You may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:

This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de Southwest Life & Health Insurance Company's para informacion o para someter una queja al:

(800) 240-3270

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

(800) 252-3439

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104
FAX: (512) 475-1771
Web: http//www.tdi.state.tx.us
E-mail: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con Southwest Life & Health Insurance Company primero. Si no se resuelva la disputa, puede entoneces comunicarse con al Departmento de Seguros de Texas.

UNA ESTE AVISO A SU POLIZA:

Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

Information Important To Understanding the Benefits In This Policy

Section 1 – Definitions

Section 2 – Eligibility
- *Eligibility*
  - *Conditions of Eligibility*
  - *Dependent Coverage*
- *Enrollment*
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  - *Newly Eligible Dependents*
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- *Notice of Ineligibility*

Section 3 – How Benefits Are Paid
- *Deductible*
- *Family Deductible*
- *Coinsurance*
- *Out-of-Pocket Maximum*
- *Out-of-Pocket Maximum for Specific Services*
- *Lifetime Maximum*
- *Pre-Existing Condition*
- *Subrogation*
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- *Payment to TX. Dept. of Human Services*
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Section 4 – What Is Covered
- ***Inpatient Services***
  - *Semi-Private Room & Board Charges*
  - *Intensive Care Unit*
  - *Inpatient Services to Treat Breast Cancer*
  - *Other Hospital Services and Supplies*
- ***Outpatient Services***
  - *Health Care Provider Services*
  - *Outpatient Surgery*
  - *Laboratory & Radiology Services*
- ***Preventive Health Care Services***
  - *Routine Physical Exam*
  - *Well-Baby & Well-Child Preventive Care*
  - *Immunizations*
  - *Ophthalmologic Exams*
  - *Routine Sight, Speech, & Hearing Screening*
  - *Newborn Hearing Screenings*
  - *Screening Mammograms*
  - *Screening for the Detection of Colorectal Cancer*
  - *Bone Mass Measurement*
  - *Prostate Cancer Testing*
  - *Pap Smear Screening*
- ***Family Planning***
  - *Family Planning Services*
- ***Other Health Care Services***
  - *Spinal Manipulation Services*
  - *Rehabilitative Services*
  - *Reconstructive Surgery*
  - *Prosthetics/Orthotics*
  - *Internal Implantable Devices*
  - *Dorsal Column Stimulators*
  - *Pain Management*
  - *Acquired Brain Injury*
  - *Second Surgical Opinion*
  - *Dialysis Services*
  - *Organ Transplant Services*
  - *Durable Medical Equipment*
  - *Medical Supplies*
  - *Limited Accidental Dental Care Services*
  - *Temporomandibular Joint Disorder (TMJ)*
  - *Blood & Blood Products*
  - *Home Health Care Services*
  - *Skilled Nursing Facility Services*
  - *Hospice Care*
  - *Injectable Drugs*
  - *Home Infusion Therapy*
  - *Treatment of Diabetes*
- ***Emergency Care Services***
  - *Emergency Care*
  - *Ambulance Services*
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Section 5 – What Is Not Covered

Section 6 – Utilization Review (UR) Program
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- *Effect on Benefits*
- *Utilization Review Program Requirements*
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- *Claims Requirements*
- *Payment of Claims*
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Section 8 – Complaint Procedures
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- *Filing Complaints with the Texas Department of Insurance*
- *Release of Medical Records*
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Section 9 – Termination of Coverage
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- *Automatic Termination*
- *Termination of Benefits*
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- *Waiver of Rights*
- *Entire Policy*
- *Incontestability*
- *Grace Period*
- *Reinstatement Provision*
- *Time Limit on Certain Defenses*
- *Misstatements on the Application at Issuance of this Policy*
- *Confidentiality of Medical Records*
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SERVICE AREA MAP

INFORMATION IMPORTANT TO UNDERSTANDING THE BENEFITS IN THE INDIVIDUAL INSURANCE POLICY

You have selected this Preferred Provider Organization (PPO) plan for Your individual health insurance coverage. To obtain maximum benefits from Your Plan, always use one of Our Preferred Providers.

A Preferred Provider is a Hospital, Facility, Home Health Agency, or other Health Care Provider that is located within Our Service Area and has contracted with Southwest Life & Health Insurance Company (SWL&H) to provide services and treatment under this Policy. See *Section 1 - Definitions*, for additional details.

A Non-Preferred Provider is any Hospital, Facility, Home Health Agency, or other Health Care Provider that has not contracted with SWL&H. When an Insured receives covered Emergency Care services from a Non-Preferred Provider, those services will be paid as if they were received from a Preferred Provider. However, once the Insured can be safely transferred to a Preferred Provider, the Insured will be required to transfer to a Preferred Provider in order to continue receiving the Preferred Provider level of benefits. If the Insured chooses not to transfer, benefits will be payable at the Non-Preferred Provider level of benefits. See *Section 1 - Definitions*, for additional details.

PPO Service Area is the geographical area in which Southwest Life & Health Insurance Company's contracted Preferred Providers are located.

SECTION 1 DEFINITIONS

Some words and phrases used in this Policy are defined below. Other words and phrases are defined where they appear.

Throughout this document, "You" and "Your" refer to a Southwest Life & Health Insurance Company Insured, including any Dependents (such as spouses and children) that are also enrolled in the Plan. "We," "Our," or "Us" refers to Southwest Life & Health Insurance Company. "Your Plan" and "this Plan" refers to the Southwest Life & Health Insurance Company Policy, which is described in this document, together with Your Schedule of Benefits and any applicable Riders.

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 utilization review agent or health maintenance organization that the health care services furnished or proposed to be furnished to an Insured are not medically necessary.

Allowable Amount - the amount We determine to be eligible for consideration of payment for a particular Covered Health Service, supply, or procedure.

Application - all forms required to be completed by the Policyholder or the Insured.

Assignment of Benefits - a written transfer of benefits payable for Covered Health Services made by the Insured and obtained by or delivered to Us with the Claim for benefits. We will pay the benefit payment directly to the Hospital, Facility, Home Agency, or other Health Care Provider. This written Assignment of Benefits does not relieve the Insured of any contractual responsibility to pay the Deductible or the Coinsurance.

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.

Claim - notification that a service has been rendered or supplies have been furnished to an Insured. This notification must set forth in full, the details of the service or supplies, as required by Us.

Coinsurance - the percentage of charges for Covered Health Services that You pay. The Coinsurance percentage is 100% minus the benefits payable shown in the Schedule of Benefits.

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 - 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, 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 the satisfaction of the Insured and does not include a Plan Provider's or the Insured's oral or written dissatisfaction or disagreement with an Adverse Determination.

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 Year - a 12 month period beginning with the effective date of coverage for a Policy, and each succeeding 12 month period thereafter that the Policy is effective.

Copayment - the amount You are required to pay to a Plan Provider or other authorized provider in connection with the provision of Covered Health Services. The Copayment amounts are indicated in the Schedule of Copayments.

Covered Health Services - those Medically Necessary services, supplies, or benefits described in *Section 4 - What is Covered,* of this Policy, as well as in any applicable Riders provided under the terms and conditions of this Policy.

Creditable Coverage - an individual's coverage is creditable for purposes of eliminating or reducing the period of Pre-Existing Condition if the coverage is provided under:

- A self-funded or self-insured employee welfare benefit plan that provides health benefits that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 USC Section 1001 et seq);

- A group health benefit plan provided by a health insurance carrier or health maintenance organization;
- An individual health insurance Policy or evidence of coverage;
- Part A or Part B of Title XVIII of the Social Security Act (42 USC Section 1395c et seq);
- Title XIX of the Social Security Act (42 USC. Section 1396 et seq), other than coverage consisting solely of benefits under Section 1928 of that Act (42 USC Section 1396s);
- Chapter 55, Title 10, United States Code (10 USC Section 1071 et. seq.);
- A Medical Care program of the Indian Health Service or of a tribal organization;
- A state or political subdivision health benefits risk pool;
- A health plan offered under Chapter 89 of Title 5, United States Code (5 USC Section 8901 et seq.)
- A public health plan as defined in this section;
- A health benefit plan under Section 5 (e) of the Peace Corp Act (22 USC Section 2504 (e)); and
- Short-term limited duration insurance as defined in Section 26.4 of the Texas Administrative Code.

Creditable Coverage does ***NOT*** include the following:

- accident-only, disability income insurance, or a combination of accident-only and disability income insurance;
- coverage issued as a supplement to liability insurance;
- liability insurance, including general liability insurance and automobile liability insurance;
- workers' compensation or similar insurance;
- automobile medial payment insurance;
- credit only insurance;
- coverage for onsite medical clinics;
- other coverage that is similar to the coverage described in this subparagraph under which benefits for medical care are secondary or incidental to other insurance benefits and specified in federal regulations;
- if offered separately, coverage for other limited benefits specified by federal regulations;
- if offered separately, long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community based care coverage or benefits, or any combination of those coverages or benefits;
- if offered separately, coverage for other limited benefits specified by federal regulations;
- if offered as independent, noncoordinated benefits, coverage for specified disease or illness;
- if offered as independent, noncoordinated benefits, hospital indemnity or other fixed indemnity insurance; or
- Medicare supplemental health insurance as defined under Section 1882(g)(1), Social Security Act (42 USC Section 1395ss), coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 USC Section 1071 et seq.), and similar supplemental coverage provided under a group plan, but only if such insurance or coverages are provided under a separate policy, certificate, or contract of insurance.

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

Custodial Care - care not given primarily for therapeutic value in the treatment of an Illness or Injury and is provided primarily for the maintenance of the Insured, 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 Policy Year before benefits become payable under this Policy. The *Deductible* is the amount of Covered Expenses You must pay for each Insured before any benefits are available regardless of provider type. Deductibles do not count towards your Out-Of-Pocket Maximum. The *Out-of-Network Deductible* is the additional amount of Covered Expenses You must pay for each Insured when using Non-Preferred Providers. Refer to Your Schedule of Benefits for details.

Dependent - a member of an Insured's Family who meets the eligibility requirements specified in *Section 2 - Eligibility,* and who is enrolled in this plan.

DESI Drugs - any drug targeted in the FDA's Drug Efficacy Study Implementation (DESI) which demonstrates a lack of evidence supporting the drug's efficacy.

Diabetes Self-Management Training - (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.

Diabetic Supplies and Equipment - equipment and supplies for the treatment of diabetes for which a physician or practitioner has written an order, including invasive and non-invasive 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.

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.

Durable Medical Equipment (DME) - medical equipment that in the absence of Illness or Injury is of no medical or other value to You. DME is able to withstand repeated use by more than one person and is not disposable. Examples of such equipment include crutches, hospital beds, wheelchairs, canes, walkers, and traction devices.

Effective Date - with respect to this Policy, the coverage date of the Policy begins and, with respect to any Insured, the date the Insured is first covered under this Policy.

Emergency Care - health care services provided in a Hospital emergency Facility or comparable Facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine to believe that his condition, Illness, 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.

Medical screening evaluations, which are necessary to determine whether an emergency medical condition exists, shall be provided to the Insured in the Hospital emergency department or comparable Facility, and all necessary Emergency Care services will be provided to the Insured regardless of whether services are received within the Service Area or outside the Service Area. Some Covered Health Services originating in a Hospital emergency department following stabilization of an emergency condition are subject to Pre-Authorization by Us in order to receive the maximum benefit.

Facility - a health care treatment center licensed by the state in which it operates to provide medical inpatient, residential, day treatment, partial hospitalization, or outpatient care.

Family - You and Your Dependents who are covered under this Policy who are otherwise covered by this Policy.

Health Care Facility - a Facility which is licensed, certified, or otherwise authorized, according to the laws of the state where located to provide Covered Health Services.

Health Care Provider - with respect to any Medical Care and service, a person who is:

- Certified or licensed under the laws of the state where treatment is provided;
- Qualified for the medical or surgical service for which the Claim is made;
- Practicing within the scope of certification or licensure; or
- Any other Health Care Provider or allied practitioner as recognized or mandated by state law. The term does not include an intern, a resident, or a person in training.

Home Health Agency - an organization licensed by the state where this Policy is issued to render home health services.

Hospital - an institution, which is licensed as a Hospital under the laws of the jurisdiction where it is located, and meets the following conditions:

- Is engaged in providing for pay and on its own premises, inpatient care and treatment of Ill and Injured persons through medical and diagnostic Facilities;
- Provides 24-hour nursing service by or supervised by a registered nurse;
- Has major surgery Facilities on its premises, or a written contractual agreement with an accredited Hospital for the performance of surgery;
- Is accredited under a program of the Joint Commission on Accreditation of Health Care Organizations; and
- Is under the supervision of a staff of one or more duly licensed physicians.

Hospital Confinement - being registered as a bed patient in a Hospital on the recommendation of a Health Care Provider.

Hybrid Injectables - any injectables 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.

Illness - a bodily disorder or infirmity, including Complications of Pregnancy that results in expenses covered under this Policy. Illness does not include any Illness or Injury for which benefits are provided under any Workers' Compensation, occupational disease, employer's liability, or similar statute.

Injury - physical damage to the Insured's body, including all related conditions and recurrent symptoms caused by accidental means and independent of all other causes.

Insured(s) or Subscriber(s) - the person(s), or parent/guardian of said person(s), whose individual Application has been approved by Southwest Life & Health Insurance Company and is entitled to benefits under this Policy.

Insurer - means any life, health and accidental; health and accident; or health insurance company authorized to issue, deliver, or issue for delivery in this state, health insurance policies, certificates, or contracts.

Level 1 Strips - Includes those strips offered by one of our contracted vendors. A list of these meters can be obtained by contacting customer service.

Level 2 Strips - Includes all strips not covered as Level 1.

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 is the maximum We will pay for any Insured under all policies issued by Us providing Covered Health Services for the lifetime of any Insured. When this maximum is reached, coverage for such Insured will end.

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

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

Medical Care - furnishing those services defined as the practice of medicine.

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 - treatments, service, supply, drug, or Hospital Confinement (or part of a Hospital Confinement):

- Is appropriate to diagnose or treat the patient's Illness or Injury;
- Does not exceed in scope, duration, or intensity, the level of care which is needed to provide safe, adequate, and appropriate diagnosis and/or treatment;
- Is prescribed by a Physician;
- Is consistent with widely accepted professional standards of medical practice in the United States;

- 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
- For inpatient care, cannot be supplied safely on an outpatient basis.

The fact that a Physician has prescribed, recommended, or supplied a treatment, service, or supply does not make it Medically Necessary. Our Utilization Review Agent evaluates all conditions listed above. 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.

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-Preferred Provider - any Hospital, Facility, Home Health Agency, or Health Care Provider who is not contracted with Us at the time services are rendered. The Allowable Amount for Covered Health Services provided by Non-Preferred Providers will be considered based upon Usual, Customary, and Reasonable (UCR) amounts. See this Section for the definition of UCR amounts. When an Insured receives covered Emergency Care services from a Non-Preferred Provider, those services will be paid as if they were received from a Preferred Provider. However, once the Insured can be safely transferred to a Preferred Provider, the Insured will be required to transfer to a Preferred Provider in order to continue

receiving the Preferred Provider level of benefits. If the Insured chooses not to transfer, benefits will be payable at the Non-Preferred Provider level of benefits.

Non-Specialist Physician - a Physician who practices general medicine, family medicine, internal medicine or pediatrics who provides basic health care services to You. Please see Your Schedule of Benefits for further details.

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.

Out-of-Pocket Maximum - the total amount You must pay each Policy Year before We pay benefits at 100% up to the Usual, Customary, and Reasonable amount. Coinsurance amounts count toward the Out-of-Pocket Maximum. Deductibles do not count towards your Out-of-Pocket Maximum. All Out-of-Pocket Maximum amounts are listed in the Schedule of Benefits. Copayments that are not subject to the Deductible do not apply to Your Out-of-Pocket Maximum, and must continue to be paid even though You have reached Your Out-of-Pocket Maximum.

Pharmacy Injectables - any medication that is injected subcutaneously or specifically designed and generally accepted to be self-injected and does not require direct medical professional oversight. These drugs will be defined by the FirstCare Pharmacy and Therapeutics committee.

Physician - any Physician who is licensed and qualified to practice within the scope of a medical practice license issued under the laws of the state in which treatment is received. This term does not include an intern or a person in training.

Plan, Your Plan, or **The Plan** - the coverage of health care services available to You under the terms of this Policy.

Policy - this Document, the Application, and any subsequent amendment, Rider, or endorsement that We issue to the Policyholder.

Policyholder - the person/Insured shown on the face page of this Policy who has purchased this Policy from Southwest Life & Health Insurance Company.

Policy Year - the annual period that begins on the anniversary of this Policy's Effective Date. See the Schedule of Benefits for details as to if Your Policy 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.

Pre-Authorization - the medical review process examining the Medical Necessity of a procedure or service which You must obtain from Us prior to receiving such procedure or service from a Health Care Provider. Pre-Authorization must be obtained to receive the maximum benefits under this Policy. You or Your Health Care Provider must contact Us at least five days prior to any scheduled outpatient tests or any other treatments that require Pre-Authorization.

Pre-Authorization Penalty - a monetary penalty, which is levied upon You when You or Your Health Care Provider fails to Pre-Authorize, as required by this Policy. We will charge a Failure to Pre-Authorize Penalty if You or Your healthcare provider do not obtain Pre-Authorization for the services, tests, or other treatments listed in *Section 6 - Utilization Review (U.R.) Program.* The Failure to Pre-Authorize Penalty applies each time the service or treatment is provided without the proper Pre-Authorization.

Pre-Existing Condition - any disease or physical condition for which the Insured received medical advice or treatment during the continuous 12 month period before the Effective Date of coverage. Pre-Existing Conditions are not covered under this Policy for the first 12 months after the Effective Date of the

Insured's coverage. A Pre-existing Condition will not apply to an Insured who was continuously covered for an aggregate period of 18 months, under Creditable Coverage, that was in effect up to a date not more than 63 days before the Effective Date of the Insured's coverage under this Policy. If there has been a break of more than 63 days of coverage from the previous plan and this plan, We will credit any Creditable Coverage if such coverage was in effect any time during the previous 12 months. For example, if You were covered under Creditable Coverage for seven months during the past 12 months, but there was a break of more than 63 days prior to coverage under this Policy, the Insured would then have a five-month Pre-Existing Condition period in effect, which would include any waiting period, if applicable.

After receipt of a certificate of Creditable Coverage, We will make a determination regarding the Insured's period of Creditable Coverage. We will notify the Insured of any Pre-Existing Condition limitation period that applies.

Preferred Provider - any Hospital, Facility, Home Health Agency, Physician, Health Care Provider, practitioner, Institutional Provider, or organization of Health Care Providers who has contracted with Us to provide services and treatments to You under this Policy. These Preferred Providers have signed an agreement with Us and have agreed to file Claims on Your behalf. If services are not available through Preferred Providers, Non-Preferred Providers shall be reimbursed at the same rate the Preferred Providers would have been reimbursed, had You been treated by contracted Preferred Providers up to Our determination of UCR amounts.

Premium or Premiums - money paid monthly or quarterly to Us by the Policyholder in order for You to receive services and benefits under this Policy.

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

Prior Plan - the health plan provided by the Policyholder immediately prior to this Policy provided by Southwest Life & Health Insurance Company.

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

Rider(s) - benefit options, which are made available to a Policyholder, pursuant to applicable underwriting requirements and Premium rates. Such Riders, when purchased, will be attached to or incorporated into the applicable Policy.

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

Service Area - a geographic area where or within which Preferred Providers that have contracted with Us are located. Refer to the Provider Directory to determine if You live in Our Service Area or visit Our website at www.firstcare.com.

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.

Specialist Physician - a Physician who practices specialized medicine (i.e.- oncology, orthopedics, cardiology, neurology, nephrology, etc.), and who can provide these services, above and beyond what is offered by a Non-Specialist Physician, for You. Please see Your Schedule of Benefits for further details.

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.

Usual, Customary, and Reasonable (UCR) - costs that do not exceed negotiated schedules of payments developed by Us that are accepted by Preferred Providers within a geographic area specified by Us as payment in full, after applicable Deductible and Coinsurance amounts have been met. Non-Preferred Providers may bill Insureds for charges over Our determination of the UCR amount. The Insured is responsible for these charges, in addition to all applicable Coinsurance and Deductibles.

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.

We, Our, or Us - Southwest Life & Health Insurance Company.

You or Your - an Insured.

SECTION 2 ELIGIBILITY

ELIGIBILITY

Conditions of Eligibility

This Plan is for residents of the state of Texas who are not insured under, or covered by any other group or individual health care plan or insurance policy, and live in Our Service Area. You must notify Us of changes that may affect any Insured's eligibility under this Plan.

You are eligible for coverage under this Plan when You have submitted an application, met Underwriting guidelines, been approved, and insured by Southwest Life & Health Insurance Company (SWL&H).

Dependent Coverage

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

1. Meet Underwriting guidelines;
2. Be an eligible Dependent of an Insured who is enrolled in the program;
3. Meet all Dependent eligibility criteria established by the applicable Policyholder; and
   - Be the Insured's lawful spouse;
   - Be Your or Your spouse's unmarried child (including a step-child, a legally adopted child, or a child for whom You or Your spouse is party in suit for adoption) who is under age 25; or;
   - Be a child for whom You or Your spouse is a court appointed legal guardian, and provided proof of such guardianship is submitted with the Application;
   - Be an unmarried child who is and continues to be both:
     a. Incapable of self-sustaining employment by reason of mental or physical handicap; and
     b. Is chiefly dependent upon You or Your spouse for economic support and maintenance. You must provide proof of such incapacity and dependency to Us within 31 days of the child's attainment of the applicable limiting age.

        Subsequently, We may require that You continue to provide proof of Your child's incapacity and dependency to Us, but not more frequently than once per year, after the two-year period following the child's attainment of the limiting age;
   - Be a newborn child of You or Your spouse. Your newborn has coverage for the first 31 days after birth. To continue coverage for Your child, You must notify Us within 31 days following Your child's birth, and pay any necessary Premium charges;
   - Be an unmarried grandchild who is dependent upon You for federal income tax purposes at the time Application for coverage of the child is made, 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 a Dependent of the Policyholder for federal income tax purposes;
   - Be an unmarried child for whom You or Your spouse must provide medical support by order issued under Section 14.061, Texas Family Code or similar state law; or
   - Be an unmarried child of any age who is medically certified as disabled and dependent on the parent.

ENROLLMENT

Subject to SWL&H's approval and acceptance of a completed enrollment application and the payment of applicable premiums, your coverage shall become effective as follows:

1. **Initial Enrollment**

   Coverage under this Policy shall become effective as of the date approved by SWL&H.

2. **Newly Eligible Dependents**

   Coverage will be effective as of the date of the event establishing eligibility, (such as marriage, adoption, guardianship or birth), and no proof of insurability is required, provided appropriate enrollment forms and applicable premium payments are received by SWL&H within 31 days of the event. Newborn children of the Insured or Insured's spouse and newborn children of enrolled Dependents are covered for the first 31 days from date of birth. If the optional Maternity Rider is purchased, coverage will continue beyond the 31st day. If the Rider is not purchased, continued coverage, beyond the 31st day, for these newborn children is dependent upon enrollment as explained in this Policy.

   A child is considered to be a child of the Insured or Insured's spouse if the Insured or Insured's spouse is a party in a suit in which the adoption of the child is sought. The adopted child may be enrolled within either:

   - Thirty-one days after the Insured is a party in a suit for adoption; or
   - Thirty-one days of the date the adoption is final.

   Note: If the optional Maternity Rider is purchased, coverage will continue beyond the 31st day. If the Rider is not purchased, continued coverage, beyond the 31st day, for these Newly Eligible Dependents is dependent upon enrollment as explained in this Policy.

NOTICE OF INELIGIBILITY

It shall be the Insured's responsibility to notify SWL&H of any changes, which will affect his or her eligibility or that of Dependents, for services or benefits under this Evidence of Coverage, within 31 days of the event.

SECTION 3 HOW BENEFITS ARE PAID

We will pay benefits at the Coinsurance rate after any applicable Deductible, as shown in the Schedule of Benefits. All benefits are subject to the definitions, benefit limitations, and general provisions listed in this Policy.

DEDUCTIBLE

The Deductible shown in the Schedule of Benefits means the amount of Covered Health Services which You must incur each Policy Year before benefits are paid under this Policy. The Deductible applies to all Covered Health Services. The Deductible *does not* apply toward the Out-of-Pocket Maximum.

Family Deductible

When the Family Deductible, as noted in the Schedule of Benefits, has been met by combining the per Insured Deductibles that have been satisfied, then no further Deductible will apply for the remainder of that Policy Year.

COINSURANCE

The Coinsurance rate is Your and/or Your Dependent's share of covered medical benefits that each of You must pay. The Coinsurance percentage is 100% minus the benefits payable percentage shown in the Schedule of Benefits. The Coinsurance amount applies toward the Out-of-Pocket Maximum. You are responsible for all amounts above the Usual, Customary, and Reasonable (UCR) amount.

OUT-OF-POCKET MAXIMUM

Out-of-Pocket Maximum amounts are listed in the Schedule of Benefits. The Out-of-Pocket Maximum is the total amount that You and/or Your Dependents must pay each Policy Year before We pay benefits at 100% up to the Usual, Customary, and Reasonable amount. Coinsurance amounts apply toward the Out-of-Pocket Maximum. Copayments that are not subject to the Deductible do not apply to Your Out-of-Pocket Maximum.

The following do not apply toward the Out-of-Pocket Maximum:

- Deductibles;
- Any amount over Usual, Customary, and Reasonable amounts;
- Charges not covered by this Policy; and
- Any Pre-Authorization Penalty.

OUT-OF-POCKET MAXIMUM FOR SPECIFIC SERVICES

The total amount You or Your Dependents are responsible to pay for Medical Injectable Drugs, Defined Hybrid Injectables, Radiation Therapy, Transplant Anti-Rejection Therapy, Home Infusion Therapy (excluding "self injectable" drugs), Specified Cancer Chemotherapy and Defined Associated Agents per Policy Year. Once You reach Your Out-of-Pocket Maximum amount for these specific medically necessary services (as listed in Your Schedule of Benefits), We will pay 100% of Our contracted rate for the remainder of the Policy Year.

LIFETIME MAXIUMUM

The lifetime maximum is the maximum We will pay for any Insured under all policies issued by Us providing Covered Health Services for the lifetime of any Insured. When this maximum is reached, coverage for such Insured will end.

PRE-EXISTING CONDITION

The length of the Pre-Existing Conditions Limitation may be reduced or eliminated if an eligible person has Creditable Coverage from another health plan.

An eligible person may request a Certificate of Creditable Coverage from his or her prior plan within 12 months after losing coverage. A Covered Person will be provided a Certificate of Creditable Coverage if he or she requests one either before losing coverage or within 12 months of coverage ceasing. If you need assistance in obtaining a Certificate of Creditable Coverage from your prior plan or issuer, you may call us at **(800) 240-3270,** and we will assist you in obtaining the Certificate.

A Pre-existing Condition will not apply to an Insured who was continuously covered for an aggregate period of 18 months under Creditable Coverage that was in effect up to a date not more than 63 days before the Effective Date of the Insured's coverage under this Policy, including any waiting period. If there has been a break of more than 63 days of coverage from the previous plan and this plan, We will credit any Creditable Coverage if such coverage was in effect any time during the previous 12 months, but you will not receive any coverage for any Pre-existing Conditions for the remaining period of time in which Your Creditable Coverage does not cover. For example, if You were covered under Creditable Coverage for seven months during the past 12 months, but there was a break of more than 63 days prior to coverage under this Policy, the Insured would then have a five-month Pre-Existing Condition period in effect, which would include any waiting period, if applicable.

If, after Creditable Coverage has been taken into account, a Pre-Existing Conditions Limitation is imposed on an individual, that individual will be so notified and informed of the length of the pre-existing condition limitation period.

SUBROGATION

If We provide services to an Insured or such insured's Dependent, due directly or indirectly to the act or omission of another person or entity, then We shall be entitled to receive and shall be fully subrogated to all rights of recovery acquired by or accruing to such Insured (or Insured's Dependent), but only up to 100% of the dollar amounts paid for such benefits by Us or Our costs of recovery. Our rights become effective as to all third parties, their insurers, or attorneys. It is agreed that by receipt of such benefits form Us, the Insured (or Insured's Dependent) shall be legally considered to have all first and prior rights of recovery to Us and to have agreed to cooperate and help Us to obtain such recovery by settlement or judgment. We shall have the right to intervene in any action brought by the Insured (or Insured's Dependent) against any third party alleged to be responsible for the Insured's (or Insured's Dependent's) illness or injury, in order to protect and prosecute Our rights of recovery. It is further agreed that, should the Insured (or Insured's Dependent) receive any payment applicable to such rights of recovery of SWLH, that reimbursement shall be made to SWLH within a responsible time frame by the Insured (or Insured's Dependent).

PAYMENTS TO THE TEXAS DEPARTMENT OF HUMAN SERVICES

If notified in writing, Southwest Life & Health Insurance Company must pay any benefits for Your Dependent child to the Texas Department of Human Services if the Agency is paying benefits on behalf of Your Dependent child under Chapter 31 or Chapter 32, Human Resources Code.

If notified in writing, Southwest Life & Health Insurance Company must pay the Texas Department of Human Services for the actual cost of medical expenses the Department pays through medical assistance for an Insured under this Policy, if the Insured is entitled to payment for the Covered Health Services.

PAYMENT TO A POSSESSORY OR MANAGING CONSERVATOR

If notified in writing, We must pay any benefits for the Insured's Dependent child to the possessory or managing conservator of the child. A certified copy of a court order establishing the person as

possessory or managing conservator must be submitted with the Claim or other evidence designated by rule of the Texas Department of Insurance that the person qualifies to be paid the benefits as provided by §1204.251 of the Texas Insurance Code.

SECTION 4 WHAT IS COVERED

Southwest Life & Health Insurance Company will pay benefits upon receipt of proper proof that any Insured incurs Covered Health Services for treatment of an Illness or Injury covered under this Policy.

COVERED HEALTH SERVICES

Benefits are paid for the Usual, Customary, and Reasonable amount for the following Medically Necessary treatments, services, and supplies for Covered Health Services:

PLEASE REFER TO THE SCHEDULE OF BENEFITS FOR APPLICABLE COINSURANCE AND DEDUCTIBLE AMOUNTS, AND ANY BENEFIT LIMITATIONS THAT MAY APPLY FOR CERTAIN SERVICES.

A. Inpatient Services

1. *Semi-Private Room and Board Charges*

   Hospital room and board, including regular daily medical services and supplies, will be payable as shown on the Schedule of Benefits. 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.

2. *Inpatient Services for the Treatment of Breast Cancer*

   Inpatient services required to diagnose and treat breast cancer are provided for a minimum 48-hour inpatient stay following a mastectomy and a 24-hour inpatient stay following a lymph node dissection. The inpatient stay may be less than the minimum hours of inpatient care, if the Insured and the Insured's treating Physician determine that a shorter period of inpatient care is appropriate.

3. *Other Hospital Services and Supplies*

   We cover other Hospital Services and Supplies, including, but not limited to: general nursing care; medications and biologics; anesthesia and oxygen; the administration of whole blood or blood products; laboratory tests and x-rays; special foods or diets when Medically Necessary; use of operating, recovery, and delivery rooms; radiation, inhalation, chemotherapy, and short-term physical/occupational therapy.

B. Outpatient Services

PLEASE REFER TO THE SCHEDULE OF BENEFITS FOR APPLICABLE COINSURANCE AND DEDUCTIBLE AMOUNTS, AND ANY BENEFIT LIMITATIONS THAT MAY APPLY FOR CERTAIN SERVICES.

Covered Health Services include treatment performed in a Facility other than a Hospital for a covered Illness or Injury, if the treatment is:

- Provided by a Health Care Provider whose services would be covered under this Policy if the treatment were performed in a Hospital;
- Medically Necessary; and
- Provided as an alternative to inpatient treatment in a Hospital.

Other covered outpatient care services include:

1. Health Care Provider Services

Covered Health Care Services include the following:

- Inpatient and outpatient surgery;
- Physician Hospital visits;
- Physician office and home care;
- Allergy testing, serum, services, and treatment of allergy symptoms.

2. Outpatient Surgery

Covered Health Services include scheduled outpatient surgery in a Hospital, outpatient Facility, or other Facility covered under this Policy.

3. Laboratory and Radiology Services

Covered Health Services include, but are not limited to: x-rays, fluoroscopy, electrocardiograms, blood, urine, and other laboratory tests, Digital & X-Ray Mammography, Breast Ultrasound, radium, radioactive, and isotope therapy, Magnetic Resonance Imaging (MRI), CT scan, and pre-admission testing.

C. Preventive Health Care Services

PLEASE REFER TO THE SCHEDULE OF BENEFITS FOR APPLICABLE COINSURANCE AND DEDUCTIBLE AMOUNTS, AND ANY BENEFIT LIMITATIONS THAT MAY APPLY FOR CERTAIN SERVICES.

1. *Annual Routine physical exams* for adults based on age, sex, and medical history includes history, physical examination, laboratory, x-rays, and PAP tests.

2. *Well-baby and well-child preventive care* for children through age 18. Well-child care visits at the following intervals: birth, 2 months, 4 months, 6 months, 9 months, 12 months, 18 months, 2 years, and annually thereafter.

3. *Immunizations* for all Insureds according to generally accepted medical practice standards, including "preventive health" immunizations & vaccines (e.g. flu, pneumonia, tetanus, etc.), and for those immunizations approved by the Center for Disease Control for travel outside the United States.

4. *Ophthalmologic examinations* for infants at risk for eye problems.

5. *Routine sight, speech, and hearing screenings* for children through age 18. One hearing screening per Policy Year is covered for all Insureds. Speech and hearing services include care or treatment of a speech or hearing impairment or loss; services necessary to restore speech loss; services provided to correct a congenital malformation for which corrective surgery has been performed.

6. *Screening Test for Hearing Impairment* in newborns from birth through the date the child is 30 days old, and necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old.

7. *Screening mammograms* (non-diagnostic) for women age 35 and older to detect breast cancer. In addition to routine screening, mammograms are covered when prescribed by a Physician as Medically Necessary to diagnose or treat Illness.

8. *Screening for Detection of Colorectal Cancer* includes screening examinations and procedures for Insureds 50 years old or older and at a normal risk for developing colon cancer. These annual exams include fecal occult blood tests, a flexible sigmoidoscopy performed every five years, or a colonoscopy performed every 10 years.

9. *Bone mass measurement* services include bone mass measurement for the detection of low bone mass and to determine the risk of osteoporosis and fractures associated with osteoporosis.

10. *Prostate cancer testing (annually)* to detect prostate cancer, including a physical examination and a prostate-specific antigen (PSA) test. Not all men need this examination; however You are eligible for this benefit if You are at least 50 years old, or at least 40 years old with a Family history of prostate cancer or other recognized prostate cancer risk factors.

11. *Pap Smear Screen (annually)*, for women who are insured under this plan and are age 18 and over, we cover 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.

D. Family Planning

PLEASE REFER TO THE SCHEDULE OF BENEFITS FOR APPLICABLE COINSURANCE AND DEDUCTIBLE AMOUNTS, AND ANY BENEFIT LIMITATIONS THAT MAY APPLY FOR CERTAIN SERVICES.

Family Planning Services

We cover these Family planning services:

- Physical exams, related laboratory tests, and medical supervision;
- Information and counseling on contraception;
- Materials and services to insert or remove an intrauterine device (IUD);
- Materials and services to fit a diaphragm contraceptive;
- Materials and services to insert or remove a birth control device implanted under the skin (such as Norplant); and
- Vasectomy and tubal ligation (voluntary sterilization).
- Depo-Provera™ Injections

E. Other Health Care Services

PLEASE REFER TO THE SCHEDULE OF BENEFITS FOR APPLICABLE COINSURANCE AND DEDUCTIBLE AMOUNTS, AND ANY BENEFIT LIMITATIONS THAT MAY APPLY FOR CERTAIN SERVICES.

Spinal Manipulation Services

Your plan may include coverage for Spinal Manipulation Services. Services may be rendered by a participating In-Plan Provider.

All services must be pre-authorized by the Medical Services Department, or the Pre-Authorization Penalty may apply.

Rehabilitative Services

Covered Health Services for short-term Physical/Occupational (PT/OT) Therapy are covered when directed and monitored by a Health Care Provider. Short-term is defined as 2 months or less. The services provided must be expected to result in significant improvement within two months from the start of treatment and is limited to a maximum treatment period, as listed in the Schedule of Benefits, from the start of therapy for each Injury or diagnosis.

Benefits are paid for charges billed by a Physician or by a licensed or certified physical or occupational therapist, for therapy that is:

- Furnished to an Insured, on an outpatient or inpatient basis, in a Facility covered under this Policy; and
- Provided in accordance with a specific written treatment plan which:
    - details the treatment, including frequency and duration;
    - provides for on-going reviews; and
    - only allows renewal of the treatment plan if the therapy remains Medically Necessary.

Reconstructive Surgery

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 is present at birth in a child who is younger than 18 years of age;
- 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 a child who is younger than 18 years of age 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.

Prosthetics and Orthotics

We cover standard external, non-cosmetic prosthetic or orthotic devices if We pre-authorize them. If these devices are not pre-authorized, the Pre-Authorization Penalty may apply. Examples of covered devices include artificial arms, legs, hands, feet and eyes, breast prostheses and surgical brassieres after mastectomy for breast cancer.

We do not cover repair or maintenance of any external prosthetic or orthotic device. We do not cover replacement of any external prosthetic or orthotic device, except for standard replacements needed because of physical growth by an Insured who are under 18 years of age.

We do not cover corrective orthopedic shoes, shoe inserts, orthotic inserts, arch supports, splints or other foot care items, except for the treatment of diabetes. We do not cover ankle braces with the exception of braces required for recovery after surgery, for the treatment of diabetes, and for certain illness and injury, but only if they are authorized by Us.

For more information, see the Schedule of Benefits for further benefit details.

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*. All such devices must be pre-authorized by Us in order for the maximum benefit to apply. If these devices are not pre-authorized, the Pre-Authorization Penalty may apply..

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 organic lens missing because of congenital absence. Benefits are provided for 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 types of internal implantable devices are covered and must be pre-authorized by Us.

Dorsal Column Stimulators

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

Pain Management Services

We cover Medically Necessary pain management treatment and related services. All Covered Health Services must meet these conditions:

- Services must be ordered by Physician Services and can be expected to meet or exceed treatment goals established for You by Your Physician;
- Services are scientifically proven and evidenced-based to improve Your medical condition; and
- All services must be pre-authorized prior to receiving treatment to receive the maximum benefit. If these services are not pre-authorized, the Pre-Authorization Penalty may apply.

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 or treatment;
- Neurofeedback therapy;
- Remediation required for and related to treatment of an acquired brain injury
- Post-acute transition 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.
- Pre-Authorization is required for these services (see *Section 6 - Utilization Review Program*). If these services are not pre-authorized, the Pre-Authorization Penalty may apply.

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.

For more information, see the Schedule of Benefits for further benefit details.

Second Surgical Opinion

We cover services for second surgical opinions.

Dialysis Services

Dialysis Services are covered. Pre-Authorization is not required if the services are received by a contracted provider. Pre-Authorization is required for these services if they are received by an out-of-plan provider. If these services are not pre-authorized, the Pre-Authorization Penalty may apply.

Organ Transplant Services

Covered Health Services include the services necessary to procure the organ, all Physician, and Hospital services for the following Organ Transplants:

- Kidney transplant;
- Corneal transplant;
- Liver transplant for children with biliary atresia or other rare congenital abnormality; and
- Bone marrow transplant for aplastic anemia, leukemia, severe combined immuno-deficiency disease, and Wiskott Aldrich syndrome.

Covered Health Services include organ acquisition fees and the Medically Necessary surgical expenses of a person who is acting as a donor for an Insured. Organ Transplants not listed above are excluded.

Durable Medical Equipment

The following Durable Medical Equipment are covered:

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, wheelchairs, walkers, lymphedema pumps, traction devices, canes, Continuous Passive Motion (CPM) devices, infusion pumps, phototherapy light, alternating pressure pads and pumps.

Your DME benefit is limited as shown in your Schedule of Benefits.

Coverage is provided for the Medically Necessary DME meeting the following conditions:

- DME must be ordered or prescribed by a Health Care Provider;
- DME must be Medically Necessary as determined by Us;
- DME must be pre-authorized, or it is subject to the Pre-Authorization Penalty;
- DME may be purchased or rented, whichever is most cost effective, as determined by Us;
- Coverage is provided for the initial equipment only; and
- Only the standard equipment is covered. Special features which 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 Our property. 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;
- DME used for the treatment of diabetes; and
- Monitoring devices, such as apnea, glucose and uterine monitors, for use in the home when prescribed and directed by a Health Care Provider.

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 1 - 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. Supplies, which can be purchased over-the-counter without a Physician order, are not covered. See *Section 5 - What is Not Covered.*
- Allergy syringes.

Limited Accidental Dental – Related Services

We provide limited coverage for dental services that would otherwise be excluded from coverage but are determined by 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 or neck

We provided 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;
- Both the injury and treatment occur while Your coverage under this Plan is in effect;
- You seek treatment within **48 hours** of the time of the accident;
- Restoration or replacement is completed within 6 months of the date of the injury;
- We pre-authorize the service. If these services are not pre-authorized, the Pre-Authorization Penalty may apply.

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

- We pre-authorize the service. If these services are not pre-authorized, the Pre-Authorization Penalty may apply.

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

- Exclusion of neoplasm, including benign, malignant and pre-malignant lesions, tumors and non-odontogenic cysts.
- Incision and drainage of cellulites 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 Insured's physical, mental, or medical condition. The services must meet all of these requirements:

- We pre-authorize the services. If these services are not pre-authorized, the Pre-Authorization Penalty may apply.

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

Temporomandibular Joint Disorder

We cover the diagnosis and surgical treatment of disorders of, and conditions affecting the temporomandibular joint, which includes the jaw and the craniomandibular joint resulting from an accident, a trauma, a congenital defect, a developmental defect, or a pathology. Surgical treatments must be pre-authorized, or else they will be subject to the Pre-Authorization Penalty.

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.*

Blood and Blood Products

Covered Health Services are provided for both inpatient and outpatient care.

Home Health Care Services

Covered 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;
- The service of a home health aide under the supervision of a registered nurse; and
- The furnishing of medical equipment and medical supplies other than drugs and medicines.

Home Health Care is limited to health services provided on a part-time or intermittent basis to an Insured who is confined to his home due to Injury or Illness for a condition that would require hospitalization in the absence of Home Health Care. The Home Health Care visit limitation can be extended in the event that it would result in not having to admit the Insured to a Facility for continued Medical Care.

Skilled Nursing Facility Services

We cover Semi-Private Room and Board, and charges for other Facility services and supplies. Private room charges that exceed Semi-Private Room rates are not covered. If the Facility does not have Semi-Private Rooms, benefits are limited to the most common rate for Semi-Private Rooms charged by similar Facilities located in the surrounding geographical area. Covered charges are limited to a maximum of 60 days per Policy Year.

Hospice Care

We cover all care provided by a hospice to a terminally ill patient. Terminally Ill Patient means an Insured who does not have a reasonable prospect for cure and who has a life expectancy of six months or less. The attending Physician must authorize that the Insured is terminally ill.

The services may be provided in the Insured's home or in the hospice. Covered Health Services include:

- Inpatient care - room and board, not to exceed the Semi-Private Room rate, and other necessary services and supplies;
- Outpatient care - part-time nursing care by or under the supervision of a registered nurse (R.N.); home health aide services; nutrition services; and medical supplies, drugs, and medicines that are prescribed by a Health Care Provider and that can be administered only by a licensed health professional, but only to the extent that such items or services would have been covered under this Policy if the Insured had been confined in a Hospital or Skilled Nursing Facility; and

Medical Injectable Drugs, Defined Hybrid Injectables, Radiation Therapy, Transplant Anti-rejection Therapy, Chemotherapy and Defined Associated Agents

We cover medically injectable drugs, defined hybrid injectables, radiation therapy, specified transplant anti-rejection therapy, specified cancer chemotherapy and defined associated agents administered in Your Physician's office or in an outpatient facility. Refer to the Schedule of Benefits for details.

Home Infusion Therapy

We cover the administration of medication (including chemotherapy), fluids or nutrition by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the Insured's home. Home infusion therapy includes:

- Medical Injectable Drugs and IV solutions;
- Pharmacy charges;
- 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 You have purchased the prescription drug Rider or coverage is otherwise specified in this document.. Refer to Your prescription drug Rider for details.

Treatment of Diabetes

1. Diabetic Medications

We cover the following medications for insured persons diagnosed with diabetes, elevated blood glucose levels induced by pregnancy, or another medical condition associated with elevated blood glucose levels:

- 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 Our Customer Service Department at (800) 240-3270.

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

2. Diabetic supplies, equipment and self-management education

We cover Diabetic Supplies and Equipment as defined in *Section 1 - Definitions.* Diabetes Self-Management Training programs are covered as Basic Plan Benefits under the following circumstances:

- After the initial diagnosis, including nutritional counseling and proper use of Diabetes Equipment and supplies;
- When Your Physician diagnoses a significant change in Your condition which requires a change in Your self-management regimen; or
- When Your Physician prescribes, orders, or recommends such additional training in order to teach You about new techniques and treatments for diabetes.

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 SWL&H Customer Service Department at (800) 884-4901 for more information.

PLEASE REFER TO THE SCHEDULE OF BENEFITS FOR APPLICABLE COINSURANCE AND DEDUCTIBLE AMOUNTS, AND ANY BENEFIT LIMITATIONS THAT MAY APPLY FOR CERTAIN SERVICES.

F. Emergency and Urgent Care Services

PLEASE REFER TO THE SCHEDULE OF BENEFITS FOR APPLICABLE COINSURANCE AND DEDUCTIBLE AMOUNTS, AND ANY BENEFIT LIMITATIONS THAT MAY APPLY FOR CERTAIN SERVICES.

Emergency Care

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 or comparable Facility. You, Your Physician, or Family member must notify Us if You are admitted to the Hospital.

See the definition of Emergency Care in *Section 1 - Definitions.*

Ambulance Services

Covered Health Services include professional ambulance service to transport the Insured directly to the nearest Hospital equipped to treat the Illness or Injury. Air ambulance services are covered when Medically Necessary.

Urgent Care Services

If You or Your covered Dependent urgently need Covered Health Services while You are inside Our Service Area, but Your condition is not serious enough to be a medical emergency, You may seek care through one of Our Preferred Providers or Facilities. Call Our Customer Service Department at (800) 240-3270, or go to Our website at www.firstcare.com to locate a Preferred Provider.

If You are not able to go to a Preferred Provider, You may seek Medically Necessary urgent care services from a Non-Preferred Provider. If You had no choice but to receive services from the Non-Preferred Provider, You will receive benefits at the In-Network level. If there was a choice between seeing a Preferred Provider or Non-Preferred Provider, and You opted for the Non-Preferred Provider, You will be responsible for the higher Non-Preferred Provider Deductible, Out-of-Pocket Maximum, and Coinsurance amounts listed on Your Schedule of Benefits.

Urgent care means medical services that:

- Do not meet the requirements necessary to be considered "Emergency Care" described above in *Section 1 - Definitions;*
- You or Your Dependent urgently need such services, and if You are outside Our Service Area, You could not reasonably have anticipated needing such services before You left the SWL&H Service Area; and
- If treatment is delayed, the urgent medical condition could become worse or result in a more serious condition.

Preferred Providers:

We will pay Preferred Providers at their contracted rate, less all applicable Coinsurance and Deductible amounts for urgent care services. Refer to Your Schedule of Benefits for details.

Non-Preferred Providers:

Payment for urgent care received from Non-Preferred Providers is provided in one of two ways:

- We will pay the Usual, Customary, and Reasonable (UCR) amount (see *Section 1 - Definitions)* for care received from Non-Preferred Providers; or
- We will arrange to pay those providers at rates negotiated with the provider by Us.

PLEASE REFER TO THE SCHEDULE OF BENEFITS FOR APPLICABLE COINSURANCE AND DEDUCTIBLE AMOUNTS, AND ANY BENEFIT LIMITATIONS THAT MAY APPLY FOR CERTAIN SERVICES.

SECTION 5 WHAT IS NOT COVERED

Exclusions are named medical conditions or health services that are not covered under this Policy. In addition to any specific limitations or exclusions listed elsewhere, no benefits are paid under this Policy for:

1. **Additional expenses** incurred as a result of the Insured's failure to follow a Plan Provider's medical orders.

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

3. **Assistant surgeons**, unless determined to be Medically Necessary.

4. Treatments for **Autism Spectrum Disorder** including but not limited to Inpatient and Outpatient settings.

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

6. **Chemical Dependency Services** including but not limited to Inpatient and Outpatient settings.

7. **Circumcision** in any male other than a newborn, unless Medically Necessary.

8. Personal **comfort,** hygiene or **convenience** items, services or supplies not directly related to the Insured's care, including, but not limited to: guest meals, accommodations, telephone charges, admission kits, radio, television, beauty/barber services, wigs, clothing, take-home supplies, travel or travel time, even if prescribed by a Physician.

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 other reconstructive procedures (including any relates prosthesis, except breast prosthesis following mastectomy), unless specifically provided in Section 4 - *What is Covered*. Among the procedures that We do not cover are:

   - Excision or reformation of any skin on any part of the body, hair transplantation, removal of port wine stains *(except for newborns)*, 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 *(except for newborns)*; and
   - Rhinoplasty and associated surgery.

10. In the absence of **Creditable Coverage**, any charges incurred during the first 24 consecutive months of the Insured's coverage under SWL&H Policy, which are due to Pre-Existing Conditions.

11. PolarCare™ devices used in **Cryotherapy**.

12. **Custodial Care**, respite, or domiciliary care. Custodial care is caring that:

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

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.

13. 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, peridontium) 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 Insureds over age 18, 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 4 - What Is Covered.*

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

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

- Corrective shoes, shoe inserts, arch supports, orthotic inserts and devices except for those described in *Section 4 - What is Covered*, or for the treatment of diabetes.
- Comfort or convenience items, such as bathtub chairs, whirlpool tubs, safety grab bars, stair gliders or elevators, over-the-bed tables, bed boards, saunas, exercise equipment, and institutional equipment, such as air fluidized beds and diathermy machines.
- Environmental control equipment such as air purifiers, air conditioners, humidifiers, dehumidifiers, electrostatic machines, and heat lamps.
- Foam cervical collars;
- Stethoscopes, sphygmomanometes, and recording or hand-held oximeters;
- Hygienic or self help items or equipment;
- 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, unless the Policy is amended to provide coverage;
    - 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 if otherwise covered by a Rider.
    - Experimental drugs and agents; or
    - Drugs used to treat cosmetic conditions.
    - 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 Acquired Brain Injuries as described in *Section 4 - What Is Covered*.
17. Special **education,** counseling, therapy, care, evaluation, training, and treatment of learning disabilities, disorders, deficiencies, or behavioral problem.
18. **Electron Beam Tomograph**y (EBT)
19. Treatments, services, or supplies for **non-Emergency Care** at an emergency room.
20. Weekend admission charges for **non-Emergency Care** services.
21. **Non-Emergency** confinement, treatment, services, or supplies received outside the United States.
22. **Equine** or Hippo therapy.
23. The following **equipment and supplies,** except as provided for the treatment of diabetes:
    - All Durable Medical Equipment, except as provided herein; and
    - Disposable or consumable outpatient supplies, such as needles, blood or urine testing supplies (except supplies used in the treatment of diabetes and allergy syringes) and sheaths, bags, elastic garments and bandages, home testing kits, vitamins, dietary supplements, and replacements, special food items and formulas (except for formulas necessary to treat phenylketonuria or other heritable diseases).
24. **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; or
    - 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; the research is an experimental study or investigational arm of ongoing Phase III clinical trials; or is otherwise under study to determine

its maximum tolerated dose, toxicity, safety, effectiveness, or 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, toxicity, safety, effectiveness, or 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.

25. Fabry Disease medical and drug treatment.

26. 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 4 - What Is Covered.*

27. Genetic counseling and testing, except Medically Necessary peri-natal genetic counseling and certain genetic testing approved by FirstCare's Medical Technology Assessment Committee. Genetic testing related to pre-implantation of embryos for in-vitro fertilization is not covered.

28. Growth hormone drugs for persons 18 years of age or older. However, growth hormone therapy for the treatment of documented growth hormone deficiency in children for which epiphyseal closure has not occurred, are covered when services are pre-authorized by Us and if You have purchased the Prescription Drug Rider. If these services are not pre-authorized, the Pre-Authorization Penalty may apply.

29. Hearing Devices: hearing aids, hearing aid batteries, temporary or disposable hearing aids and repair or replacement of hearing aids due to normal wear, loss, or damage.

30. Hemophilia medical and drug treatment.

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

32. All charges for inpatient **Hospital** days that exceed the medically recommended length of stay for the diagnosis.

33. Health care services for any work-related **illness or injury**, if any other source of coverage or reimbursement is (or was) available to You for the services. Sources of coverage or reimbursement available to You may include Your employer, a work-related benefit plan maintained by Your employer, and any Workers' Compensation, occupational disease or similar program under local, state, or federal law.

34. 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; by committing or attempting to commit a felony or to which a contributing cause whas the Insured's being engaged in an illegal occupation. This exclusion does not apply if the Injury resulted from an act of domestic violence or medical condition (including both physical and mental health).

35. **Illness or Injury** incurred as a result of war or any act of war, whether declared or undeclared, and whether or not the Insured served in the military.

36. **Immunoglobulin Deficiency** medical and drug treatment.

37. **Infertility** treatment including the diagnostic testing to determine the cause(s) of infertility, medical services for artificial insemination and all drugs/medications associated with the treatment of infertility.

38. Any services or items for which You have no **legal obligation** to pay, or for which no charge would ordinarily be made, unless We have authorized such services in advance, or the care provided was of an emergent or urgent nature. Examples of this include care for conditions related to Your military service, care will You are in the custody of any government authority, and any care that is required by law to be given in a public facility.

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

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

41. **Mastectomy** for relief of pain, to prevent breast cancer, (except when You have been previously diagnosed with breast cancer), or due to any disease or illness other than for the treatment of breast cancer.

42. **Maternity** and Obstetrical care, including but not limited to Inpatient Maternity Services, including newborn nursery and delivery room services, and Physician services for both pre- and post-natal care.

43. **Medications** prescribed for non-FDA approved indications, referred to as off-labeled drug use, and are not covered. This includes experimental, investigational, any disease or condition that is excluded from coverage; or that the FDA has determined to be contraindicated for treatment of the current indication. Off-labeled drug use may be covered if the drug is approved by the FDA for at least one indication; and is recognized for treatment of the indication for which the drug is prescribed in substantially accepted peer-reviewed national medical professional journals.

44. **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 if otherwise covered by a Rider.

45. Inpatient and outpatient treatment, surgery, service, procedures, or supplies that are not **Medically Necessary**; even if they are prescribed or recommended by a Health Care Provider, dentist, or ordered by a court of law, except when prescribed for the treatment of diabetes

46. **Mental health services** for the following conditions: mental retardation; gender identity disorder; senile deterioration, such as progressive dementia of Alzheimer's and Alzheimer's like diseases; sleep disorders and factitious disorders. Treatments for Serious Mental Illness and Acute/Non-Chronic/Short Term Mental Health Services are not covered in either Inpatient or Outpatient settings. Marriage counseling is not a covered health service. Court ordered evaluation; diagnosis and treatment for mental conditions are excluded unless this Policy would otherwise cover such services. Court ordered testimony is not a covered health service.

47. Charges for **missed appointments** and charges for completion of Claim forms.

48. Implanted **neurological stimulators**, including but not limited to spinal or dorsal column stimulators for Parkinson's, movement disorder, or seizures, except for stimulators implanted for

relief of neurogenic pain as approved by FirstCare's Medical Technology Assessment Committee and when meeting established clinical criteria; and except for neurogenic bladder.

49. If a service is **not covered** under this Policy, We will not cover any services that are related to it. Related services are:
    - Services provided in preparation for the non-covered service;
    - Services provided in connection with providing the non-covered service; or
    - Services that are usually provided following the non-covered service, such as follow-up care or therapy after surgery.
    - All care related to services that are not covered, including direct complications and pre or post care except for complications of pregnancy.

    For example, if an Insured 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 Policy.

50. **Nutritional counseling**, (except for the treatment and self-management of diabetes) testing and diet planning, unless We have pre-authorized it. We do not cover Lifestyle Eating and Performance (LEAP) program and/or mediator release testing.

51. Services intended primarily to treat **obesity**, such as gastric bypasses and balloons, vertical banding, stomach stapling and jaw-wiring, weight reduction programs, gym memberships, gym equipment, prescription drugs or other treatments for obesity (except dietary counseling and nutritional education services for morbid obesity) even if prescribed by a Physician or the Insured has medical conditions that might be helped by weight loss, regardless of medical necessity. Any complications/services related to the treatment of obesity will not be covered under this Policy.

52. Any **Organ Transplant** not specifically listed unless the Organ Transplant Rider has been purchased, all artificial organs, and services when the Insured acts as a donor, unless We also cover the recipient.

53. **Orthotripsy** and related procedures.

54. **Outpatient services** received in federal Facilities or any items or services provided in any institutions operated by any state government or agency when an Insured 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.

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

56. **Physical examinations**, health reports, and treatments and/or evaluations required for employment, flight clearance, camp, insurance, school, sports, or legal proceedings.

57. **Physicals** are limited to one per Policy Year unless Medically Necessary.

58. 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.

59. All internal and external **prosthetic items and devices,** except for those specified in Section 4 - *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.

60. **Pulmonary Arterial Hypertension** medical and drug treatment.

61. **Rare Enzyme Disorders** medical and drug treatment.

62. **Reduction mammoplasty**; breast augmentation, correction of breast asymmetry, and cosmetic procedures, except as stated under reconstructive surgery after a mastectomy.

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

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

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

66. Any **services or supplies** furnished by a provider, which is primarily a place of rest, a place for the aged, a nursing home, or similar institution.

67. All **services or supplies** provided while the Insured is not covered under this Policy; either before the Effective Date of coverage or after this Policy ended.

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

69. **Services** provided and independently billed by interns, residents, or other employees of Hospitals, laboratories, or other medical Facilities.

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

71. **Services,** except Dental services that are supplied by a person who ordinarily resides in Insured's home or is a Family member of the Insured.

72. **Services** received while not under the care and treatment of a Physician.

73. **Services** not completed in accordance with the attending Physician's orders.

74. **Services** required as a result of Experimental/Investigational drug testing done voluntarily by the Insured without Our authorization.

75. Volunteer **services**, which would normally be provided at no charge to the Insured

76. The following types of therapy, counseling, and related **services, or supplies**:
    - For or in connection with marriage, Family, child, career, social adjustment, finances, or medical social services;
    - Acupuncture, naturopathy, psychosurgery, megavitamin, and nutritionally based alcohol therapy;
    - Hypnotherapy or hypnotic anesthesia, or biofeedback; or
    - Psychiatric therapy on Court Order or as a condition of parole or probation.

77. Procedures, services, or supplies for or related to **sex change**, transformation or reassignment; modification surgery and services, any treatment of gender identity disorders, or any treatment or

surgery related to sexual dysfunction or inadequacies including, but not limited to, hormone therapy, impotency, regardless of Medical Necessity.

78. Anti-**smoking** programs including but not limited to, tobacco abuse and smoking cessation programs.

79. All surgical procedures for **snoring and sleep apnea** except in members under age 12. (Procedures that are frequently performed in relation to treatment of snoring and sleep apnea, such as adenoidectomy and/or tonsillectomy for members over age 12; excision and/or resection of turbinate; septoplasty; or submucous resection require prior authorization in order to determine the reason for the procedure and coverage.)

80. Reversal of a **sterilization** procedure regardless of Medical Necessity.

81. Infertility drugs, reversal of voluntary **sterilization**; gamete intra-fallopian transfer (GIFT); zygote intra-fallopian transfer (ZIFT); in vitro fertilization (IVF) unless the Insured has subscribed to the In-Vitro Fertilization Rider; any costs related to surrogate parenting; infertility services required because of a sex change by the Insured or the Insured's partner; or any assisted reproductive technology or related treatment that is not specified in *Section 4 - What is Covered.*

82. **Sports cords** and TENS units.

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

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

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

86. Charges that exceed **Usual, Customary, and Reasonable** amounts.

87. **Vision** exams, eye exercises, training, orthoptics, or 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) and photo refractive keratectomy (PRK-laser) unless specifically provided in *Section 4 - What Is Covered,* or as provided by a Rider.

Limitations Due to Certain Conditions

In the event that due to circumstances not within the control of SWL&H, including but not limited to a major disaster, epidemic, the complete or partial destruction of Facilities, war, riot, terrorism, civil insurrection, disability of a significant number of providers and their personnel, or similar causes, the rendering of Covered Health Services provided under this Policy is delayed or rendered impractical, SWL&H shall make a good faith effort to arrange for an alternative method of providing coverage. In such event, SWL&H and its providers shall render Covered Health Services insofar as practical, and according to their best judgment; but SWL&H and 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 Southwest Life & Health Insurance Company Policy. If You do not comply with these provisions, We will reduce Your benefits under this Policy, as stated below and in the Schedule of Benefits.

DEFINITIONS

Pre-Authorization, 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 Benefits and subject to all provisions of this Policy, when the Utilization Review requirements are properly followed and the applicable Medical Care is Pre-Authorized. You are responsible for obtaining Pre-Authorization. We will reduce payment for Covered Health Services by the amount of the failure to Pre-Authorize penalty if You do not properly follow the Utilization Review Program. The additional amounts that You are charged as a result of the benefit reduction, will not count toward the Deductibles or the Out-of-Pocket Maximums in this Policy.

In the event of an Adverse Determination, the URA will provide a written notification to You and Your Health Care Provider. The URA will provide notification within one working day by telephone or electronic transmission if You are an inpatient or within three working days if You are not an inpatient. In the event of an Adverse Determination denying post-stabilization care for emergency treatment, as requested by a treating physician or provider, notification will be provided within one (1) hour of the determination having been made by Our Utilization Review Agent. You can request an appeal if Your Health Care Provider does not agree with an Adverse Determination made by Our Utilization Review Agent.

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.

UTILIZATION REVIEW PROGRAM REQUIREMENTS

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

PRE-AUTHORIZATION REQUIREMENTS

We require that certain medical services, care, or treatments be Pre-Authorized before We will pay for Covered Health Services. Pre-Authorization means that We review and confirm that proposed services, care, or treatments are Medically Necessary. You or Your Physician are responsible to Pre-Authorize any proposed services at least five days before You receive them. We will reduce payment for covered services by the Pre-Authorization Penalty (50% or $500, whichever is less), if You do not Pre-Authorize the following services:

- Adenoidectomy, primary (age 12 or over);
- Adenoidectomy, secondary (age 12 or over);
- All anesthesia for GI cases other than conscious sedation anesthesia;
- Ambulance transfers-air and non-emergent;

- Assistant Surgeon requests for procedures not designated as allowing for an assist per the approved Assistant Surgeon List;
- Blepharoplasty;
- Bone Growth Stimulators & Implantation;
- Breast Reduction/Reconstruction;
- Capsule Endoscopy;
- Cardiac Spiral CT;
- Spinal Manipulation;
- Cognitive Therapy;
- Cosmetic Surgery/Reconstructive Surgery/Plastic Surgery Procedures - Cosmetic surgery may be covered if a result of trauma, cancer, or a congenital anomaly;
- Dental Procedures;
- DME;
- Dietary education/counseling - for any diagnosis other than diabetes and hypoglycemia;
- Excision of Turbinate;
- Genetic Testing - Excludes prenatal genetic testing;
- Growth Hormone Therapy - for growth hormone deficiency only (if covered by the Prescription Drug Rider);
- Hearing Aids;
- Home Health Care;
- Hospice Services;
- Hyperbaric Oxygen Treatment;
- Inpatient Hospital Admissions;
- Inpatient Rehabilitation Admissions;
- Implantation of pumps for pain control;
- Intensity Modulated Radiation Therapy (IMRT) - Excluding prostate, head and neck cancers;
- Intermediate Care Facility;
- Laser Vision Corrective Surgery - Only covered for diagnosis of Keratoconus;
- LEAP (Lifestyle Eating and Performance);
- Military Treatment Center;
- MRI - Cardiac only;
- Procedures related to treatment for Morbid Obesity, including, but not limited to gastric bypass surgery;
- Mental Health Services & Chemical Dependency Treatment;
- Neuropsychological testing;
- Non-Emergent Transportation;
- Observation Stays;
- Occupational Therapy;
- Oral Surgery Procedures;
- Orthognathic Surgery;
- Orthotripsy;
- Distribution of Oxygen Equipment for use in the home;

- Pain Management Procedures (Pre-authorization is not required for nerve blocks, facet injections, or epidural steroid injections administered in the Physician's office; or in the outpatient setting by the Physician);
- Peripheral Nerve Stimulators - Trial and Permanent Placement;
- PET Scans;
- Physical Therapy, excluding Cardiac and Pulmonary Rehab;
- Prosthetics & Orthotics;
- Psychological/Psychiatric services for the treatment of Acquired Brain Injury;
- Rhizotomy;
- Septoplasty or Submucous Resection;
- Skilled Nursing Facility Admissions;
- Sleep Studies (When in conjunction with an overnight stay);
- Speech Therapy;
- Spinal Cord Stimulators and Implantation;
- Strabismus Surgery - No authorization is required through age 21 and performed in-plan;
- Submucous Resection Turbinate;
- Tonsillectomy & Adenoidectomy (age 12 and over);
- Tonsillectomy, Primary or Secondary (age 12 and over);
- Transplants;
- Uvulectomy, Excision of Uvula;
- Uvulopalatopharyngoplasty (UPPP); and
- Wound Care.

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 Benefits.

Catastrophic Case Management

Any case that is expected to exceed $25,000 or any case in the following categories is considered a catastrophic case:

- AIDS;
- Amputations;
- Cancer;
- Coronary disease;
- Head injuries;
- Lung & respiratory disease;
- Multiple fractures;
- Multiple Sclerosis;
- Multiple trauma;
- Neonatal high risk infants;
- Severe burns;
- Spinal cord injuries; and
- Stroke.

We will automatically review the case and confer with the Insured's attending Physician. Once a Catastrophic Case is identified, Medical Care coordinators will work with Your Family and medical professionals to develop an effective long-term treatment plan tailored to the Insured's unique needs.

The treatment plan includes a comprehensive medical evaluation, an outline of specific treatment goals, and a concise plan of action around which You, Your Family, Physician, and Providers can focus their efforts. Once the treatment plan is implemented, We will continue to monitor the case and provide You and Your Family with an ongoing source of information about additional treatment alternatives.

SECTION 7 CLAIM REQUIREMENTS

CLAIM REQUIREMENTS

You or Your Dependents do not need to file a Claim form when a Preferred Provider renders services or supplies. When You receive services or supplies from a Non-Preferred Provider, You may obtain a Claim form from Us. If the Claim Forms are not sent to You within 15 days after We receive the Notice of Claim, You may file a Claim by submitting written proof of loss within 180 days.

Written proof of loss should be given to Us within 180 days after the date of loss. Proof of loss must include the nature and extent of the loss. You must provide any information pertaining to the Claim, such as original bills or explanation of benefits.

We will not reduce or deny a Claim because You or Your Dependent did not furnish a proof of loss within 180 days, if proof is furnished as soon as reasonably possible. We will not accept any proof of loss, unless You are legally unable to furnish one, after one year from the time it was incurred.

PAYMENT OF CLAIMS

We will pay all benefits to You, Your designated Beneficiary or Beneficiaries, or to Your estate, unless You assign benefits to another person. You must provide the written Assignment of Benefits to Us by the time proof of loss is filed. We will pay the party We determine is entitled to the payment, if You or Your Dependent is not legally capable of giving a valid receipt for payment of benefits, or there is no legal guardian. Payment made in good faith under this provision will release Us from their obligation.

Payment of Claims to You will be handled as follows:

- No later than the 15th day after receipt of 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.
- No later than the 15th day after receipt of all requested items and information, We will:
  - Notify You of the acceptance or denial of the Claim and the reason if denied; or
  - Notify You that additional time is needed and state the reason. No later than the 45th day after the date of notification of the additional time requirement, We shall accept or deny the Claim.

  Claims will be paid no later than the 5th day after notification of acceptance of the Claim.
- Through the end of the grace period of this Policy.

LEGAL ACTION

No action at law or in equity shall be brought to recover under this Policy prior to the expiration of 60 days after proof of claim has been filed in accordance with the requirements of this Policy, 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 Policy.

SECTION 8 COMPLAINT PROCEDURES

COMPLAINT PROCEDURE

If You notify Us orally or in writing of a Complaint, We will no 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 (800) 240-3270 or in writing to:

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

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, TX 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 department occur.

RELEASE OF MEDICAL RECORDS

Any Insured who files a Complaint, appeal, or request for arbitration thereby authorizes Us or anyone designated by Us, as permitted by law, to review or disseminate, as necessary to the resolution of the Complaint, Your individual medical records, without notice to You or any other person.

RETALIATION

We will not take any retaliatory action against (a) an Insured because an Insured, or other person on behalf of an Insured, appeals a decision made by Us or files a Complaint against Us or a Preferred Provider; (b) a Preferred Provider who, on behalf of an Insured, reasonably files a Complaint against Us or appeals a decision made by Us.

SECTION 9 TERMINATION OF COVERAGE

TERMINATION OF COVERAGE

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

- The date of Your death;
- The date the Maximum Benefit amount under this Policy has been paid to You or on Your behalf;
- Nonpayment of Premium;
- Fraud or intentional material misrepresentation, coverage may be canceled after not less than 15 days written notice; subject, however to the Time Limit on Certain Defenses provision described in *Section 10 - General Provisions*;
- The date You are no longer a covered Dependent; or
- Termination by discontinuance of a particular type of individual coverage by Southwest Life & Health Insurance Company in that Service Area. This provision only applies if coverage is terminated uniformly without regard to any health status-related factor of Insureds. Coverage may be canceled after 90 days written notice, in which case We must offer to each Insured on a guaranteed issue basis any other individual basic health care coverage offered by Southwest Life & Health Insurance Company in that Service Area. This applies only if coverage is discontinued uniformly without regard to health status-related factors of Insured and Dependents of Insured who may become eligible for coverage. Coverage may be canceled after 180 days written notice to the commissioner and the Insureds, in which case Southwest Life & Health Insurance Company may not re-enter the individual market in that Service Area for five (5) years beginning on the date of discontinuance at the last coverage not renewed. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.
- You no longer reside, live, or work in an area in which SWL&H is authorized to provide coverage, but only if all Policies are not renewed or not continued.

If coverage terminates due to the death of the Policyholder, the spouse of the Policyholder will become the named Policyholder, provided the spouse is an Insured under the Policy on the date of death.

If Your spouse is no longer eligible for coverage under this Policy due to divorce, Your former spouse is eligible to obtain a similar Policy. Evidence of insurability will not be required, notification must be made within 60 days after Your former spouse's coverage terminates.

AUTOMATIC TERMINATION

The coverage of any Insured who ceases to be eligible under *Section 2 - Eligibility*, shall automatically terminate at 12:01 a.m. on the date on which eligibility ceases, and such termination of coverage shall also apply to each Dependent of such Insured whose coverage so terminates, for whatever reason, including the death of such Insured. If this Policy is terminated for nonpayment of premium, an Insured's coverage shall be terminated retroactively to the date through which premium payment was received.

If You or a covered Dependent moves out of the Southwest Life & Health Insurance Company Service Area, You may continue coverage under this Policy. However, all health care services received from Non-Preferred Providers require the higher Non-Preferred Provider Deductible, Out-of-Pocket Maximum and Co-insurance amounts listed on Your Schedule of Benefits.

TERMINATION OF BENEFITS

Upon the effective date of a termination of coverage, the Insured shall not be entitled to any further benefits hereunder after such effective date. Neither Southwest Life & Health Insurance Company nor any Plan Provider shall have any further obligation to provide services or facilities pursuant to this Policy.

REFUNDS

If your coverage is terminated, premium payments received on your behalf which apply to periods after the effective date of termination of coverage shall be prorate refunded to you within 30 days after We have actual knowledge of your termination. Upon the making of such refund to you, neither Southwest Life & Health Insurance Company nor any Plan Provider shall have any further liability under this Policy with respect to the refunded amount. Any claims for refunds must be made within 60 days from the effective date of termination of an Insured's coverage, or such right to a refund shall be deemed to have been waived by the Insured.

SECTION 10 GENERAL PROVISIONS

WAIVER OF RIGHTS

If We fail to enforce a provision of this Policy earlier, we do not lose the right to enforce that provision later. Our failure to enforce one provision does not affect Our ability to enforce any other Policy provision.

ENTIRE POLICY

A copy of any Applications, amendments, Riders, or endorsements attached to this Policy constitutes the entire contract of insurance. All statements made by the Insured, are considered representations and not warranties.

This Policy cannot be amended or changed without the permission of both the Insured and Us. No change is valid unless it is made through an endorsement to this Policy, or by an amendment or Rider, signed by an officer of Southwest Life & Health Insurance Company, and agreed to by the Insured. Each Insured and any other individuals referred to in this Policy are bound by any change that is made.

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.

GRACE PERIOD

A period of 31 days after a Premium due date, during which premiums may be paid to Southwest Life & Health Insurance Company without lapse of your coverage and that of your Dependents, if any, under this Policy. If payment is not received within 31 days, coverage may be canceled after the 31st day.

REINSTATEMENT PROVISION

An Insured, or Insured Dependent(s), shall not be reinstated automatically if their coverage is terminated. To be reinstated, the Insured must provide evidence of insurability to Southwest Life & Health Insurance Company.

TIME LIMIT ON CERTAIN DEFENSES

This provision limits Our use of statements made by the Policyholder and You in contesting coverage under this Policy. All statements made by the Policyholder and You shall be considered representations and not warranties. We issue this coverage based upon statements made by the Policyholder and You. The statements are considered to be truthful and are made to the best of the Policyholder's and Your knowledge and belief.

MISSTATEMENTS ON THE APPLICATION AT ISSUANCE OF THIS POLICY

The following rules apply to each statement:

The statement will not be used in a contest to void, cancel, or non-renew the coverage unless:

- It is in written Application signed by the Policyholder or You;

- A copy of the Application is or has been furnished to the Policyholder or to You or Your personal representative; and
- Within the first two years from the issue date, an intentional misrepresentation is material to Our agreement to issue this Policy, or after two years, the Application contains a fraudulent misstatement.

In lieu of voiding, canceling, or non-renewing the coverage, We may increase the Premium for this Policy to the appropriate level if We determine that You made a misstatement on the Application/enrollment form. We must give the Policyholder written notice of any Premium rate change at least 31 days prior to the change.

CONFIDENTIALITY OF MEDICAL RECORDS

The Insured must authorize the release of all medical information requested by Us. We agree to maintain and preserve the confidentiality of all medical information. We may supply medical information to its Utilization Review Agent, a peer review committee, or a governmental agency. We can deny the Claim if the Insured refuses to authorize a release of the medical information requested by Us.

CONTINUITY OF TREATMENT

Upon termination of a Preferred Provider's contract, Insureds currently being treated by the Preferred Provider will be notified of the termination. Unless the Preferred Provider was terminated for reason of medical incompetence or unprofessional behavior, the Preferred Provider may request to continue treatment of an Insured with special circumstances. Special circumstances means a condition such that the treating Preferred Provider reasonably believes that discontinuing care by the treating Preferred Provider could cause harm to the Insured.

Special circumstances may include a person who has a disability, an acute condition, or a Life-threatening Illness, or who is past the 24th week of pregnancy. The period of continued treatment may not exceed 90 days from the Effective Date of termination, or beyond nine months in the case of an Insured who at the time of termination has been diagnosed with a terminal Illness. Coverage for an Insured, who at the time of termination is past the 24th week of pregnancy, will extend through delivery of the child, immediate post-partum care, and the follow-up checkup within the first six weeks of delivery. The Preferred Provider must agree to accept the contracted payment rates in effect prior to the termination.

EXTENSION OF BENEFITS

Any person covered under this Policy who is totally disabled at the date of discontinuance of this Policy will continue coverage under this Policy for a period of 90 days or the period of total disability, whichever is less. If coverage continues under this provision, benefits will only be paid for expenses of treatment of the condition causing the disability. Benefits payable will be subject to the stated benefit levels in Your Schedule of Benefits.

This provision will not apply if the totally disabled person's coverage under the Policy being discontinued is replaced by coverage with a succeeding carrier providing substantially equivalent or greater benefits than those provided under this Policy.

PREMIUMS

Premium rates are set out in the Premium Rate Schedule. The Insured agrees to remit the entire Premium payment on or before the due date. Premiums may be paid quarterly or monthly and may be paid by automatic deduction from a personal checking account (bank draft). Due date is the first day of the month or quarter for which the payment is due.

CHANGE IN PREMIUM UPON NOTICE:

- We reserve the right to adjust the premium upon 60 days notice to You. Such adjustments in rates shall become effective on the date specified in said notice.
- If You change Your place of residence and such change results in a change in Premium, the Premium applicable to this Policy shall automatically change to the rate applicable to the new place of residence effective on the first day of the Policy month following the date of such change in residence. If such change is to a lower Premium rate and You fail to notify Us in writing of such change prior to the date of change, Your right to refund of overpayment shall be limited to the overpayment for the 6 months immediately preceding the date of notification to Us.
- If You and/or Your covered spouse and/or Dependent(s) attain an age resulting in an increased Premium rate, the Premium applicable to this Policy shall automatically change to the rate applicable to the new age effective on the first day of the Policy month following Your and/or Your spouse's and/or Dependent's birthday.

MISSTATEMENT OF AGE

If the age of an Insured has been misstated, all amounts payable under this Policy shall be adjusted by the ratio of the Premium for the correct age to the Premium for the age in the application of such.

PHYSICAL EXAMINATION

We reserve the right to choose a Health Care Provider to examine any Insured whose condition, Illness, or Injury is the basis of a Claim. All examinations are at Our expense. Our rights may be exercised when and as often as it may require during the investigation of a Claim. We will deny the Claim if the Insured refuses to be examined.

AUTOPSY

We can request that an autopsy be performed on any deceased Insured whose condition, Illness, or Injury is the basis of a Claim. Our rights exist only where not prohibited by law.

CONFORMITY WITH STATE STATUTES

Any provision of this Policy which, on its Effective Date, conflicts with the state laws where this Policy was issued or delivered, is amended to meet the minimum requirements of the law.

CLERICAL ERRORS

Clerical errors or delays in record keeping:

- Will not deny coverage that otherwise would have been issued;
- Will not continue coverage that otherwise would have been issued; and
- May require a change in Premium.

NOTICE OF CLAIM

It is not expected that You will make payment for Covered Health Services received from Preferred Providers, other than required Coinsurance. However, if You pay for Covered Health Services in addition to the required Coinsurance, You must file a written notice of claim to Us within 90 days from the date You received Covered Health Services, unless You can document as soon as reasonably possible after the 90-day period, to Our satisfaction, good cause why such claim could not be filed within the 90-day period. We will not reimburse a claim that is made beyond one (1) year from the day You first received

those Covered Health Services.

We will provide claim forms for Your submission of written proof of payment and to request reimbursement. You may contact Our Customer Service Department at (800) 240-3270 to request a claim form or You (or someone acting on Your behalf or Your beneficiary) may send a completed claim form to:

Southwest Life & Health Insurance Company
12940 N. Hwy 183
Austin, TX 78750

RECOVERY OF PAYMENTS

We will deduct from any benefits payable under this Policy the amount of any payment, which has been made:

- In error;
- Based on a misstatement contained in a Claim;
- Based on a misstatement made to obtain coverage under this Policy within two years after the date the Insured's coverage begins; or
- On behalf of an ineligible person.

AGENCY RELATIONSHIP

Nothing in this Policy establishes that the Insured is an agent of Southwest Life & Health Insurance Company.