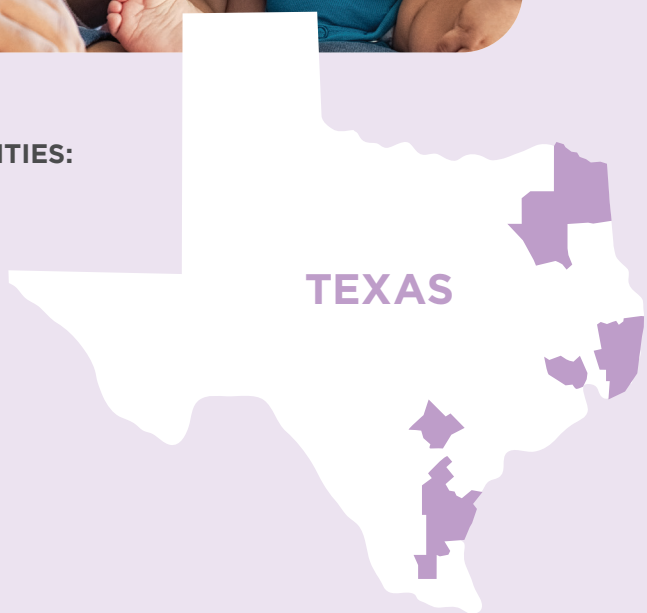
CHRISTUS Health Plan

TEXAS HEALTH EXCHANGE
COMPLETE

2024 Evidence of Coverage

CHRISTUS HEALTH PLAN TEXAS HEALTH EXCHANGE COMPLETE COVERS MEMBERS IN THE FOLLOWING COUNTIES:

- Anderson
- Aransas
- Bee
- Bowie
- Brooks
- Caldwell
- Cass
- Cherokee
- Comal
- Franklin
- Gregg
- Guadalupe
- Hardin
- Harrison
- Hays
- Hopkins
- Jasper
- Jefferson
- Jim Wells
- Karnes
- Kenedy
- Kleberg
- Live Oak
- Marion
- Morris
- Newton
- Nueces
- Orange
- Smith
- Rains
- Red River
- Refugio
- San Patricio
- Titus
- Tyler
- Upshur
- Van Zandt
- Wood



NOTICE: Upon Renewal of this Contract, Your premium may increase. Please contact Us for more information.

CHRISTUS Health Plan
CONTRACT AND EVIDENCE OF COVERAGE

Texas Complete Plan
Individual and Family Coverage

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

THIS VONTRACT IS NOT A MEDICARE SUPPLEMENT CONTRACT. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

This contract takes effect at 12:01 a.m. of the date on which the Member's coverage begins and terminates at 11:59 pm on the last day of the month for which premiums were paid and the date that the Member's coverage ends.

CHRISTUS HEALTH PLAN
5101 North O'Connor Boulevard
Irving, Texas 75039
Toll-Free Phone Number: 1-844-282-3025
www.christushealthplan.org

WELCOME TO CHRISTUS Health Plan

We are glad You have chosen CHRISTUS Health Plan. We have been serving You, Your family and Your community for 150 years. We are pleased to now serve You through our health plan.

When You join CHRISTUS Health Plan, You are joining a health plan that is part of a larger health system. Our health system is faith-based and not-for-profit. As a health system, We can coordinate Your care. Whether You are healthy and want preventive care, need to see a doctor, or have a more serious health need, We are here to serve You. We believe that You, Your family, and Your community are critical to Your well-being. We will engage You in Your health care decisions and give You the tools and support You need to manage Your health and benefits.

This Contract and Evidence of Coverage ("Contract") is offered by CHRISTUS Health Plan, Inc., a Texas licensed Health Maintenance Organization (HMO). This Contract describes Your rights and benefits under this individual and family Health Maintenance Organization (HMO) Contract and CHRISTUS Health Plan. The Contract includes the *Schedule of Benefits* and is a legal contract between You, the Member (referred to as Member, You, or Your) and CHRISTUS Health Plan (referred to as CHRISTUS Health Plan, We, Our, and Us). The *Schedule of Benefits* are separate documents which are included in your welcome packet.

Throughout this Contract, please refer to Your *Schedule of Benefits* provided with this Contract, which shows some specific Covered Benefits this Contract provides, the specific amounts You may have to pay (Cost Sharing), and certain Coverage Limitations and Exclusions. The *Schedule of Benefits* is part of this Contract, and together the Contract and the *Schedule of Benefits* provide a full description of the Covered Benefits, Exclusions, and conditions of the Plan.

PLEASE READ THIS CONTRACT CAREFULLY and keep this Contract, along with the *Schedule of Benefits* in a safe place that you can access quickly. Please also be aware that Your Physicians and Providers do not have a copy of this Contract and are not responsible for knowing or communicating Your Covered Benefits to You.

This Contract provides important information about:

- Your Rights and Responsibilities as a Member;
- Covered Benefits under the Plan and how to access them;
- Limitations and Exclusions from the Plan; and
- How to seek assistance from CHRISTUS Health Plan.

Key Terms Used in this Contract

Since this is a legal document, there are certain key terms that have special meanings. These terms are defined in the DEFINITIONS section of this Contract. Review this section carefully.

IMPORTANT PHONE NUMBERS AND ADDRESSES

Member Services	**Address:** CHRISTUS Health Plan Attn: Member Service Department 5101 North O'Connor Boulevard Irving, Texas 75039	**Toll-Free** **1-844-282-3025** **TTY** **7-1-1**
Preauthorization	**Address:** CHRISTUS Health Plan Attn: Preauthorization Department 5101 North O'Connor Boulevard Irving, Texas 75039	**Toll-Free** **1-844-282-3025** **TTY** **7-1-1**
Claims	**Address:** CHRISTUS Health Plan Exchange Attn: Claims Department P.O. Box 169012 Irving, Texas 75039	**Toll-Free** **1-844-282-3025** **TTY** **7-1-1**
Complaints, Appeals and Grievances	**Address:** CHRISTUS Health Plan Exchange Attn: Complaints, Appeals & Grievances Department P.O. Box 169009 Irving, Texas 75039	**Toll-Free** **1-844-282-0380** **TTY** **7-1-1**
Fraud, Waste and Abuse	**Email:** CHRISTUSHealthSIU@CHRISTUSHealth.org	**Toll-Free** **1-855-771-8072** **TYY** **7-1-1**
Website: www.CHRISTUSHealthPlan.org		
Language Access Services Toll Free 1-800-752-6096		

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MEMBER RIGHTS AND RESPONSIBILITIES

CHRISTUS Health Plan is committed to providing high-quality health care benefits to You. As a Member of the CHRISTUS Health Plan (Plan), there are certain rights that you are entitled to, as well as some responsibilities. It is important that You fully understand both Your rights and Your responsibilities under this Contract. This Section explains Your rights and responsibilities under this Contract and how You can participate in Our Consumer Advisory Board.

NOTICE TO MEMBERS OF TEXAS HMO

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

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

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

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

You may obtain a current directory of network physicians and providers at the following website: www.christushealthplan.org or by calling 1-844-282-3025 for assistance in finding available network physicians and providers. If you relied on materially inaccurate directory information, You may be entitled to have a claim by an out-of-network physician or provider paid as if it were from a network physician or provider, if You present a copy of the inaccurate directory information to the HMO, dated not more than 30 days before You received the service.

Member Rights

As a Member of the Plan, You have the right to:

- Available and accessible services for Medically Necessary and Covered Services, including 24 hours per day, 7 days per week for Urgent or Emergency Care Services, and for other Health Care Services as defined by this Contract or *Schedule of Benefits*.
- Be treated in a prompt, courteous and responsible manner that respects Your dignity and privacy.
- Detailed information about Your coverage; benefits; and services offered under this Contract. This includes any Exclusions of specific Conditions; ailments or disorders, including restricted prescription benefits; the Plan's policies and procedures regarding

products, services, Providers appeal procedures and other information about the Plan and the benefits We provide to You. This also includes access to a current list of Participating Providers in the Plan's network; information about a particular Participating Provider's education, training, and practice; and the Member Rights and Responsibilities, as well as the right to make recommendations regarding Our Member Rights and Responsibilities policies.

- Affordable health care including information regarding Your out-of-pocket expenses; limitations; the right to seek care from a Non-Participating Provider; and an explanation of Your financial responsibility when services are provided by a Non-Participating Provider or without Prior Authorization.
- Choose a Primary Care Provider within the limits of the Covered Services, the Plan's network, and as provided by the Contract, including the right to refuse care of specific Health Care Professionals. In addition, You have the right to participate with Your Providers in making decisions about Your health care.
- Be given an explanation of Your medical Condition, recommended treatment, risks of the treatment, expected results, and reasonable medical alternatives by Your Participating Provider in terms that You understand. If You are unable to understand the information, an explanation must be given to Your next of kin, guardian or another authorized person. This information shall be documented in Your medical records.
- All rights afforded by law, rule, or regulation as a patient in a licensed Health Care Facility, including the right to be informed about Your treatment by Your Participating Provider in terms that You understand; to request Your consent (agreement) to the treatment; to refuse treatment, including medication; and to be told of possible consequences of refusing such treatment. This right exists even if treatment is not a Covered Benefit or Medically Necessary under the Plan. The right to consent or agree to treatment by You or Your next of kin, guardian, or another authorized person may not be possible in an emergency where Your life and health are in serious danger.
- Voice Complaints or Appeals with the Plan or the Commissioner of Insurance (Commissioner) about the Plan or the coverage We provide. You as a Member also have the right to receive an answer within a reasonable time and in accordance with existing law and without fear of retaliation.
- Be promptly notified of termination or changes in benefits, services or the Provider Network.
- Confidential handling of all communications, including medical and financial information maintained by the Plan. Privacy of Your medical and financial records will be maintained by Us and Our Providers in accordance with existing law.
- A complete explanation of why a benefit is denied, the opportunity to appeal the denial decision, to our internal review and the right to request help from the Commissioner.
- Know, upon request, of any financial arrangements or provisions between the Plan and Our Participating Providers, which may restrict referrals or treatment options or limit the services offered to You.
- Qualified Health Care Professionals for treatment and services that are Covered Benefits near where You live or work within the Plan's Service Area.

- Receive information about how benefits are authorized or denied. You have the right to know how new technology for Covered Benefits are evaluated. You can also request and receive information about the Plan's quality assurance plan and Utilization Review methodology.
- Receive detailed information about all requirements that You must follow for Prior Authorization and Utilization Review.

Member Responsibilities

As a Member of the Plan, You have the responsibility to:

- Provide honest and complete information to those providing You care.
- Review and fully understand the information You receive about Your Plan.
- Know the proper use of the services covered by the Plan.
- Present Your Plan ID card before You receive care.
- Consult Your Physician before receiving medical care, unless Your Condition is life threatening.
- Promptly notify Your Provider if You will be delayed or unable to keep an appointment.
- Pay all charges or Cost Sharing amounts, including those for missed appointments.
- Express Your opinions, Complaints or Concerns in a constructive way to CHRISTUS Health Plan Member Services or to your Provider.
- Inform the Plan of any changes in family size, address, phone number or Membership status within thirty (30) calendar days of the change.
- Make Premium payments on time.
- Notify the Plan of other coverage.
- Follow Our Complaint and Appeal process when displeased with the Plan or a Providers' actions or decisions.
- Understand Your health problems and participate in developing treatment goals that You agree to with Your Providers.
- Follow plans and instructions for care that You have agreed to with Your Provider.

All Members are responsible for understanding how the Plan works. You should carefully read and refer to this Contract and Your *Schedule of Benefits*. Contact the Member Services Department when You have questions or Concerns about Your Plan.

ELIGIBILITY AND ENROLLMENT

Eligibility
To be eligible for Covered Benefits in accordance with this Contract, You must be enrolled as a Member. In this context, the Member is the individual who has applied for coverage on behalf of his/herself and his/her Dependents, and to whom this Contract has been issued.

To enroll in CHRISTUS Health Plan, You must be a Qualified Individual:

- Be a citizen or natural of the United States;
- Must reside, live, or work in the CHRISTUS Health Plan Service Area and the legal residence of any enrolled dependents must be the same as the Subscriber, or must be:
    - In the service area with the person having temporary or permanent conservatorship or guardianship of the dependents, including adoptees or children who have become the subject of a suit of adoption by the enrollee where the subscriber has legal responsibility for the health care of the dependents; or
    - In the service area under other circumstances where the subscriber is legally responsible for the health care of the dependents; or
    - In the service area with the subscriber's spouse; or
    - Anywhere in the United States for a child whose coverage under a plan is required by a medical or dental support order.
- Be lawfully present in the United States, if not a citizen or natural of the United States;
- Not be incarcerated, other than incarceration pending disposition of charges;
- Be ineligible for Medicare due to age, illness or disability, other than individuals with end stage renal disease, or be over age 65 and eligible for premium-free part A, but is not collecting Social Security benefits and has not enrolled in either Part A or Part B.

You may add newborn and other Dependents to Your Plan by completing an enrollment form for the Dependent and submitting it to Us. You must notify Us within 31 days after the birth of a child You wish to add as a Dependent and pay any premium required to continue the coverage. We will not exclude or limit coverage for a newborn child of the Subscriber or Subscriber's spouse; congenital defects will be treated the same as any other illness or injury for which coverage is provided. We will not require that Your newborn child receive services from Participating Providers if the newborn child is born outside the Service Area due to an emergency, or born in a Non-Participating Facility to a mother who does not have HMO coverage. We may require that the newborn be transferred to a Participating Facility at Our expense and, if applicable, to a Participating Provider when such transfer is medically appropriate as determined by the newborn's treating physician.

A newborn child of the Subscriber or the Subscriber's spouse is entitled to coverage during the initial 31 days following birth. We allow an enrollee 31 days after the birth of a child to notify Us, either verbally or in writing, of the addition of the newborn as a covered Dependent. In addition, grandchildren living with and in the household of the Subscriber may also qualify as a Dependent.

To qualify, grandchildren must be:

- Unmarried;
- Younger than 25 years of age; and
- A dependent for federal income tax purposes at the time of the application for coverage.

Coverage for a grandchild may not be terminated solely because the grandchild is no longer a dependent for income tax purposes.

Unless special circumstances apply, coverage of such Dependents is limited to those under the age of twenty-six (26). Dependent children, age 26 or older, may qualify for continued dependent coverage while the child is incapable of self-sustaining employment due to a mental retardation or physical disability, which existed prior to attaining and chiefly dependent upon the Subscriber for support and maintenance.

To be eligible as a Dependent:

- Be enrolled at the same time as the Member;
- Be a Dependent of the Subscriber under Texas law;
- Be enrolled within 31 days of birth.

A Dependent is a Member's lawful spouse, or Domestic Partner, and children under age 26. The term "child/children" includes a natural child, a stepchild, legally or adopted child, including children who have become subject of a suit for adoption of the Member or the Members' spouse or Domestic Partner, or a child for whom the Member or the Member's spouse or Domestic Partner are the legal guardian.

Dependent also includes any child twenty-six (26) or older who is continuously incapable of self-sustaining support because of a mental or a physical handicap. You must submit proof of the child's mental or physical handicap and dependency to Us within thirty-one (31) days after the date the child ceases to qualify as a Dependent. Once a year, we may require proof of the continuation of the child's disability and dependence.

Any child(ren) for whom You are the permanent legal guardian must be supported pursuant to a court order imposed on You (such as a Qualified Medical Child Support Order). We will provide coverage to Dependent children as required due to a Qualified Medical Child Support Order in accordance with applicable federal or state laws or regulations. These Dependents are not bound by enrollment season restrictions.

The Rights of Custodial Parents

If a Dependent child has coverage under a noncustodial parent, or a parent that does not have primary custody of the child, We will provide information to the custodial parent, as necessary, for the child to obtain benefits; permit the custodial parent or the Provider to submit claims for Covered Services without the approval of the noncustodial parent; and make payments on claims

submitted in accordance with Texas law directly to the custodial parent, the Provider or the state Medicaid agency.

The Rights of Non-Custodial Parents
We acknowledge the rights of the non-custodial parents of children who are covered under a custodial parent's Contract, unless these rights have been rescinded per court order or divorce decree. Non-custodial parents are able to contact Us to obtain and provide necessary information including but not limited to Provider information, claim information, claims payment, and benefits or services information for the child.

Enrollment
If You meet the Member or Dependent eligibility criteria, You may enroll by submitting a completed enrollment application to Us. A paper version of the application may be found at www.christushealthplan.org.

If approved, Members and Dependents will have coverage effective at 12:01 a.m. on the approved effective date set by Us.

The effective date of coverage for Dependents enrolled due to a Qualified Medical Child Support Order is the first of the month following receipt of the Order or the effective date of the Order, not to exceed sixty (60) days retroactive coverage.

Initial Enrollment
Coverage under this Contract shall become effective as of the date approved by Us.

Notification of Change of Status
Any change in a Member's status after the Effective Date of coverage should be reported to Member Services. Changes may also be cause for a change in premiums. Examples include:

- Change in address or contact information;
- Change in eligibility status; or
- Change in tobacco use.

In the event of a change in marital status, the person losing coverage shall be issued a policy which most nearly approximates the coverage of the policy which was in effect prior to the change in marital status with the same effective date as the prior policy as well.

Cancellation of Coverage
A Member's coverage will end under this Contract on the earliest of the following dates when:

- The premium is not received by Us when due, subject to the Grace Period provision of this Contract.
- After not less than 30 days written notice, the Member no longer lives, resides or works in the Service Area; except that We will not cancel the coverage for a child who is the subject of a medical support order because the child does not reside in the Service Area;

- The Plan or a particular type of individual coverage is terminated; but only if coverage is terminated uniformly without regard to any health status-related factor of enrollees and dependents of enrollees who may become eligible for coverage. We may cancel terminate coverage after 90 days written notice, and must offer each enrollee on a guaranteed-issue basis any other individual basic health care coverage offered by Us in that Service Area. In case of termination by discontinuance of all individual basic health care coverage by Us in that area, but only if coverage is discontinued uniformly without regard to health status-related factors of enrollees and dependent of enrollees who may become eligible for coverage, We may terminate coverage after written notice to the commissioner and the enrollees.
- The Member engages in fraud or intentional misrepresentation of a material fact in the enrollment application, after not less than a 30 days written notice;
- The Member engages in fraud in the use of services or facilities, after not less than a 30 days written notice.

Unless otherwise stated above, coverage will end on at 11:59 pm on the last day of the month for which premiums were paid. The Member will be responsible for claims paid after the Termination Date.

We will not pay for any Covered Services provided to a Member or Dependent after the date of termination. Unless We agree, in writing, no Covered Benefits will be provided under this Contract following the date this Contract terminates, including if Your or Your Dependent are or remain in the hospital after the date of termination of this Contract.

Conversion of Coverage

Eligible Dependents under this Contract have a right to a conversion to a new Contract upon:

- the death of the Member; or
- Divorce, annulment or dissolution of marriage or legal separation of the spouse from the Member.

The right to conversion does not apply if:

- coverage ends due to non-payment of premium,
- the Dependent is eligible for or enrolled in Medicare.

The Dependent must notify Us of their desire to convert their coverage. We will then send notice of conversion rights. The Dependent must pay the applicable premium within thirty days following receipt of the notice of conversion rights sent by Us.

A Dependent who becomes a Member under the new Contract must continue to reside in the Service Area. Dependents of the Member are not required to reside in the Services Area. The conversion plan will be the same form of coverage then being offered by Us that the original Member and his/her Dependents had, prior to conversion. Required Premiums must be paid on

time. If the Dependent wishes to enroll on a different benefit plan, he/she may be required to reapply for coverage.

HOW YOUR PLAN WORKS

This section explains how Your Plan works, how to access Your Primary Care Provider to get healthcare, and the rules You must follow when getting care.

The Plan is an "HMO" style plan, which means that You select a Primary Care Provider (PCP) to arrange all of Your care. The Plan also requires that:

- You must live, reside, or work in the Service Area, unless You are a Dependent, and meet all the rules for Coverage in this Contract.
- You must receive healthcare services by our network of Participating Providers. Our network is made of doctors and hospitals that we contract with to provide You medical services. If You do not use Our network of Participating Providers, you may have to pay for the services you receive.
- You may obtain Covered Services from a Non-Participating Provider only when a Participating Provider is not available within the Service Area. To get an Authorization for these Covered Services, Your PCP will submit a referral request to Us. Urgent Care and Emergency Care Services are covered even if the provider is not a Participating Provider.
- You pay Your Cost Sharing at the time You receive Covered Services. CHRISTUS Health Plan will pay the Provider the balance due for Covered Services. Your *Schedule of Benefits* provides specific information on the Cost Sharing requirements.
- Some healthcare services will require Preauthorization to be covered under the Plan. For example, Preauthorization is required for some Hospitalizations (maternity care does not require a Preauthorization) and some types of outpatient care. Your Participating Provider is required to make sure that Preauthorization is in place when it is required. Please refer to the HOW PREAUTHORIZATION WORKS section of this Contract for more details.
- Emergency Care Services and Urgent Care Services outside the Service Area are Covered, but other types of care may not be Covered.

Primary Care Providers

A strong relationship with Your Primary Care Provider (PCP) will help You and Your family make the most of Your Plan benefits. As a CHRISTUS Health Plan Member, You can select a PCP for Yourself and each Covered Dependent. You may consult Our online Provider Directory by visiting Our website at www.christushealthplan.org, or contact Member Services to assist You in selecting a PCP who is a part of the CHRISTUS Health Plan provider network.

If You do not select a PCP at the time of Your enrollment, a PCP near Your home will be selected for You by Us. However, You are not required to use the PCP we automatically assign to You, if You do not select a PCP at the time of Your enrollment. Please contact Member Services at 1-844¬282-3025 to change this or any PCP You select.

PCPs include, but are not limited to family practice physicians; general practitioners; internists; pediatricians; obstetricians and/or gynecologists (OB/GYN). Each Member may choose what type of PCP they prefer. Female Members may choose to have an OB/GYN as their Primary Care Provider, if desired. For female Members who do not choose an OB/GYN as their PCP, no referral is required for services provided from OB/GYN Participating Providers. Your PCP is responsible for providing Your Primary Care Services. These include annual examinations, routine immunizations, and treatment of non-emergency acute illnesses and injuries. A female member may also select an OB/GYN in addition to a PCP.

If You are a new Member and have a medical problem or are on medication, You should contact Your PCP's office and arrange for an appointment as soon as possible following Your Effective Date.

Specialist as PCP
Some Specialists may act as a PCP for Members with a severe chronic, disabling, or life-threatening medical Condition. This is permitted if the Specialist provides all basic Health Care Services and they are contracted with Us to perform PCP duties. Contact Member Services to find out which Providers serve in both roles.

CHRISTUS Health Plan Provider Directory
Our Provider directory is a list of Physicians, Hospitals, pharmacies, and other Providers that are contracted with Us. The Provider directory is subject to change as new Providers become contracted or their contracts end. If a Provider is listed in the directory, it does not guarantee that the Provider is still contracted or that the Provider is accepting new patients.

If You would like to check the status of a Participating Provider, You can access the online Provider directory on Our website at www.christushealthplan.org. You can also contact Member Services for information about a Participating Provider.

ID Card
You have been issued a Plan ID card. If additional cards are needed, please contact Member Services. Always carry Your Plan ID card with You. The Plan ID card lists some of those benefits to which Members are entitled that may require Copayment amounts. Additional Cost Sharing information can be found in Your *Schedule of Benefits*, if applicable.

You are entitled to Plan benefits for Covered Services if all applicable Cost Sharing amounts have been paid and You are eligible to receive Plan benefits. Possession of a Plan ID card alone does not entitle You to benefits. Do not allow others to use Your Plan ID card. By doing so, You will be responsible for the cost of services provided to the non-Member. In addition, Your Plan Membership and that of Your covered Dependents, may be terminated. Contact Member Services immediately if Your Plan ID card is lost or stolen.

Unauthorized, Fraudulent, Improper, or Abusive Use of Identification (ID) Cards
WARNING: It is important to follow the advice of medical professionals and to receive the best care and treatment possible. This section does not provide any guidance or advisement for medical treatment and may not be interpreted as prescribed medical services. Do not use any information in this section to make decisions about your health care needs.

This section is designed to provide general information to protect the unauthorized use of your medical benefits and ID card. The information can help raise awareness of strategies used by unscrupulous people to take advantage of you for financial gain. Also, in the event there is use of your ID card or health care benefits for anyone other than you, you are asked to make a report using the phone, fax or email listed in the next paragraph.

- The use of your ID card or Personal Health Information by anyone else, whether you know him/her or not, may be considered fraud and must be reported immediately to the CHRISTUS Fraud Hot Line 855-771-8072, Fraud secure fax 210-766-8849 or dedicated email CHRISTUSHealthPlanSIU@CHRISTUSHealth.org .
- Please report any occurrence of the following:
    - A health care provider bills for medical treatment, services or equipment you did not receive, or on a date other than the date of treatment.
    - A health care provider or other person offers you cash, a gift card or other benefits in exchange for you visiting a specific health care provider.
    - If you are solicited with an offer for free treatment at an inpatient sober living house, whether in state or out of town.
    - A health care provider bills an excessive amount for treatment you received.
    - A health care provider performs treatment or services that are medically unnecessary and unrelated to any condition for which you sought treatment.
    - A health care provider asks you to recruit family or friends for any treatment or services.
    - You continue to receive ongoing delivery of medical equipment you no longer need or use. (Please DO NOT stop any prescribed treatment without consulting a medical professional)
    - Your treatment period lasts significantly longer than the prescribed time period or appears to have no end date, or no Plan of Care has been presented to you.
    - Your treatment is abnormally spread out over multiple visits without any medical reason.
- The unauthorized, fraudulent, improper, or abusive use of ID cards issued to Members include, but are not limited to, any of the following actions, when intentional:
    - Use of the ID card prior to Your effective date;
    - Use of the ID card after Your termination of coverage under the Plan;
    - Obtaining Prescription Drugs or other benefits for persons not covered under the Plan;
    - Obtaining Prescription Drugs or other benefits that are not covered under the Plan;

    - Obtaining Prescription Drugs for resale or for use by any person other than the person for whom the drugs are prescribed, even though the person is otherwise covered under the Plan;
    - Obtaining Prescription Drugs without a prescription or through the use of a forged or altered prescription;
    - Obtaining quantities of prescription drugs in excess of Medically Necessary or prudent standards of use or in circumventions of the quality limitations of the Plan;
    - Obtaining prescription drugs using prescriptions for the same drugs from multiple providers; or
    - Obtaining prescription drugs from multiple Pharmacies through the use of the same prescription.
- The fraudulent or intentionally unauthorized, abusive, or other improper use of ID cards by any Member can result in, but is not limited to:
    - Denial of benefits;
    - Cancellation of coverage;
    - Limitation on the use of the ID card to one designated Physician, other Provider, or In-Network Pharmacy;
    - Recoupment from You of any benefit payment made;
    - Pre-approval of drug purchases and medical services; or
    - Notice to proper authorities of potential violations of law or professional ethics.

YOUR COST SHARING OBLIGATIONS

Cost Sharing is the share of the cost that You pay for Covered Benefits under the Plan. The Cost Sharing payments under Your Plan include the Copayment amounts for each type of service as listed in Your *Schedule of Benefits*.

Annual Out-of-Pocket Maximum
Your Plan includes an Annual Out-of-Pocket Maximum to protect You and Your Dependents from the high cost of a catastrophic event. The Annual Out-of-Pocket Maximum is the most You will pay for Cost Sharing in a Calendar Year for certain Covered Benefits. Please refer to Your *Schedule of Benefits* for the Out-of-Pocket Maximum.

Only Copay amounts paid out of Your pocket for Covered Benefits are applied to the Annual Out-of–Pocket Maximum. Once this amount is met then Covered Benefits are paid at 100% for the remainder of the Calendar Year.

Copays amounts paid for vision services do not apply toward this Plan Out-of-Pocket Maximum as well.

Copay payments that You pay for Covered Services will apply to Your Out-of-Pocket Maximum. Amounts or services that do not apply to Your Out-of-Pocket Maximum are:

- penalty amounts;
- premium payments; and
- amounts paid for non-Covered Benefits.

Per Person Out-of-Pocket Maximum
If You have single coverage, You have an Individual Per Person Out-of-Pocket Maximum to meet. Once You have met this amount, Covered Benefits are paid at 100% for the remainder of the Calendar Year.

Family Coverage Out-of-Pocket Maximum
For Members who have family coverage, there is a Family Out-of-Pocket Maximum. Each individual Member's Per-Person Out–of-Pocket Maximum applies until the Family Out-of-Pocket Maximum has been met. Any combination of family Members can contribute toward meeting the Family Out-of-Pocket Maximum. Once the Family Out-of-Pocket Maximum is met, Covered Benefits are paid at 100% for the remainder of the Calendar Year. For example, if the individual

Member's Per Person Out-of-Pocket Maximum is $2,000, then up to $2,000 per Member can be applied to the Family Out-of-Pocket Maximum. Any remaining amount on the Family Out-of-Pocket Maximum must be satisfied by other family Members.

If You have questions, or wish to report that You have reached Your Out-of-Pocket Maximum, please contact Member Services at 1-844-282-3025.

Copayments
Section 11.506(2)(A), Subchapter F, Title 28 Texas Insurance Code: A reasonable copayment option may not exceed 50 percent of the total cost of services provided. A basic service HMO may not impose copayment charges on any enrollee in any calendar year, when the copayments made by the enrolled in that calendar year total two hundred percent of the total annual premium cost which is required to be paid by or on behalf of that enrollee.

The Copayment or Copay is the amount shown on Your *Schedule of Benefits* that must be paid by You directly to the Provider each time certain Covered Services are received.
Copays may be due for each Service Your Provider conducts, even if You have more than one appointment in the same day. Copays do apply toward the Out-of-Pocket Maximum.

If You are unsure of the benefits covered under Your Plan or the Cost Sharing amounts, please contact Member Services at 1-844-282-3025.

HOW TO SEEK HEALTH CARE

The Plan offers You a network of doctors, healthcare facilities, labs and pharmacies. This section of the Contract explains how and where You can obtain care. Please also refer to the Schedule of Benefits attachment to this Contract for specific information.

When You need care:

- Contact Your Primary Care Provider (PCP).
- Identify Yourself as a Member. Your PCP may ask for information on Your Member ID Card, so have it ready.
- At the healthcare visit, show Your Member ID Card.
- If necessary, get a Preauthorization from Your PCP for certain Covered Benefits. More information on this is available in the HOW PREAUTHORIZATION WORKS section of this Contract.

Please contact Member Services at 1-844-282-3025 if You have any questions or wish to file a complaint.

Emergency Care

If You have an emergency, You should call 911, or seek treatment at the nearest emergency facility, whether or not it is a Participating Provider. An emergency is any medical problem that you reasonably believe could cause death or permanent injury if not treated quickly.

If You are able, tell the emergency room staff that You are a Member and provide them Your Member ID Card.

Emergency Care Services may be required to treat an accidental injury or the sudden onset of a medical Condition causing severe symptoms such as new, severe pain. A reasonable layperson would expect the lack of immediate medical attention to result in jeopardy to a Member's health, impairment of bodily functions, serious dysfunction of a bodily organ or part, or disfigurement to a person, or for a pregnant woman, could result in serious jeopardy to the health of the fetus. Emergency Care Services may also be required to treat Conditions that may become more serious or life threatening if not treated promptly, such as severe bleeding, severe abdominal pain, chest pain, a severe eye injury, or the sudden inability to breathe.

If You seek Emergency Care for an illness or injury that You believe requires immediate medical attention, the services will be covered by Your Plan. Emergency Care does not require Preauthorization. However, if Your emergency causes You to be admitted to the Hospital, notification and authorization may be required for Your Hospital Admission.

Emergency Care Services at a Non-Participating Provider/Facility

In an emergency, You should go to the nearest available Provider or Facility. You do not need Preauthorization to obtain Emergency Care Services from Participating and Non-Participating Providers.

Emergency Care Services obtained from Non-Participating Providers will be paid by Us at the maximum amount payable as described below in the section entitled "Costs for Non-Participating Providers". However, You may be transferred to a Participating Provider for continued care if it is medically wise to do so. You will pay the same Cost Sharing You would pay for a Participating Provider. If You receive a balance bill from a Non-Participating Provider, contact Us.

Make sure You contact Us and We will determine in consult with Your Provider if arrangements should be made to transfer You. If You receive non-emergency follow-up care from an Out-of-Network Provider after You are discharged, You will be responsible for the cost of those services.

Non-Emergency Care Services, such as follow-up care from a prior emergency require Preauthorization from the Plan. If You do not receive Preauthorization for non-Emergency Care Services that require Preauthorization, We will not pay for the services that You receive.

All Inpatient admissions require Preauthorization by Us. If You are admitted to a Non-Participating or Out–of-Network Facility, You must contact the Plan for Preauthorization when appropriate. An authorized family member or caregiver should contact Us if You are not able to do so. Preauthorization must be obtained in order for Covered Services to be paid at the highest benefit level. Upon receiving Preauthorization and admission, a physician other than Your PCP may direct and oversee Your care.

Urgent Care

Urgent Care includes Medically Necessary services provided to treat Urgent Illness or Injury that are not life-threatening but may require prompt medical attention. Care that is needed after a Primary Care Provider's normal business hours is also considered to be Urgent Care.

Members are encouraged to contact their Primary Care Provider for an appointment before seeking care from another Provider. If the Primary Care Provider is not available and the Condition persists, call the Nurse Advice Line at 1-800-678-4367. The Nurse Advice Line is available twenty-four (24) hours a day, seven (7) days a week. A Registered Nurse can help You decide the kind of care most appropriate for Your specific need.

A few examples or Urgent Illness or Injury are:

- Sprains or a possible broken bone;
- A cut that may need stitches;
- A rising fever;
- Severe vomiting or diarrhea;

- Ear pain; and
- Flu symptoms.

Urgent Care is not limited to these situations. If You need assistance finding an Urgent Care Provider, please contact Member Services at 1-844-282-3025.

Office Visits
Physicians and other Providers who You see in an office setting will provide You with both primary care and specialty care services. These Covered Services may include annual examinations, routine immunizations, and treatment of non-emergency/acute illnesses and injuries. For preventive, routine or specialty care, call or make an appointment with Your Physician or other Provider. Your Provider will arrange for Preauthorization as needed.

If You need a same day appointment or have an Urgent Illness, call Your Physician's office to make an appointment. If Your Provider is unable to see You, You may be offered an appointment with another Physician, Certified Nurse Practitioner or Physician Assistant in his/her group. After hours, Your Physician may offer an answering service.

When You arrive for Your appointment show Your Plan ID card to the receptionist. You may be required to make a Copay before receiving services. If You are unable to keep an appointment, cancel as soon as possible, as missed appointment charges may apply and those charges are not covered under the Plan.

Telemedicine, telehealth, and teledentistry services are Covered Services under this Contract at the same level and copayment amounts as other office visits.

Ambulance Service
If you need an Ambulance, call 911 or a local Ambulance service. This service is covered if it is Medically Necessary because of an emergency. The Plan's Medical Director determines this by reviewing Ambulance and medical records.

Non-Emergency Ambulance transport requires Preauthorization from the Plan. If Ambulance services are not Medically Necessary and are not authorized by the Plan, You are responsible for payment.

Continuity of Care
If You are receiving an ongoing course of treatment from a Non-Participating Provider or a Participating Provider whose contract ends during an on-going or active course of treatment, You may be eligible to continue to receive services as though Your Provider was still a Participating Provider. This is called Continuity of Care.

If a Participating Provider/Practitioner terminates from the Plan, We will continue to reimburse the Provider/Practitioner for providing Medically Necessary treatment to a Member with a

"special circumstance". "Special circumstance" means a condition regarding which a treating Provider or Practitioner reasonably believes that discontinuing care by that Provider or Practitioner could cause harm to the Member (including without limitation a disability, acute condition, life- threatening illness, or pregnancy).

The Plan will continue to cover Covered Services until the latest of: (a) the 90th day after the effective date of termination from the provider network; (b) if the Member has been diagnosed with a terminal illness at the time of termination, the expiration of the nine-month period after the effective date of the termination; or (c) if the Member is pregnant at the time of termination, through delivery of the child, immediate post-partum care and the six-week follow-up checkup.

For New Members
If You are receiving an ongoing course of treatment with a Provider that is not within the CHRISTUS Health Plan Provider Network, You may be able to receive services from that Provider and have them paid for at the Participating Provider benefit level. Members with certain Conditions may request for Continuity of Care from Us within thirty (30) days of the date of enrollment.

For Existing Members
If Your Provider's contract with CHRISTUS Health Plan ends during Your course of treatment, You may be eligible to continue seeing that Provider. Existing Members with certain medical Conditions may be eligible for Continuity of Care. This transitional period will allow a Member to have continued access to a Provider. You do not need to request for care to be continued since care is coordinated through the Plan.

Access to Non-Participating Providers
If a Covered Service is Medically Necessary and is not available through a Participating Provider, We will refer You to a Non-Participating Provider no more than five business days after receipt of Your request and documentation, or sooner depending on your Condition. We will coordinate the referral. **You must have Our approval before receiving the services, or You will be responsible for payment.**

We will pay the Provider at the usual and customary rate or at a rate that We agree upon with the Provider. You will pay the same Cost Sharing You would pay for a Participating Provider. If You receive a balance bill from a Non-Participating Provider, contact Us.

Before We deny a referral to a Non-Participating Provider, We will ensure that the request is reviewed by a Specialist that is familiar with Your medical Condition and is of the same or similar specialty as the physician or provider on your referral request.

Transparency in Coverage

CHRISTUS Health Exchange HMO plans require that you select an in-network Primary Care Provider (PCP) to coordinate all of your care. We will pay for covered services that our members receive from our in-network providers. However, members who receive care from an in-network provider without receiving the appropriate prior authorization, when prior authorization is required, will incur higher out-of-pocket expenses.

Services from an out-of-network provider are not covered, and providers may bill you for their services. Out-of-Network services are from doctors, hospitals, and other health care professionals that have not contracted with CHRISTUS Health Plan. A healthcare professional who is out of your plan network can set a higher cost for a service than professionals who are in your health plan network. Depending on the health care professional, the service could cost more or not be paid for at all by your plan. Charging this extra amount is called balance billing.

Except for emergency services, members who go to an out-of-network provider will have to pay all charges out of pocket for the health services they receive. Emergency services are covered whether or not members use an in-network or out-of-network provider or emergency room. Members will pay in-network cost sharing (copayment) for covered emergency services.

No Surprises Act

When you get emergency care or get treated by an out-of-network provider at an in-network hospital, hospital outpatient department, critical access hospital, ambulatory surgical center, and any other facility, specified by the Secretary, that provides items or services for which coverage is provided under the plan, you are protected from surprise billing or balance billing.

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network. "Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

When balance billing isn't allowed, you also have the following protections: You are only responsible for paying your share of the cost (like the copayments that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly. Your health plan generally must:

- Cover emergency services without requiring you to get approval for services in advance (prior authorization).

- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your out-of-pocket limit.

Costs for Non-Participating Providers
The Allowable Charge is the amount that We have determined to be the maximum amount payable for a Covered Service. For Covered Services provided by Non-Participating Providers, the amount payable will be either a rate agreed upon by Us and the Non-Participating Provider, or based upon Our out-of-network fee schedule. Our out-of-network fee schedule is based on generally accepted industry standards and practices for determining the customary billed charge for a service, and fairly and accurately reflects market rates, including geographic differences in costs, and is consistent with nationally recognized and generally accepted bundling edits and logic.

These Non-Participating Providers may not balance bill You for amounts not paid by Us. If You receive a balance bill from a Non-Participating Provider, contact Us.

Facility-Based Providers
A facility-based Provider, non-network diagnostic imaging Provider or laboratory service Provider may not be a Participating Provider. These Non-Participating Providers may balance bill You for amounts not paid by Us. If You receive a balance bill from a Non- Participating facility-based Provider, contact Us.

HOW PREAUTHORIZATION WORKS

Under Your Plan, some healthcare services are not Covered Benefits unless You have Preauthorization. This Section explains the Preauthorization process and explains what services require Preauthorization. **This is not a complete list.** More information can be obtained on Our website at https://www.christushealthplan.org/provider-resources/prior-authorization or by calling Member Services 1-844-282-3025.

What is Preauthorization?
Preauthorization is a clinical review process where We review Your case to determine if a healthcare service is Medically Necessary and a Covered Benefit before that healthcare service is provided to You.

Our Medical Director or other clinical professionals will review the proposed healthcare service, Your medical information, the place of treatment, and other information to decide whether to approve the proposed care.

Without Preauthorization, the proposed healthcare service may not be covered.
If You have questions about the Preauthorization process or what services require Preauthorization, please contact Member Services1-844-282-3025.

How Do You Get Preauthorization?
When a Participating Provider recommends care that needs to be Preauthorized, it is up to that Provider to contact Us for the approval. Your Provider is required to notify Us and obtain approval prior to receiving these services. We may need to discuss details of the requested treatment or service with Your Provider.

If You need to obtain Covered Services from a Non-Participating Provider, it is Your responsibility to obtain any necessary Preauthorization for those services. If You do not obtain Preauthorization where it is required, Your care may not be covered by Us.

After Preauthorization has been requested and all required documentation has been submitted, We will notify You and Your Provider if the request has been approved. We will also tell You and Your Provider if continued review of the Member's services will be required during the course of treatment.

To ensure that a necessary Preauthorization has been obtained, contact Member Services 1-844¬282-3025 at least fourteen (14) days prior to obtaining services. Failure to obtain Preauthorization may result in a denial of claims.

How Does The Process Work?
When We receive a request for Preauthorization, our clinical staff reviews the request using nationally recognized guidelines. The determination for non-hospitalized requests will be

provided no later than the third calendar day after the date the request is received. The determination for inpatient care services will be provided within 24 hours from receipt of the request. The determination for services for post-stabilization treatment, or a life-threatening condition, will be provided within 1 hour from receipt of the request.

A Preauthorization will specify the length of time for which it is valid. A Preauthorization may also be for only a certain number of treatments or services. Requests for renewal of an existing Preauthorization may be submitted 60 days prior to the expiration.

What Services Require Preauthorization?
The following services require Preauthorization and are subject to the Coverage rules in this Contract:

- All Medical Inpatient Acute Care Hospitalizations;
- All Inpatient Rehabilitation Hospitalizations;
- All Subacute Facility Admissions;
- All Inpatient Long Term Acute Care Hospitalization;
- Bariatric or weight loss surgical procedures and treatment of morbid obesity;
- Clinical Trial Services;
- Cosmetic or Reconstructive Surgery;
- Craniomandibular Joint (CMJ) and Temporomandibular Joint Dysfunctions (TMJ)
- Dental Services;
- Durable Medical Equipment over $500;
- Genetic Testing and counseling and treatment of Genetic Inborn Errors of Metabolism Disorders (IEM);
- Home Health Care;
- Hospice Services, Inpatient and outpatient;
- MRI, CT Scan or other imaging procedures;
- Non-Emergency Ambulance transport;
- Organ Transplant Services;
- Outpatient Physical Therapy, excluding initial evaluation;
- Outpatient Occupational Therapy, excluding initial evaluation;
- Pain Management;
- Prosthetic Appliances and Orthotics;
- Other services provided during a Medical Office Visit;
- Skilled Nursing Facility Care; and
- Surgical Procedures.

Preauthorization will not be required for some physicians and providers who meet the exemption criteria.

This list may not include all services requiring Preauthorization. If You need help determining if a service requires Preauthorization, contact Member Services at 1-844-282-3025.

Preauthorization for Prescription Drugs and Intravenous Infusions
Preauthorization is required for certain Prescription Drugs. Restricted drugs or other prescriptions that are not on the *Formulary*, but which are determined to be Medically Necessary and appropriate by the Provider may be submitted for Preauthorization to the Pharmacy Exceptions Center via fax, phone or mail with appropriate documentation to support Medical Necessity.

If You do not get this approval, Your drug might not be covered by the Plan. Please contact Member Services at 1-844-282-3025 for more information.

Decisions About Preauthorization's for Prescription Drugs and Intravenous Infusions
If Our clinical staff is not able to approve Your Preauthorization for clinical reasons, Your case will be referred to the CHRISTUS Health Plan Medical Director. The Medical Director will consider Your case, review information including information provided to Us by Your Provider, and may speak with Your Provider for more information.

You and Your Provider will be notified in writing or by electronic means if Preauthorization is approved.

You and Your Provider will be notified by phone or other means, depending on the particular services requested, if the request for Preauthorization cannot be approved based on the information We received, or if Your Plan does not cover the service.

Appeal for Prescription Drugs and Intravenous Infusions
We will evaluate non-emergent appeal requests and notify You and Your Provider of our decision within 72 hours following receipt of an Appeal for **Prescription Drugs and Intravenous Infusions.**

Expedited/Review of Ongoing Services
We will evaluate Expedited Appeal requests based on exigent circumstances.
Exigent circumstances exist when you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function or when you are undergoing a current course of treatment using a non-*Formulary* drug. We will make Expedited appeal decision and notify You and Your Provider of the decision no later than 24 hours following receipt of the request for **Prescription Drugs and Intravenous Infusions.**

We will notify You and Your Provider of an expedited decision within 24 hours of our receipt of a written or verbal request.

NOTE: Emergency Care and In-Network Urgent Care do not require Preauthorization.

The Appeal will be reviewed by a health care Provider who has not previously reviewed the case and who is of the same or similar specialty as the health care Provider that typically manages the medical condition, procedure, or treatment under review.

If we approve your request for an exception to cover drugs that are usually not covered by the plan, we will treat the excepted drug (s) as an essential health benefit, including by counting any cost-sharing towards your annual limitation on cost-sharing. We will provide coverage of the non-*Formulary* drug for the duration of the prescription, including refills.

What if Preauthorization is Denied

External Review by MAXIMUS Federal Services

You, an individual acting on Your behalf, or Your Provider has the right to request an immediate external review of Our Appeal decision by MAXIMUS Federal Services. You do not have to exhaust Our Appeal process before asking for an external review with MAXIMUS Federal Services if the Appeal process timelines are not met or if You are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function or when you are undergoing a current course of treatment using a non-*Formulary* drug. Our notice of determination of the Appeal will include complete instructions for making a request for an external review by MAXIMUS Federal Services. Expedited external review may be initiated at the same time as expedited internal appeals.

MAXIMUS Federal Services is required to issue an urgent care decision to Us and You no later than 72 hours from receipt of the request for external review and no later than 45 days for Standard request. There is no cost to You for the external review.

- You must be eligible for Coverage and covered by this Contract on the date services are provided.
- All the terms of this Contract determine whether a serviced is a Covered Benefit.
- A Member shall not rely on verbal communications from a representative of CHRISTUS Health Plan that conflict with the written terms of this Contract.
- In any instance where a verbal communication from a representative of CHRISTUS Health Plan differs from the terms of this Contract, the terms of this Contract shall prevail.

COVERED BENEFITS

Your Plan offers Coverage for a wide range of Health Care Services. This Section gives You the details about Your Covered Benefits and other requirements, Limitations and Exclusions. You will be required to pay Your Cost Sharing, as shown on the *Schedule of Benefits*, and certain other charges.

Specifically Covered

Your Plan helps pay for health care expenses that are Medically Necessary and Specifically Covered in this Contract. Specifically Covered means only those Health Care Services that are

expressly listed and described in the Benefits Sections of the Contract. Specifically Covered Benefits and Services are subject to Limitations, Exclusions, Preauthorization and other provisions of this Contract. You should refer to the Exclusions section that lists services that are not Covered Benefits under the Plan. All other benefits and services not specifically listed as Covered in this Section shall be excluded, except for Clinical Preventative Health Services.

We determine whether a Health Care Service or supply is a Specifically Covered Benefit. The fact that a Provider prescribes, orders, recommends, or approves a Health Care Service or supply does not guarantee that it is a Covered Benefit, even if it is not listed as an Exclusion.

Medical Necessity
Covered Services must be Medically Necessary, except for Clinical Preventative Care Services. Medical Necessity or Medically Necessary means Health Care Services determined by a Provider, in consultation with CHRISTUS Health Plan, to be appropriate or necessary, according to applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any other applicable clinical protocols or practice guidelines We develop consistent with such federal, national, and professional practice guidelines, for the diagnosis or direct care and treatment of a physical, behavioral or mental health Condition, illness, injury or disease.

Experimental, Investigational or Unproven drugs, medicines, treatments, procedures or devices are not Covered.

You must receive Preauthorization in order for some services to be Covered Services. The Plan will not pay for any of these services received without Preauthorization. Please refer to the Preauthorization section of this Contract or contact Member Services for more information regarding Preauthorization.

Please refer to Your *Schedule of Benefits* or call Member Services at 1-844-282-3025 for more information.

Specific Covered Benefits:
Accidental Injury (Trauma), Urgent Care, Emergency Care Services, and Observation Services
Urgent Care
Urgent Care is Medically Necessary medical or surgical procedures, treatments, or Health Care Services You receive in an Urgent Care center or in a Provider's office for a sudden Condition due to illness or injury. Urgent Conditions require prompt medical attention to prevent a serious deterioration in Your health but do not have to be life threatening. We encourage You to contact Your Primary Care Physician for an appointment, if available, before seeking care from another Provider. Preauthorization is usually required for follow-up care by a Non-Participating

Provider. If You believe Your Condition is life threatening, You should seek Emergency Care Services.

Emergency Care Services
We provide coverage for Emergency Care Services 24 hours per day, 7 days per week, when needed. You should seek medical treatment from a Participating Provider whenever possible. If You cannot reasonably access a Participating Provider, We will arrange to pay the care at a Non-Participating Provider at the Allowable Charge for:

- Any medical screening examination or evaluation required by state or federal law to be provided in the emergency facility of a Hospital that is needed to decide if an Emergency Medical Condition exists;
- Necessary Emergency Care Services including treatment and stabilization of an Emergency Medical Condition; and
- Services originating in a Hospital emergency facility, freestanding emergency medical care facility or comparable emergency facility following treatment or stabilization of an Emergency Medical Condition as authorized by Us.

Coverage for trauma services and all other Emergency Care Services will continue at least until You are medically stable, do not require critical care, and can be safely transferred to a Participating Provider based on the judgment of the attending Physician in consultation with Us and in accordance with federal law.

We will provide reimbursement when You, acting in good faith, obtain Emergency Care Services for what reasonably appears to be an acute Condition that requires immediate medical attention, even if Your Condition is later determined to not be an emergency.

Preauthorization is not required for Emergency Care Services. If You are admitted as an Inpatient to a Hospital, You or Your Practitioner needs to notify Us as soon as possible so we can review Your Hospital stay. We will approve or deny coverage of post stabilization care as requested by Your treating Practitioner within the appropriate time, depending on the services requested and Your condition, but in no more one hour from the time of the request.

We will not deny a claim for Emergency Care Services when You are referred to the emergency room by Your PCP or by Our representative. If Your Emergency Care Services results in a hospitalization directly from the emergency room, You are responsible for paying the Inpatient Hospital Cost Sharing amounts rather than the emergency room visit Copayment. Refer to Your *Schedule of Benefits* for the Cost Sharing amount.

For Emergency Care Services received from a Non-Participating Provider and/or outside of Texas, You may seek Emergency Care Services from the nearest appropriate facility where Emergency Care Services can be rendered. Non-emergency follow-up care received outside of Texas for Your convenience or preference is not a Covered Benefit.

Follow-up care from a Non-Participating Provider typically requires Our Preauthorization. You are responsible for any such charges that We do not authorize.

Whether You require hospitalization or not, You should notify Your PCP or Physician within 48 hours, or as soon as reasonably possible, of any emergency medical treatment so he can recommend the continuation of any necessary medical services.

Observation Services
Observation Services are Outpatient services provided by a Hospital and a Provider on the Hospital's premises. These services may include the use of a bed and periodic monitoring by a Hospital's nursing staff that are reasonable and necessary to evaluate Your Condition, determine the need for a possible admission to the Hospital, or when rapid improvement of the Your Condition is expected.

When a Hospital places You under Outpatient Observation, it is based upon the Provider's written order. To move from Observation to an Inpatient admission, Our level of care criteria must be met. The length of time spent in the Hospital is not the only factor determining Observation instead of an Inpatient stay. Medical criteria will also be considered.

All Accidental Injury (trauma), Urgent Care, Emergency Care Services, and Observation Services whether provide within or outside of the Plan's Service Area are subject to the Limitations listed in the Limitations Section and the Exclusions listed in the Exclusions Section.

Acquired Brain Injury
The Plan covers treatment of an Acquired Brain Injury on the same basis as treatment for any other physical condition. Cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy, and rehabilitation; neurobehavioral, neuropsychological, neurophysiological and psychophysiological testing and treatment; neuro feedback and remediation therapy, post-acute transition and reintegration services, or other treatment services are covered if such services are Medically Necessary as a result of and related to an Acquired Brain Injury.

Ambulance Services
The Plan covers the following types of Ambulance Services: (1) Emergency Ambulance Services, (2) High-Risk Ambulance Services, and (3) Inter-facility Transfer services.

Emergency Ambulance Services
Emergency Ambulance Services are defined as ground or air Ambulance Services delivered to a Member who requires Emergency Care Services under circumstances that would lead a Reasonable and Prudent Layperson acting in good faith to believe that transportation in any other

vehicle would endanger Your health. Emergency Ambulance Services are Covered only under the following circumstances:

- Within Texas, to the nearest In-network facility where Emergency Care Services and treatment can be rendered, or to an Out-of-network facility if an In-network facility is not reasonably accessible. Such services must be provided by a licensed Ambulance Service in a vehicle that is equipped and staffed with life-sustaining equipment and personnel.
- Outside of Texas, to the nearest appropriate facility where Emergency Care Services and treatment can be rendered. Such services must be provided by a licensed Ambulance
- Service in a vehicle that is equipped and staffed with life-sustaining equipment and personnel.
- We will not pay more for air Ambulance Services than We would have paid for ground Ambulance services over the same distance unless Your Condition renders the utilization of such ground transportation services medically inappropriate.
- In determining whether You acted in good faith as a Reasonable and Prudent Layperson when obtaining Emergency Ambulance Services, We will take the following factors into consideration:
    - Whether You required Emergency Care Services, as defined above
    - Your symptoms
    - Whether a Reasonable and Prudent Layperson who possesses average knowledge of health and medicine would have believed that transportation in any other vehicle would have endangered Your health
    - Whether You were advised to seek an Ambulance service by Your Practitioner/Provider or by Our staff. Any such advice will result in reimbursement for all Medically Necessary services rendered, unless otherwise limited or excluded under this Contract.
    - Ground or air Ambulance Services to any Level I or II or other appropriately designated trauma/burn center according to established emergency medical services triage and treatment protocols.

Ambulance Services (ground or air) to the coroner's office or to a mortuary is not Covered, unless the Ambulance had been dispatched prior to the pronouncement of death by an individual authorized under state law to make such pronouncement.

High-Risk Ambulance Services

High-Risk Ambulance Services are defined as non-Emergency Ambulance Services prescribed by Your Practitioner/Provider that are Medically Necessary for transporting a high-risk patient. Coverage for High-Risk Ambulance Services is limited to:

- Air Ambulance Services when Medically Necessary. However, We will not pay more for air Ambulance Services than We would have paid for transportation over the same distance by ground Ambulance Service, unless Your Condition renders the utilization of such ground Ambulance Services medically inappropriate.

- Neonatal Ambulance Services, including ground or air Ambulance Service to the nearest Tertiary Care Facility when necessary to protect the life of a newborn.
- Ground or air Ambulance Services to any Level I or II or other appropriately designated trauma/burn center according to established emergency medical services triage and treatment protocols.

Inter-facility Transfer Ambulance Services
Inter-facility Transfer Ambulance Services are defined as ground or air Ambulance Service between Hospitals, Skilled Nursing Facilities or diagnostic facilities. Inter-facility transfer services are Covered only if they are:

- Medically Necessary
- Prescribed by Your Practitioner/Provider
- Provided by a licensed Ambulance Service in a vehicle which is equipped and staffed with life-sustaining equipment and personnel.

Clinical Trials
The Plan provide coverage for Medically Necessary routine patient care at a Texas facility, incurred as a result of the Member's participation in a clinical trial if:

- The clinical trial is approved by the United States Food and Drug Administration,
- The clinical trial is approved by an institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services
- Federally funded trials. -The study or investigation is approved or funded (which may include funding through in kind contributions) by one or more of the following: (i) The National Institutes of Health. (ii) The Centers for Disease Control and Prevention. (iii) The Agency for Health Care Research and Quality. (iv) The Centers for Medicare & Medicaid Services. (v) A cooperative; group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs. (vi) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants. (vii) Any of the following if the conditions described in paragraph are met: (I) The Department of Veterans Affairs. (II) The Department of Defense. (III) The Department of Energy.
- Conditions for departments. The conditions described in this paragraph, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines:
    - to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and
    - assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

For the purposes of this specific Covered Benefit and Service, the following terms have the following meaning:

- "Routine Patient Care Cost" – means (1) A medical service or treatment that is a benefit under the Plan that would be covered if the patient were receiving cancer or life-threatening Illness treatment; or (2) A drug provided to a patient during a clinical trial if the drug has been approved by the United States Food and Drug Administration, whether or not that organization has approved the drug for use in treating the patient's particular Condition, but only to the extent that the drug is not paid for by the manufacturer, distributor or Provider of the drug; (3) Costs for types of services that are typically covered for members who have received treatment for cancer or a life threating illness; (4) All items and services consistent with the coverage provided in the plan (or coverage) that are typically covered for a qualified individual who is not enrolled in a clinical trial. Routine Patient Care Cost does not include (1) The cost of an investigational drug, device or procedure; (2) The cost of a non-Health Care Service that the patient is required to receive as a result of participation in the clinical trial; (3) Costs associated with managing the research that is associated with the clinical trial; (4) Costs that would not be covered by the patient if non-investigational treatments were provided; or (5) Costs paid or not charged for by the clinical trial Providers.

Certified Hospice Care

This Plan covers Hospice Care Program Services. To be covered, these services must be provided due to terminal illness. These services are limited as stated in Your *Schedule of Benefits*. The services must be given under a Hospice Care Program and provided by a licensed and qualified Provider. Hospice care services include Inpatient care and outpatient services. Also included are the professional services of a Physician. Other Covered Services include those of a psychologist, social worker or family counselor, physical, speech, and respiratory therapy services by licensed therapists. The following services are not covered by the Plan:

- Services provided by a family member or someone who usually lives in Your home or Your Dependent's home,
- Services or supplies not listed in the Hospice Care Program,
- Curative or life prolonging procedures,
- Services for which any other benefits are payable under the Plan,
- Services or supplies that are primarily to aid in daily living,
- Bereavement counseling,
- Nutritional supplements, non-Prescription Drugs or substances, medical supplies, vitamins or minerals; or
- Respite care.

Preventative Care Services

The Plan covers Primary Care and Specialist services for Preventative Care and periodic health exams. Although Preventative Care is covered at no charge, an office visit Copay may apply for other Covered Services provided during Your visit. The Plan also covers all Essential Health Benefits, including those listed in this Contract. There is no cost sharing for Essential Health Benefit Preventative Care Services. Coverage of Benefits is available for all USPSTF A and B recommendations, HRSA for women and HRSA and ACIP for infants, children and adolescents.

Preventative Services for Adult Members:

- Abdominal aortic aneurysm screening for male Members of specific ages (one time screening)
- Alcohol misuse screening and counseling
- Aspirin use for Members of certain ages
- Blood pressure screening
- Cholesterol screening for Members of certain ages or at higher risk
- Colorectal cancer screening for Members starting at age 45, including Colonoscopies and including a follow-up colonoscopy if the results of the initial colonoscopy, test, or procedure were abnormal
- Depression screening
- Type 2 Diabetes screening for Members with high blood pressure
- Diet counseling for Members at higher risk for chronic disease
- HIV screening for all Members at higher risk
- Immunization vaccines – doses, recommended ages and recommended populations can vary
- Obesity screening and counseling
- Sexually Transmitted Infection (STI) prevention counseling for Members at higher risk
- Tobacco use screening for all Members and cessation interventions for tobacco users, including expanded counseling for pregnant tobacco users
- Syphilis screening for all adults at higher risk

Additional Preventative Services include but are not limited to:

- Annual physical examinations, one per Calendar Year;
- Educational materials or consultations from Providers to promote healthy living;
- Periodic Glaucoma eye tests for all Members thirty-five (35) years of age or older;
- Periodic laboratory screening tests, including tests that determine metabolic, blood hemoglobin, blood glucose level, and blood cholesterol level; and
- Periodic radiological screening tests.
- Over the counter medications and drugs prescribed by a Practitioner/Provider, except as listed in the *Formulary*;
- Osteoporosis screening
- Hepatitis B screening
- Hepatitis C virus infection screening
- Skin Cancer behavioral counseling
- Falls Prevention in older adults, including exercise or physical therapy and Vitamin D
- Lung cancer screening
- Noninvasive screening tests for atherosclerosis and abnormal artery structure and function for Members who are diabetic or have a risk of developing heart disease and are:
- Men between the age of 45 and 76, and

- Women between the age of 55 and 76.

Preventative Services Specifically for Women:

- Routine anemia screening;
- Bacteriuria urinary tract or other infection screening;
- Breastfeeding comprehensive support, supplies and counseling;
- Folic acid supplements for Members who may become pregnant;
- Hepatitis B screening for pregnant Members at their first prenatal visit;
- RH incompatibility screening and follow-up testing for Members at higher risk;
- Preeclampsia prevention;
- Osteoporosis screening;
- RH incompatibility screening and follow-up testing for Members at higher risk;
- Perinatal depression counseling and intervention;
- Syphilis screening for pregnant Members;
- Annual medically recognized diagnostic examination for the early detection of ovarian and cervical cancer including conventional Pap smear screening or screening using liquid-based cytology alone or in combination with a test approved by the FDA and any other FDA-approved test for the detection of ovarian cancer for each woman 18 years of age or older.
- Cervical cancer screening every 3 years with cervical cytology alone in women aged 21 to 29 years and for women 30-65 years, every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (contesting);
- Test or screening approved by the United States Food and Drug Administration for the detection of ovarian cancer;
- BRCA risk assessment and genetic counseling/testing
- Breast cancer preventative medicine, screening, mammography and other breast diagnostic imaging;
- Chlamydia screening;
- Gestational diabetes mellitus screen in asymptomatic pregnant women after 24 weeks of gestation;
- Gonorrhea screening in sexually active women age 24 years and younger as well as in older women who are at increased risk; and
- Intimate partner violence screening for women of productive age.

Preventative Services for Children:

- Well baby and well childcare from birth in accordance with recommendations of the American Academy of Pediatrics;
- Alcohol and drug use assessments for adolescents;
- Autism screening for children at 18 and 24 months;
- Behavioral assessments for children of all ages;
- Blood pressure screening;

- Cervical dysplasia screening for sexually active females;
- Congenital hypothyroidism screening for newborns;
- Depression screening for adolescents;
- Developmental screening for children under age 3 and surveillance throughout childhood;
- Dyslipidemia screening for children at higher risk of lipid disorders;
- Fluoride chemoprevention supplements for children without fluoride in their water source;
- Gonorrhea preventive medication for the eyes of all newborns;
- Hearing screening for all newborns up to Members age 17;
- Height, weight and Body Mass Index measurements for children;
- Hematocrit or hemoglobin screening for children;
- Hemoglobinopathies or sickle cell screening for newborns;
- Hypothyroidism screening for newborns;
- HIV screening for adolescents at higher risk;
- Immunization vaccines for children from birth to age 18 – doses, recommended ages and recommended populations vary;
- Iron supplements for children ages 6 to 12 months at risk for anemia;
- Lead screening for children at risk of exposure;
- Medical History for all children throughout development;
- Obesity screening and counseling;
- Oral health risk assessment for young children (newborns to children age 10);
- Phenylketonuria (PKU) screening for this genetic disorder in newborns;
- Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk;
- Tuberculin testing for children at higher risk of tuberculosis;
- Vision screening for all children;
- Administration and cost of newborn screening test,
- Educational materials or consultations from Providers to promote a healthy lifestyle;
- Immunizations, including diphtheria, haemophilus influenza type b, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, and rotovirus; and
- Reconstructive surgery for the craniofacial abnormalities;
- Habilitative therapies for children with developmental delay as specified by an Early Childhood Intervention individualized family service plan.
- Tobacco use screening for all Members and cessation interventions for tobacco users

Complementary Therapies

Chiropractic Services

Chiropractic Services are available for specific medical Conditions and are not available for maintenance therapy such as routine adjustments. Chiropractic Services are subject to the following:

- The Practitioner/Provider determines in advance that Chiropractic treatment can be expected to result in Significant Improvement in Your Condition within a period of two months;
- Chiropractic treatment is specifically limited to treatment by means of manual manipulation; i.e., by use of hands, and other methods of treatment approved by Us including, but not limited to, ultrasound therapy; and
- Subluxation must be documented by Chiropractic examination and documented in the chiropractic record. We do not require Radiologic (X-ray) demonstration of Subluxation for Chiropractic treatment.

Chiropractic services are limited to 35 visits per Calendar Year maximum benefits.

Biofeedback is only Covered for treatment of Raynaud's disease or phenomenon and urinary or fecal incontinence. Biofeedback is limited to a Calendar Year maximum benefit. Refer to Your *Schedule of Benefits* for this maximum.

Dental Services (Limited)
Please refer to Your *Schedule of Benefits* for Cost Sharing amounts

Routine Dental Services may be covered for children only. Covered Services under this Contract include, but are not limited to:

- Services to diagnose or to prevent tooth decay and other forms of oral disease.
    - Oral exams (once every six months)
    - Bitewings (once every six months)
    - Panoramic films (once every six months)
    - Topical application of fluoride
    - Tooth sealants
    - Space maintainer
- Services to treat oral disease, including Services to:
    - Restore decayed or fractured teeth
    - Repair dentures or bridges Rebase or reline dentures
    - Repair or recement bridges, crowns, and onlays
    - Remove diseased or damaged natural teeth
- Service and supplies to treat oral disease including Services to:
    - Replace missing natural teeth with artificial ones,
    - Remove diseased or damaged natural teeth
    - Restore severely decayed or fractured teeth
- Medically Necessary Orthodontics
- Anesthesia for medically covered dental Services provided in a hospital setting

Dental services related to accidental injury are Covered Services regardless of age.

This is not an all-inclusive list of benefits and the required FEDVIP dental benefits are provided to children until age 19.

Diabetes Services
When used to treat insulin dependent diabetes, non-insulin dependent diabetes, high blood glucose levels induced by pregnancy, or another medical condition associated with elevated blood glucose levels the Plan will cover the following Medically Necessary services and supplies:

- Blood glucose monitors, including those for the legally blind, and test strips;
- Glucagon emergency kits;
- Insulin, insulin analogs, insulin pumps and associated appurtenances;
- Insulin infusion devices;
- Prescriptive oral agents and non-prescriptive oral agents for controlling blood sugar levels;
- Injection aids, including those adaptable to meet the needs of the legally blind;
- Lancet and lancet devices;
- Podiatric appliances for the prevention of foot complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment;
- Physician visits and post-diagnosis follow-up care;
- Self-management training, including medical nutritional therapy related to diabetes management; Medically Necessary visits upon diagnosis of diabetes; visits following a Physician diagnosis that represents a significant change in patient; and visits for re-education;
- Syringes; and
- Visual reading Urine and Ketone strips.

Contact Member Services for questions regarding these requirements at 1-844-282-3025.

The Plan will evaluate if changes to the *Formulary* or Contract are needed when new or improved equipment is approved by the Food and Drug Administration (FDA). This may include new or improved appliances, Prescription Drugs, insulin or diabetic supplies. Cost-sharing for insulin that is on the *Formulary* cannot exceed $25 per prescription for a 30-day supply. Emergency refills of insulin and insulin-related equipment are covered in the same manner as a nonemergency. Contact the Plan or visit Our website at www.christushealthplan.org for up-to-date information.

Diagnostic Services

Laboratory, x-ray and other diagnostic tests are a Covered Service when Medically Necessary and provided under the direction of Your Provider; including, but not limited to:

- Blood tests;
- Urinalysis;
- Pathology tests;
- X-rays, ultrasounds, and other imaging studies;
- Electrocardiograms (EKGs), Electroencephalograms (EEGs), and other electronic diagnostic procedures; and
- CT scans; PET scans; MRIs; and CT colonoscopies (virtual colonoscopies).

Some Diagnostic Services require Preauthorization. Refer to the Preauthorization Section for more information.

Durable Medical Equipment, Orthotic Appliances, Prosthetic Devices, Repair and Replacement of Durable Medical Equipment, Prosthetics and Orthotic Devices and Hearing Aids

Durable Medical Equipment (DME)

DME is a Covered Service when it is Medically Necessary and Preauthorized by the Plan when appropriate. Equipment must be necessary for a person's case or health status.

Coverage includes the rental or purchase of DME, at Our option. Examples of DME include, but are not limited to:

- Crutches;
- Hospital beds;
- Oxygen equipment;
- Wheelchairs; and
- Walkers.

In addition to being Medically Necessary and Preauthorized by the Plan, Durable Medical Equipment should meet the following criteria:

- Be able to withstand repeated use;
- Be reusable by other people;
- Be used to serve a medical purpose; and
- The equipment is generally not useful to a person who is not ill or injured.

There are some Exclusions and limitations to DME coverage:

- DME coverage is for medically appropriate equipment only, and does not include special features, upgrades or equipment accessories unless Medically Necessary.
- The Plan will cover the rental or purchase of Medically Necessary DME, including repair and adjustment of DME. We will not cover repairs that exceed the purchase price.
- Repair or replacement of DME is covered if it is Medically Necessary, as determined by Us, or due to a change in the Member's physical or medical Condition. Repair of DME or

prosthetic or orthotic devices which were previously owned by the Member and not supplied to them through the Plan may be covered, except as defined under Diabetes Supplies and Treatment. Coverage for these repairs shall be at Our discretion.

- The Plan follows guidelines established by Medicare for the lifetime of DME. Equipment is expected to last at least 5 years;
- Replacement due to loss, theft, misuse, abuse, or destruction is not covered. The Plan also will not cover replacement in cases where the patient improperly sells or gives away the equipment;
- The Plan does not cover replacement of DME solely for warranty expiration, or new improved equipment becoming available. The Plan does not cover duplicate or extra DME for the purpose of Member comfort, convenience or travel.

Orthotic Appliances

Orthotic Appliances are Covered when Medically Necessary. Orthotic Appliances include braces and other external devices used to correct a body function including clubfoot deformity. Professional services related to the fitting and use of those devices that equals the coverage provided under federal laws for health insurance for the aged and disabled. Orthotic Appliances are subject to the following limitations:

- Foot Orthotics or shoe appliances are not Covered, except for Our Members with diabetic neuropathy or other significant neuropathy. Custom fabricated knee-ankle-foot orthoses (KAFO) and ankle-foot orthoses (AFO) are Covered for Our Members in accordance with nationally recognized guidelines.

Prosthetic Devices

Internal prosthetics and/or medical appliances are covered when ordered by a Physician and Preauthorized by Us when appropriate.

An External Prosthetic Appliance (EPA) is covered with Preauthorization when appropriate and when it is Medically Necessary for a person's case or health status. External Prosthetic Appliances are artificial substitutes worn on, or attached to, the outside of the body; are used to replace a missing part (such as the leg, arm, or hand); or are needed to alleviate or correct an illness, injury, or congenital defect.

We will cover EPA that is necessary to accomplish ordinary activities of daily living. Professional services related to the fitting and use of those devices that equals the coverage provided under federal laws for health insurance for the aged and disabled. Braces are considered EPA. (This does not include orthodontic braces.)

There are some Exclusions and limitations that apply to coverage for EPA:

- The Plan covers EPA for K1-3 ambulators. EPA for Level 0 or Level 4 ambulators are not covered.

- This Plan will cover replacement of EPA if it is needed due to normal body growth or for changes due to illness or injury.
- The Plan follows Medicare guidelines to determine the lifetime of EPA.
- The Plan covers pre-fabricated EPA unless there is clinical documentation supporting that custom EPA is Medically Necessary. This includes upgrades or accessories that do not serve a therapeutic purpose.
- EPA for the purpose of being able to participate in recreational or leisure activities is not covered.
- EPA for the purpose of being able to play a sport is not covered.
- Repair or replacement of EPA is covered if it is Medically Necessary as determined by the Plan.
- Repair or replacement of EPA is not covered if due to loss, theft or destruction.
- The Plan does not cover duplicate or extra EPA for Your convenience or comfort.

Implanted Medical Devices
The Plan covers Implanted medical devices when Medically Necessary and ordered by a Participating Provider. These devices include but are not limited to pacemakers, artificial hip joints, cochlear implants and cardiac stents. Coverage consists of permanent or temporary internal aids and supports for defective body parts. We will also cover the cost for repairs or maintenance of covered appliances. Services typically require Preauthorization; refer to the Preauthorization Section for more information.

Hearing Aids
The Plan covers Hearing aids and certain related services, Services include fitting and dispensing fees; and ear molds, as necessary, to maintain optimal fit of the hearing aids. Hearing aid means durable medical equipment that is of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by children. Services must be provided by an audiologist, hearing aid dispenser or Physician. This benefit is limited to one hearing aid in each ear every three years.

Medically or audio logically necessary cochlear implants for each ear with internal replacement are Covered under this Plan for individuals 18 years and younger. Services include fitting and dispensing services, treatment for habilitation and rehabilitation, and external speech processor and controller with necessary component and replacement every three years.

Genetic Inborn Errors of Metabolism Disorders (IEM)
A genetic inborn error of metabolism is a rare, inherited, disorder that is present at birth and can result in death if untreated. Inherited or genetic errors of metabolism are genetic Conditions that result in metabolism problems. Most people with inherited metabolic disorders have a defective gene that results in an enzyme deficiency. There are many different metabolic disorders, but each disorder is usually rare in the general population. Inherited metabolic disorders are present at birth.

Covered Services for Genetic Inborn Errors of Metabolism include the treatment of genetic inborn errors of metabolism that involve amino acids, carbohydrate and fat metabolism for which medically standard methods of diagnosis, treatment, and monitoring exist. Such treatments include special diets that eliminate or replace certain nutrients, taking enzyme replacements or other supplements to support metabolism, treating the blood to remove toxic products of metabolism, clinical services, biochemical analysis, medical supplies, Prescription drugs, and corrective lenses for Conditions related to the genetic inborn error of metabolism.

An inborn error of metabolism is not just allergy or intolerance to certain foods, such as lactose intolerance or gluten sensitivity.

Covered Services under this section must be performed by Providers with specific training in managing patients diagnosed with genetic inborn errors of metabolism diagnosing, monitoring, and controlling disorders by nutritional and medical assessment.

Special Medical Foods for Genetic Inborn Errors of Metabolism
The Plan will cover Special medical foods such as amino acid-based elemental formulas, regardless of the formula delivery method, to treat inborn errors of metabolism. Special medical foods include nutritional substances that:

- Are intended for the medical and nutritional management of a patient with limited capacity to metabolize ordinary food;
- Are specifically processed or formulated to be distinct in one or more nutrients that is present in natural foods;
- Are formulated to be consumed or administered internally; and
- Are essential for optimal growth, health and metabolic homeostasis.

Special medical foods must be obtained from a Plan Participating vendor or Provider, and must be prescribed by a Physician for the treatment of an inborn error of metabolism. We cover formulas necessary to treat phenylketonuria or a heritable disease to the same extent that We provide coverage for drugs that are available only on the orders of physician.

Habilitative Services
Habilitative Services help a person keep, learn or improve the skills and functions required for daily living. Such functions may include eating and bathing. The Plan covers Habilitative Services such as Physical and Occupational Therapy; speech-language pathology; and other services for people with disabilities.

Autism Spectrum Disorder
"Autism spectrum disorder" means a neurobiological disorder that includes autism, Asperger's syndrome, or Pervasive Developmental Disorder--Not Otherwise Specified.

Coverage includes well-baby and well-child screenings for diagnosing the presence of Autism Spectrum Disorder as well as treatment of Autism Spectrum Disorder through Speech,

Occupational, and Physical Therapy. Providers of these services must be certified, registered or licensed to provide these services. In addition, providers must be recognized and accepted by an appropriate agency of the United States or certified as a Provider under the TRICARE military health system, or acting as under the supervision of such a provider.

Coverage is limited to all generally recognized services in the treatment plan as prescribed by the Member's Primary Care Physician. Generally recognized services may include (1) evaluation and assessment services; (2) applied behavior analysis; (3) behavior training and behavior management; (4) speech therapy; (5) occupational therapy; (6) physical therapy; or (7) medications or nutritional supplements used to address symptoms of autism spectrum disorder. Some services may need to be Preauthorized by the Plan.

Home Health Care Services
Medically Necessary home health services are covered under certain conditions. Home Health Services must be provided based on an attending Physician's certification that hospitalization or confinement in a skilled facility would be required if a treatment plan for home care is not provided. Services must be provided by a licensed and qualified Provider. Coverage is limited under this Plan.

Home health services may include:

- Visits from professional nurses including but not limited to Registered Nurses, licensed professional nurses, and other Participating health professionals such as physical, occupational and respiratory therapists, speech pathologists, home health aides, social workers and dieticians;
- The administration or use of consumable medical supplies and DME by professional staff during an authorized home health visit;
- home infusion therapy;
- Covered Drugs and medications prescribed by a Participating Provider for the duration of home health services;
- Private duty nursing for extended care services, when medically necessary.

Physical, occupational, respiratory, and speech therapy provided in the home will be covered by the Plan. These are limited to services provided on the written order of a Provider provided the order is renewed at least every sixty (60) days.

Inpatient Hospital Services
The Plan covers Inpatient Hospital services when Medically Necessary. Services include the treatment and evaluation of Conditions for which outpatient care would not be appropriate. Inpatient Hospital Services include:

- Semi-private room and board;
- Use of Intensive care unit services;
- Medications, Biologicals, fluids and chemotherapy;
- Meals;

- Medically Necessary special diet and nutritional supplements;
- Dressings and casts;
- Medically Necessary general nursing care and special duty nursing;
- The Use of the operating room and related facilities;
- Whole blood and blood, including the cost of blood, blood plasma, and blood plasma expanders that are not replaced by or for the Member;
- Administration of whole blood and blood plasma;
- X-rays, laboratory and other diagnostic services;
- Anesthesia and oxygen services;
- Inhalation therapy (Respiratory Therapy);
- Private duty nursing when medically necessary,
- Radiation therapy; and
- Other services provided in an acute care Hospital.

Inpatient Acute Care Hospital Services require Preauthorization; please refer to the Preauthorization Section for more information.

Inpatient Long Term Acute Care

The Plan covers Long Term Acute Care (LTAC) hospitalizations when Medically Necessary. LTAC Hospitals provide care for Members that require longer-term Inpatient care due to complex Conditions that cannot be treated at a facility with a lower level of care. LTAC may include pulmonary care, advanced wound care, and critical care services.

Services that are covered by the Plan include:

- Laboratory testing;
- Respiratory therapy;
- 3 or more IV antibiotics, other IV medications, TPN, and IV fluids;
- Pain management;
- Limited Rehabilitation, including Physical, Occupational, cognitive, and Speech therapy;
- Frequent vital sign, neurologic sign, or vascular checks;
- Cardiac monitoring;
- Medication monitoring;
- Nutrition management;
- Fluid management, intake and output, and daily weights; and
- Education for the Patient, family, and/or the patient's caregivers.

Inpatient Long Term Acute Care Hospital Services require Preauthorization; please refer to the Preauthorization Section for more information.

Inpatient Physician Care Services

The Plan covers Inpatient services provided by Physicians or other health professionals. These services must be Medically Necessary. Inpatient Physician Care Services include services performed, prescribed, or supervised by Physicians or other health professionals, including:

- Diagnostic;
- Therapeutic;
- Medical;
- Surgical;
- Preventative;
- Referral; and
- Consultative Health Care Services.

Inpatient Rehabilitation Services

The Plan covers Inpatient services at an acute Rehabilitation facility. These services must be Medically Necessary. These services are also Covered Services for children with developmental delays and include occupational therapy evaluations and services; physical therapy evaluations and services; speech therapy evaluations and services; and dietary or nutritional evaluations.

Services must be rendered by a licensed and qualified Provider and include the following:

- Semi-private room and board;
- Physician services;
- Skilled nursing services;
- Skilled therapy services (PT/OT/ST);
- Multidisciplinary team services (dietician, MSW services);
- Medications, Biologicals, fluids;
- Meals, including Medically Necessary diet and nutritional supplements;
- X-rays, laboratory and other diagnostic services; and
- Oxygen and inhalation therapy (Respiratory Therapy services).

Inpatient Rehabilitation Services require Preauthorization, please refer to the Preauthorization Section for more information.

Hyperbaric Oxygen Therapy

Hyperbaric Oxygen Therapy is a covered benefit only if the therapy is proposed for a Condition recognized as one of the accepted indications as defined by the Hyperbaric Oxygen Therapy Committee of the Undersea and Hyperbaric Medical Society (UHMS). Hyperbaric Oxygen Therapy is Excluded for any other Condition. Hyperbaric Oxygen Therapy requires Preauthorization and services must be provided by a Participating Provider in order to be Covered.

Mental Health Services, Behavioral Health Treatment, Alcoholism and Substance Abuse Services

We provide benefits and coverage for mental health conditions and substance use disorders under the same terms and conditions applicable to the plan's medical and surgical benefits and

coverage. Coverage may not impose quantitative or non-quantitative treatment limitations on benefits for a mental health condition or substance use disorder that are more restrictive than quantitative or non-quantitative treatment limitations imposed on coverage of benefits for medical or surgical expenses.

Alcohol and Substance Abuse Services
This Plan will cover the diagnosis and treatment of Substance Abuse, which includes alcohol and drug abuse disorders in an Inpatient and outpatient setting.

Inpatient services include Hospitalization for alcohol and drug abuse detoxification, Rehabilitation partial Hospitalization. Rehabilitation does not include a Residential Treatment Center or other facility using a social model to provide Rehabilitation. Inpatient services must be furnished by a licensed and qualified Provider.

Outpatient services includes assessment, outpatient detoxification, individual, family or couple therapy and counseling, intensive outpatient program (IOP), group therapy, as well as medication management by a licensed and qualified Provider.

Behavioral Health Treatment
This Plan will cover the diagnosis and treatment of Behavioral Disorders or Mental Illness disorders in an Inpatient and outpatient setting.

Inpatient services include Hospitalization and electroconvulsive therapy (ECT). Inpatient and ECT services require Preauthorization and must be furnished by a licensed and qualified Provider. Continued stay must meet medical necessity criteria and any applicable state law requirements.

Outpatient services include assessment, individual, group, family or couple therapy and counseling, intensive outpatient program (IOP), electroconvulsive therapy (ECT) and medication management. All services must be provided by a licensed and qualified Provider.

Nutritional Support and Supplements
This Plan will cover the following Nutritional Supplements that are prescribed by a licensed and qualified Provider:

- Nutritional Supplements for prenatal care for a pregnant Member;
- Nutritional Supplements when Medically Necessary to replace a specific documented deficiency;
- Nutritional Supplements when Medically Necessary and administered by injection at the Provider's office;
- Enteral formulas or products, as Nutritional support, when administered by enteral tube feedings;
- Total Parental Nutrition (TPN) through intravenous catheters via central or peripheral veins; and

- Special Medical Foods as listed in the IEM Benefit section of this Contract.

Some Nutritional Support and Supplements require Preauthorization; please refer to the Preauthorization Section for more information.

The Plan also covers amino acid-based elemental formulas, regardless of the formula delivery method, that are used for the diagnosis and treatment of:

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

Nutritional Evaluation
The Plan covers dietary evaluations and counseling for the medical management of a documented disease. This includes coverage for obesity. These services must be obtained from a licensed and qualified Provider or a registered dietician. Refer to the Exclusions section of this Contract for further details.

Oral Anticancer Medications
The Plan covers a prescribed, orally administered anticancer medication that is used to kill or slow the growth of cancerous cells with the same coverage terms as intravenously administered or injected cancer medications that are Covered Services. Prior Authorization is required.

Outpatient Medical Services
The Plan covers Outpatient Hospital and/or ambulatory surgical procedures. These services must be Medically Necessary and prescribed by Your Primary Care Provider or attending Health Care Professional. Services may be provided at a Hospital; a Physician's office; or any other appropriately licensed facility. The Provider delivering services must be licensed to practice; and must be practicing under authority of the health care plan, a medical group, an independent practice association or other authority as applicable by Texas law.

Outpatient Hospital or Ambulatory Surgical Procedures may include:

- Primary care and specialist Physician services;
- Outpatient services by other providers;
- Diagnostic services, including laboratory, imaging and radiological services;
- Therapeutic radiology services;
- Prenatal services;
- Outpatient rehabilitation therapies, including physical therapy, speech therapy and occupational therapy;

- Home health services, as prescribed or directed by the responsible Physician or other authority designated by the Plan;
- Preventative Services required by law, including certain periodic health examinations for adults, immunizations for children, well-child care from birth, cancer screenings relating to mammography, prostate cancer or colorectal cancer, eye and ear examinations for children through age 17, and immunizations for adults;
- Treatment for PKU and other genetic disorders;
- Outpatient mental health visits;
- Emergency services;
- Physician and surgeon services;
- Diagnostic laboratory tests, x-rays and pathology services;
- Pre-surgical testing;
- Whole blood, including cost of blood, blood plasma, and blood plasma expanders that are not replaced by or for the enrollee;
- Administration of blood, blood plasma and other Biologicals;
- Dressings, casts and sterile tray services;
- Medical supplies;
- Outpatient hospital services, including treatment services, ambulatory surgery services, diagnostic services (including laboratory, radiology, and imaging services); and
- Anesthetics and/or anesthesia services.

Some Outpatient Hospital or Ambulatory Services require Preauthorization; please refer to the Preauthorization Section for more information.

Practitioner/Provider Services
Practitioner/Provider services are those services that are reasonably required to maintain good health. These services include, but are not limited to, periodic examinations and office visits.

Medical Office Visits
The Plan will cover Primary Care and Specialist services for the diagnosis and treatment of an Illness or injury.

Allergy Treatment
Coverage is provided for allergy consultation, testing, treatment and injections by an allergy Specialist or Immunologist.

Second Opinions
Second Opinions can be obtained from In-Network Participating Providers without need for Preauthorization. If We determine, in consultation with a Participating Provider, that a Second Opinion is not available in network, coverage is limited to one out of network consultation per diagnosis. An out of network Second Opinion typically requires Preauthorization by Us.

Prescription Drugs/Medications
The Plan will provide coverage for drugs, supplies, supplements and administration of a drug (if such services would not otherwise be excluded from coverage) when prescribed by a licensed and qualified Provider and obtained at a Pharmacy or through the Plan's Mail Order program. Coverage for Prescription Drugs includes generic, brand name or non-preferred drugs.

We use a *Formulary*, which is a list of Prescription Drugs that are covered by the Plan. The *Formulary* includes drugs for a variety of disease states and Conditions. If there is any modification of the *Formulary*, the Plan will send Members a 60-day notification. Drugs listed on the Plan's *Formulary* will continue to be offered at the contracted benefit level until the Plan's renewal date. Sometimes it is Medically Necessary for a Member to use a drug that is not on the *Formulary*. When this occurs, the prescribing Physician may request an exception for coverage through the Plan's Pharmacy Exception Center. In addition, some of the *Formulary* drugs may require a Preauthorization, a Step Therapy requirement, or may have quantity limits before coverage. See the Exclusions Section for more information on Prescription Drugs that are not Covered.

Step Therapy protocol complies with all mandated requirements, which includes disclosing an exceptions request process to You and disclosing Your expedited Adverse Determination appeal rights and external review rights for denials of exception requests. Prescription Drugs associated with the treatment of stage-four advanced, metastatic cancer or associated conditions do not apply.

Some Prescription Drugs may be limited to a Specialty Pharmacy or a specific pharmacy based upon FDA approval. These drugs will be designated in the *Formulary* with such limitations.

If a Member received out-of-area Emergency Care and had a prescription filled, the Plan requires that the Claim be submitted for reimbursement no later than 1 year (365 days) following the date of service. The Claim must contain an itemized statement of expenses.

The *Formulary* is developed and maintained by a medical committee made up of 15 independent doctors and pharmacists. The committee decides if a drug should be on the *Formulary* after reviewing clinical, safety, and financial information. Clinical reasons are always considered before the cost of the drug when determining coverage and placement on the *Formulary*. Some drugs may need pre-authorization.

The *Formulary* is reviewed periodically, and drugs on the list may be added, changed, or deleted. We will only remove a drug or change the requirements, limits or restrictions when your coverage is renewed. We will give you sixty (60) days notice of changes to the *Formulary*.

If You have questions regarding the *Formulary* or regarding Your Prescription Drug benefits, call Member Services for assistance. Additional information regarding Your Prescription Drug

Cost Sharing including Copays, Out of Pocket Limits, Mail Order program, Limitations and Exclusions can be found in *Schedule of Benefits*.

Some Prescription Drugs may be limited to a Specialty Pharmacy or a specific pharmacy based upon FDA approval. These drugs will be designated in the *Formulary* with such limitations. The *Formulary* includes all drugs required by the Affordable Care Act and the Texas Department of Insurance. There are certain medications that are not required to be covered by law. These drugs are related to the treatment of cancer, diabetes and smoking cessation. Please refer to the sections of this Contract and Your *Schedule of Benefits* regarding these covered Prescription Drugs.

You are required to pay for your covered Prescription Drugs according to the lesser of:

- the Copayment;
- the Allowable claim amount for the Prescription Drug; or
- the amount You would pay for the Prescription Drug if You purchased the drug without using Your health coverage.

If You receive a partial supply of a prescription drug from Your pharmacy, the cost-sharing amount will be prorated based on the number of days' supply of the drug actually dispensed. If You are needing eye drops to treat a chronic eye disease or condition, You may have Your eye drops refilled on or before the last day of the prescribed dosage period and:

- not earlier than the 21st day after the date a prescription for a 30-day supply of eye drops is dispensed;
- not earlier than the 42nd day after the date a prescription for a 60-day supply of eye drops is dispensed; or
- not earlier than the 63rd day after the date a prescription for a 90-day supply of eye drops is dispensed.

We have established a medication synchronization plan. This is a plan established for the purpose of synchronizing the filling or refilling of multiple prescriptions.

Off-label drugs are covered benefits when it has been approved by the Food and Drug Administration for at least on indication and it is recognized for treatment of the indication for which the drug is prescribe in a standard drug reference compendium or substantially accepted peer-reviewed medical literature. The drug must be prescribed to treat a Covered Services and must be medically necessary. Off-label drugs will not be denied solely on the basis that the drug is not included in the *Formulary*.

Reconstructive Surgery

This Plan will cover Medically Necessary services for surgery from which an improvement in physiologic function can reasonably be expected and performed for the correction of functional disorders resulting from accidental injury or from congenital defects or disease. Reconstructive surgery benefits are limited and include:

- Treatment provided for the correction of defects in an Accidental Injury sustained by the Member; or
- Treatment provided for reconstructive surgery following cancer surgery; or
- Surgery performed on a newborn child for the treatment or correction of a congenital defect; or
- Surgery performed on a covered Dependent child (other than a newborn child) under the age of 19 for the treatment or correction of a congenital defect other than conditions of the breast; or
- Reconstruction of the breast on which mastectomy has been performed; surgery and reconstruction of other breast to achieve a symmetrical appearance; and prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy.

Rehabilitation Therapy
Rehabilitation Therapy includes Physical; Speech; Occupational; and cardiac and pulmonary Therapy. These therapies are covered by the Plan when it has been determined that they can be expected to result in significant improvement of a Member's physical Condition. These services may be needed as a result of an injury; surgery or an acute medical Condition. Related Occupational Therapy is provided for the purpose of training Members to perform the activities of daily living.

Skilled Nursing Facility Care
Inpatient services at a Skilled Nursing Facility are covered under Your Plan. These services must be Medically Necessary and Preauthorized and be furnished by a licensed and qualified Provider. Covered Services are limited as stated in the *Schedule of Benefits* and include:

- Semi-private room and board;
- Skilled and general nursing services,
- Physician visits;
- Limited rehabilitative therapy;
- X-rays; and
- Administration of covered drugs, medications, Biologicals and fluids.

Smoking Cessation Counseling/Program
Diagnostic services and smoking cessation counseling, as set forth below, and certain smoking cessation Drugs as set forth on the *Formulary*.

Diagnostic services necessary to identify tobacco use, use-related Conditions and dependence. Group counseling, including classes or a telephone Quit Line, are covered through a Participating Provider. No Cost Sharing applies and there are no dollar limits or visit maximums.

Please contact Member Services at 1-844-282-3025 for more information.

Transplants
The Plan will cover human organ and tissue transplant services when Preauthorized as appropriate; and services are received from Plan-approved facilities within the United States.

The recipient of an organ transplant must be a Member at the time of services. Benefits are not available when the Member is a donor. Benefits are not available if the recipient is not a Member. The term recipient is defined to include a Member receiving authorized transplant-related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post-transplant care. Coverage is subject to the conditions and limitations outlined in the *Schedule of Benefits* and in this Contract.

Definition of Transplant Services
Transplant services include medical, surgical and Hospital services for the recipient. This Plan also covers organ procurement needed for human-to-human organ or tissue transplant. The types of transplants covered include, but are not limited to, kidney, kidney/pancreas, cornea, bone marrow, some stem cell, heart, heart/lung, liver and pancreas.

Preauthorization
Transplant services must be Preauthorized by the Plan. Preauthorization is based on an evaluation conducted by a Plan-approved transplant facility and on the relevant evidence-based medical guidelines.

A Member may seek authorization from the health plan for dual transplant listing. The second listing must be within a separate or different Organ Procurement Organization. While dual listing is authorized, payment will be made to only one facility for the actual transplant event.

Organ Procurement Costs
The Plan will cover costs directly related to the procurement of an organ from a cadaver or from a live donor. Surgery needed for organ removal; organ transit and the transportation; hospitalization and surgery of a live donor are also covered by the Plan. Compatibility testing that is done prior to procurement is covered if it is determined to be Medically Necessary by the Plan.

Transplant Travel
Travel expenses incurred in connection with a pre-approved transplant are covered up to $10,000 per lifetime. Benefits for transportation; lodging; and food are available to Members only if they are the recipient of a pre-approved organ/tissue transplant from a Plan approved Provider. Transplant Travel must typically be Preauthorized by the Plan.

Covered Travel expenses for a Member receiving a transplant will include charges for:

- Transportation to and from the transplant site, including charges for a rental car used during a period of care at the transplant facility;
- Lodging while at, or traveling to and from the transplant site;
- Food while at, or traveling to and from the transplant site.

The Plan will also cover travel expenses for one companion to accompany the patient as described above. Patients that are minors are allowed travel benefits for themselves, one or both parents, or a parent and a designated companion. A companion may be a spouse; a family member; a legal guardian; or any person not related to the Member but actively involved in the Member's care.

The following travel expenses travel expenses are excluded from coverage:

- travel costs incurred due to travel within sixty (60) miles of the Member's home;
- laundry bills;
- telephone bills;
- alcohol or tobacco products; and
- charges for transportation that exceed coach rates.

Immunosuppressive Drugs for Organ Transplants

The Plan will cover Inpatient immunosuppressive drugs for organ transplants. Prescription Drugs may be covered. Please refer to Your *Schedule of Benefits* for information regarding Your Prescription Drug benefits.

Vision Care

- One wellness eye exam per year for children, one wellness eye exam every 24 months for adults.
- One pair of glasses per year for children, one every 24 months for adults.
- Vision services for Dependent children that are Essential Health Benefits

Women's Health Care

Please see the SPECIAL NOTICE ABOUT REPRODUCTIVE & FAMILY PLANNING SERVICES Section of this Contract.

The Plan covers certain services related to women's health care. Some Covered Services are:

- Prenatal care, including nutritional supplements that are Medically Necessary and prescribed by a Physician;
- Mammograms for screening and diagnosis. These services include but are not limited to low-dose mammography screenings, including digital and mammography or breast tomosynthesis, performed at a designated imaging facility; and mammograms for screening and diagnostic purposes, including but not limited to low-dose mammography screenings performed at designated and approved imaging facility. At a minimum, the Plan shall cover one annual mammogram to persons age thirty-five (35) and older while diagnostic mammograms have no age limit;

- Breast Cancer Chemoprevention counseling for women at higher risk;
- Cytologic Screenings (Pap tests) including a screening for papillomavirus to determine the presence of precancerous or cancerous Conditions and other health problems, including the CA 125 blood test. These tests are available for women age thirteen (13) or older; and for women who are at risk of cancer, or at risk of other health Conditions that can be identified through a Cytological Screening;
- Human papillomavirus vaccine available to female Members age nine (9) to fourteen (14) years of age;
- Breast and ovarian cancer genetic testing and genetic counseling based on family history;
- Screening for gestational diabetes;
- Counseling and screening for HIV and other sexually transmitted diseases;
- Screening and counseling for interpersonal and domestic violence and abuse;
- Forty-eight (48) hours of Inpatient care following a mastectomy; and twenty-four (24) hours of Inpatient care following lymph node dissection for the treatment of breast cancer; and
- Mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts; prostheses; and complications resulting from a mastectomy, including lymphedema; Direct access to qualified obstetric and gynecological care for female Members.

Maternity Care
Maternity Care is covered as shown on Your *Schedule of Benefits*. You are entitled to receive the maternity services and benefits listed in this section. Some Covered Services may require Preauthorization by the Plan before services are provided.

Prenatal Maternity Care
Coverage for Prenatal Care includes:

- a minimum of one prenatal office visit per month during the first two trimesters of pregnancy;
- a minimum of two office visits per month during the seventh and eighth months; and
- a minimum of one office visit per week during the ninth month and until term by a Participating Provider.

Each office visit shall also include; prenatal counseling and education, necessary and appropriate screening, including history, physical examination and the laboratory and diagnostic procedures deemed appropriate by the Participating Provider/Practitioner. This is based upon recognized medical criteria for the risk group of which the patient is a Member.

Complications of pregnancy are covered under this Contract in the same manner as other illnesses or sicknesses. Complications of pregnancy mean conditions, requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute

nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and non-elective cesarean section, termination of ectopic pregnancy, and
spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.

Obstetrical Care
Maternity Care includes coverage for Obstetrical care, including Participating Physician's, Participating Licensed Certified Nurse Midwife's, and Participating delivery room and other Medically Necessary services directly associated with delivery.

Services Provided by a Licensed Certified Nurse Midwife
The services of a Licensed Certified Nurse Midwife are covered, subject to the following Limitations:

- The Licensed Certified Nurse Midwife is a Participating Provider.
- The Licensed Certified Nurse Midwife's services must be provided under the supervision of a Participating licensed Obstetrician or a licensed Family Practice Provider.
- The services must be provided in preparation for, or in connection with, the delivery of a newborn infant at a site that is covered under this Maternity benefit.
- For the purposes of this Maternity benefit, the only allowable sites of delivery are a Participating Hospital or a licensed birthing center. The combined fees of the Licensed Certified Nurse Midwife and any attending or supervising Physician(s), for all services provided before, during and after the birth, may not exceed the allowable fee(s) that would have been payable to the Physician had he/she been the sole Provider of those services.

Delivery Services
Medical, surgical and Hospital care during the term of pregnancy, upon delivery and during the postpartum period for normal delivery, spontaneous abortion (miscarriage) and complications of pregnancy are covered. Coverage for a mother shall be available for a minimum of forty-eight (48) hours of Inpatient care following a vaginal delivery and a minimum of ninety-six (96) hours of Inpatient care following a Cesarean section. Any decision to shorten the period of Inpatient care for the mother or the newborn must be made by the attending Physician or Provider in consultation with the mother and must include appropriate post-delivery care in either the mother's home, the Physician's office, a healthcare facility, or another appropriate location.

Transportation, including air transport to the nearest available contracted appropriately licensed Health Care Facility, is available for medically high-risk pregnant women with an impending delivery of a potentially viable infant. When necessary to protect the life of the infant,

transportation, including air transport, to the nearest available tertiary care Health Care Facility, is covered.

Postpartum Care
Maternity Care includes postpartum visits. Postpartum care in the home is covered in accordance with accepted maternal and neonatal Physician assessments, by a person with appropriate licensure, training and experience to provide postpartum care. Services provided by such person shall include, but not be limited to, parent education, assistance and training in breast and bottle feeding, and the performance of any necessary and appropriate clinical tests.

Coverage for postpartum care in the home includes a minimum of three home visits, unless one or two home visits are determined to be sufficient by the attending Physician or person with appropriate licensure, training and experience to provide postpartum care, and the mother. The home visits shall be conducted within the time period ordered by the attending Physician or person with appropriate licensure, training and experience to provide postpartum care.

Breast feeding support, supplies and counseling
The following benefits and services are covered at no cost to the Member when received from a Participating Provider:

- Member must have a prescription for a manual breast pump, supplies, and counseling to prove that the Member gave birth.
- Member will be provided with one (1) manual breast pump. One (1) replacement manual breast pump is allowed the following year and every year thereafter. A replacement set of associated supplies is allowed per Member for the duration of breastfeeding, in conjunction with each birth. Supplies include such items as breast pump, tubing and pads.
- If it is deemed Medically Necessary for the Member to use an electric breast pump, the Member's Durable Medical Equipment benefit would apply and may include a cost share.
- Breastfeeding counseling services are available for the duration of breastfeeding, in conjunction with each birth.

Alpha-fetoprotein IV Screening
The alpha-fetoprotein IV screening test for pregnant women. The test screens for certain genetic abnormalities in the fetus. This test generally occurs between the sixteenth (16th) and twentieth (20th) week of pregnancy.

Newborn and Adopted Children Coverage
The Plan will cover Injury or Illness of a newborn child. The child can be natural or adopted or in a "placement for adoption" status. This includes circumcision for newborn males, and the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Ground or air transportation to the nearest available Tertiary Care Facility is covered when necessary to protect the life of the infant.
Nutritional Supplements

This Maternity Benefit includes coverage for Medically Necessary nutritional supplements listed on the *Formulary* (as directed by the attending Participating Provider/Practitioner).

Continuity of Care
If a Participating Provider/Practitioner terminates from the Plan, We will continue to reimburse the Provider/Practitioner for providing Medically Necessary treatment to a Member with a "special circumstance". "Special circumstance" means a condition regarding which a treating Provider or Practitioner reasonably believes that discontinuing care by that Provider or Practitioner could cause harm to the Member (including without limitation a disability, acute condition, life- threatening illness, or pregnancy).

The Plan will continue to cover Covered Services until the latest of: (a) the 90th day after the effective date of termination from the provider network; (b) if the Member has been diagnosed with a terminal illness at the time of termination, the expiration of the nine-month period after the effective date of the termination; or (c) if the Member is pregnant at the time of termination, through delivery of the child, immediate post-partum care and the six-week follow-up checkup.

In the event that a member is seeing a physician or provider that is pending termination from the plan, CHRISTUS Health Plan will provide notice to the member.

Additional Women's Health Care Benefits
Mastectomy Care
The Plan shall offer forty-eight (48) hours of Inpatient care for a mastectomy; and twenty-four (24) hours of Inpatient care following lymph node dissection for the treatment of breast cancer. The Plan will also cover mastectomy-related services; including all stages of breast reconstruction and surgery to achieve symmetry between the breasts; prostheses; and any complications resulting from a mastectomy, including lymphedema. Requests for reconstructions after initial reconstruction post-mastectomy require Preauthorization, and clinical information must be reviewed by a Medical Director for Medical Necessity. Requests that are not an initial reconstruction that are cosmetic in nature are not a Covered Benefit.

Osteoporosis Coverage
Services related to the diagnosis, treatment, and appropriate management of osteoporosis when Medically Necessary.

SPECIAL NOTICE ABOUT REPRODUCTIVE & FAMILY PLANNING SERVICES

CHRISTUS Health Plan is an affiliate of a Catholic health care system, which is subject to the Ethical and Religious Directives for Catholic Health Care Services. Based on religious beliefs, we limit performance of certain services. Such services include sterilization, tubal ligation and artificial contraceptives, or any counseling or referrals for such services, when performed for family planning purposes. However, certain of these services are designated under federal law as covered Essential Health Benefits for women with reproductive capacity; these covered services may include:

- FDA-approved contraceptive methods (not including abortifacient drugs), such as:
    - Barrier methods (used during intercourse), like diaphragms and sponges
    - Hormonal methods, like birth control pills and vaginal rings
    - Implanted devices, like intrauterine devices (IUDs)
    - Emergency contraception, like Plan B® and Ella®
    - Sterilization procedures
    - Patient education and counseling
- FDA-approved sterilization procedures
- Patient education and counseling

EXCLUSIONS

This Contract only covered certain Medically Necessary healthcare benefits. This EXCLUSIONS Section lists services that are specifically excluded from coverage under this Contract. All other benefits and services not specifically listed in the COVERED BENEFITS section of this Contract are also Excluded Services.

If You are uncertain about whether a service or item is covered by this Contract, please contact Member Services at 1-844-282-3025 before the service or item is provided.

The following are specifically excluded from coverage:

- **Acupuncture**
- **Accident and Emergency Care Services**
    - Use of an emergency facility for non-emergent services (including without limitation, Urgent Care or observation)
- **Autopsies and Ambulance Services**
    - Autopsy costs for deceased Members.
    - Ambulance services to the coroner's office or to a mortuary, unless the Ambulance has been dispatched prior to the pronouncement of death by an individual authorized under state law to make such pronouncements.
- **Bariatric Surgery**
- **Before or After Coverage Period**
    - Services received, items purchased, prescriptions filled or expenses incurred before the effective date of coverage under this Policies or after the effective date of termination of Coverage.
- **Cancer Clinical Trials**
    - Any Cancer Clinical Trials provided outside of Texas, as well as those that do not meet the requirements of the COVERED BENEFITS section of this Contract.
    - Costs of Cancer Clinical Trials that are customarily paid for by government, biotechnical, pharmaceutical or medical device industry sources.
    - Services from non-Participating Providers, unless services are not available from a Participating Provider. Preauthorization is typically required for any Out-of-Network Services, which must be provided in Texas.
    - Costs of a non-FDA approved Investigational drug, device or procedure.
    - Costs associated with managing the research associate with the Cancer Clinical Trial.
    - Costs of tests necessary for the research of the Cancer Clinical Trial.
    - Costs paid for or not charged by the Cancer Clinical Trial Providers.
- **Certified Hospital Care Benefits**
    - Food, housing and delivered meals.
    - Volunteer services.
    - Personal or comfort items.

    - Homemaker or housekeeping services.
    - Private duty nursing (Except medically necessary or authorized by the PCP).
    - Bereavement counseling.
- **Circumcisions**
    - Performed other than for newborn stays, unless Medically Necessary.
- **Clothing or Protective Devices**
    - Clothing or other protective devices, including photoprotective clothing, windshield tinting, lighting fixtures or other items or devices whether prescribed or not.
- **Complementary Therapies**
    - Acupuncture, except as specified in COVERED BENEFITS.
    - Chiropractic Services, except as specified in COVERED BENEFITS.
    - Biofeedback, except as specified in COVERED BENEFITS.
- **Cosmetic Surgery**
    - Cosmetic therapy, drugs or medications, or procedures for the purpose of changing appearance.
    - Any surgical or non-surgical procedures that are primarily for the purpose of altering appearance and not performed for the purpose of correcting functional disorders resulting from injury, congenital defects or disease.
    - Reconstructive surgery following a mastectomy is not considered Cosmetic Surgery and will be covered.
- **Dental Services**
    - There is no dental coverage for adults.
- **Durable Medical Equipment**
    - Upgraded or deluxe Durable Medical Equipment
    - Convenience items, including items for comfort and ease and not primarily medical in nature, such as shower seats, bath grab bars, shades for wheelchairs, pillows, fans, special beds and chairs, and other items.
    - Duplicate Durable Medical Equipment items.
    - Repair or replacement of Durable Medical Equipment due to loss, neglect, misused, abuse to, or to improve appearance or convenience.
    - Repair or replacement of items under the manufacturer or supplier's warranty.
    - Additional wheelchairs, if the Member has a functional wheelchair.
- **Excessive Charges**
    - Charges or costs in excess of Usual, Customary and Reasonable Charges.
- **Exercise Equipment and Services**
    - Exercise equipment, videos, personal trainers, club memberships and weight reduction programs.
- **Experimental, Investigational or Unproven Drugs, Medicines, Treatments, Procedures, Devices or Services**
- **Extracorporeal shock wave therapy**

- **Foot Care**
    - Routine foot care, such as treatment of flat feet or other structural misalignments of the removal of corns, and calluses, unless Medically Necessary due to diabetes or other significant peripheral neuropathies.
- **Hair Loss**
    - Hair loss or baldness treatments, medications, supplies and devices, regardless of medical cause of hair loss or baldness.
- **Home Health Care Services**
    - Custodial Care needs that can be performed by non-licensed medical personnel to meet normal activities of daily living.
    - Respite care.
- **Hospital Services**
    - Rehabilitation as part of acute medical detoxification.
- **Infertility Services**
- **Long-Term Care**
    - Not covered for adults or children
- **Male Health Care**
    - Contraceptive Coverage
    - Family planning services
    - Sterilization procedures
- **Mental Health and Alcoholism and Substance Abuse**
    - Codependency treatment.
    - Bereavement and sexual counseling.
    - Psychological testing when not Medically Necessary.
    - Special education, school testing or evaluations, counseling, therapy or care for learning deficiencies or disciplinary or behavioral problems.
    - Treatment in a halfway house.
    - Alcohol or Substance Abuse Services (Except as specified in COVERED BENEFITS)
        - Treatment in a halfway house.
        - Codependency treatment.
        - Bereavement and sexual counseling.
        - Court-ordered treatment, or treatment that is a condition of parole or probation in lieu of sentence.
        - Any treatment for Alcoholism or Substance Abuse services after the maximum episodes of treatment allowed under this Contract.
- **Military Service Disabilities**
    - Care for military service connected disabilities to which You are legally entitled to and for which facilities are reasonable available to You.
- **Nutritional Supports and Supplements**
    - Baby food (including formula or breast milk) or other regular grocery products that can be used with the enteral system for oral or tube feedings.

- **Out-of-Network Services Not Authorized**
    - Services received out of network that require Preauthorization, if Preauthorization was not obtained.
- **Orthotic Appliances**
    - Functional foot Orthotics, including those for plantar fasciitis, pes planus (flat feet), heel spurs and other Conditions, Orthopedic or corrective shoes, arch supports, shoe appliances, foot Orthotics, and custom fitted braces or splints, except for Members with diabetes or other significant peripheral neuropathies.
    - Custom-fitted Orthotics, except for knee-foot-ankle Orthosis (KAFO) and/or ankle-foot Orthosis (AFO) for Members who meet nationally recognized guidelines.
- **Prescription Drugs/Medicines**
    - New Medications for which the determination of criteria for Coverage have not yet been established by Us.
    - Over the counter (OTC) medications and drugs, except as listed on the *Formulary*.
    - Prescription Drugs/Medicines that require a Preauthorization if no Preauthorization was obtained.
    - Prescription Drugs/Medicines purchased outside the United States.
    - Replacement Prescription Drugs/Medicines resulting from loss, theft or destruction.
    - Prescription Drugs/Medicine, medicines, treatments, or devices that We determine are Experimental, Investigational or Unproven.
    - Disposable medical supplies, except when provided in a Hospital or a Participating Provider's office.
    - Treatments and medications for the purpose of weight reduction or control, except as specified in COVERED BENEFITS.
    - Nutritional supplements as prescribed by the attending Provider or as sole source of nutrition.
    - Infant formula, under any circumstance.
    - Prescription Drugs/Medicines for the treatment of sexual dysfunction or Infertility.
    - Prescription Drugs/Medicines for cosmetic purposes.
- **Provider Services**
    - Services provided by a provider who is barred from participation in Medicare and/or other health care programs due to program violations.
    - Telephone visits, except as set forth in COVERED BENEFITS.
    - Electronic mail by a Provider or consultation by telephone for which a charge is made to the patient.
    - Get acquainted visits without physical assessment or diagnostic or therapeutic intervention.

- **Prosthetic Devices**
    - Artificial aids including speech synthesis devices, except as specified in COVERED BENEFITS.
- **Reconstructive Surgery for Cosmetic Purposes**
    - Cosmetic Surgery (examples include breast augmentation, dermabrasion, dermaplaning, excision of acne scarring, acne surgery, asymptomatic scar revision, micro phlebectomy, sclerotherapy (except for truncal veins), and nasal rhinoplasty.
- **Rehabilitation and Therapy**
    - Athletic trainers or treatments by athletic trainers.
    - Vocational rehabilitation services
    - Long-term therapy or rehabilitation services, including treatment for chronic or incurable Conditions for which rehabilitation produces minimal or temporary change or relief. If You have reached maximum rehabilitation potential, a point where a significant improvement is unlikely to occur, or therapy for 4 consecutive months, additional therapy is considered long-term therapy or rehabilitation.
    - Treatment of chronic Conditions (such as muscular dystrophy, down syndrome, cerebral palsy).
- **Services Covered Under Another Program**
    - Services for which You or Your Dependent are eligible under any governmental program (except Medicaid), to the extent determined by law.
    - Services for which, in the absence of any health service plan, no charge would be made to You or Your Dependent.
- **Services Provided Outside the United States**
    - Any services or materials for non-Emergency Care or non-Urgent Care received outside the United States.
- **Sex Dysfunction**
    - Treatment for sexual dysfunction, including medication, counseling and clinics.
- **Sex Transformation**
    - Surgery and drugs related to sex transformation.
- **Skilled Nursing Facility Care**
    - Custodial or domiciliary care.
- **Smoking Cessation**
    - Hypnotherapy for smoking cessation counseling
    - Over the counter drugs, unless listed on the *Formulary*.
    - Acupuncture for smoking cessation purposes.
- **Speech Therapy**
    - Therapy for stuttering.
    - Additional benefits beyond those listed in COVERED BENEFITS.
- **Transplant Services**
    - Transportation costs for deceased Members

    - Medical and Hospital Services of an organ transplant donor when the transplant recipient is not a Member or the transplant procedure is not a Covered Benefit.
    - Travel and lodging, except as specified in COVERED BENEFITS.
- **Treatment While Incarcerated**
    - Services or supplies a Member receives while in custody of any state or federal law enforcement authorities, including while in jail or prison.
- **Vision Care**
    - Routine vision care and eye refractions, except as specified in COVERED BENEFITS.
    - Corrective eyeglasses or sunglasses, frames, lenses, contact lenses, or fittings, except as specified in COVERED BENEFITS.
    - Eye refractive procedures, including radial keratotomy, laser procedures and other techniques.
    - Eye movement therapy.
- **Weight Loss Programs**
    - Not covered for adults or children.
- **Women's Health Care**
    - Abortifacient drugs.
    - Family planning services, excepted as specified in SPECIAL NOTICE ABOUT REPRODUCTIVE & FAMILY PLANNING SERVICES Section of this Contract.
- **Work-Related Illnesses or Injuries**, under any circumstances.

CLAIMS

Notice of Claim
Written notice of any Claim must be given to Us within **20 days** after the occurrence or commencement of any loss covered by the Plan, or as soon thereafter or as reasonably possible. Failure to give notice within 20 days will not invalidate or reduce a claim if notice is given as soon as reasonably possible.

Notice given by or on behalf of the Member to Us or to any authorized agent of the Plan, with information sufficient to identify the Member, shall be deemed notice to Us.

Claim Forms
You may call or write to Us to notify Us of a Claim. Upon receipt of notice from You, we will furnish You, or the Member who is the Contract holder for this Contract, the forms needed for filing a proof of loss (a "Claim"). Forms will be furnished within 15 days after We receive notice from You.

You may also access our website, www.christushealthplan.org, to obtain a claim form.

Claim Submission
Written Claims must be furnished to Us within 365 days after the date of service. However, in case of a Claim for loss for which We provide any periodic payment contingent upon continuing loss, this Claim may be furnished within 365 days after termination of each period for which We are liable. Failure to submit a Claim within the time required will not invalidate nor reduce any benefit if it is not reasonably possible to submit a Claim within 365 days, provided:

- it was not reasonably possible to provide proof in that time; and
- the proof is given within one year from the date Proof of Loss was otherwise required. This one-year limit will not apply in the absence of legal capacity.

Payment of Claims
Benefits payable under this Contract will be paid immediately upon receipt of a clean Claim, unless the Contract provides for periodic payment. Where the Contract provides for periodic payments, the benefits will accrue and be paid monthly, subject to submission of a clean Claim.

A Claim will be considered a "clean" Claim if it contains all of the information required by Us to process for payment in accordance with the benefits without additional information. For example, a Claim may not be "clean" if it is incomplete, lacks medical record documentation, is suspicious or appears to be fraudulent, or suggests improper medical practice by the Provider.

Claims submitted for services received by a deceased Member will be payable in accordance with the beneficiary designation and the provisions respecting such payments. If no such designation or provision is provided, claims will be payable to the estate of the Member. Any

other claims unpaid at the Member's death may, at Our option, be paid to the beneficiary. All other claims will be payable to the Member or to the Provider, at Our option.

Out-of-Network Emergency Claims and Payment
If You receive Emergency Care Services from Non-Participating Providers, You are responsible for submitting the Claim. The Claim must contain an itemized statement of treatment, expenses, and diagnosis. The itemized Claim or statement must be submitted to Us as soon as possible at the following address:

CHRISTUS Health Plan
Attn: Claims Department
5101 North O'Connor Boulevard
Irving, Texas 75039

Fraud and Abuse
Anyone who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and subject to fines and confinement in state prison.
We may terminate Coverage for any type of fraudulent activity by You or the Members covered by this Contract.

Subrogation
This section will apply when another party is, or may be considered liable for a Member's injury, illness or other Condition. This includes insurance carriers who are financially liable; settlements or awards relating to the Member's injury, sickness, or other condition; medical malpractice lawsuits; and other sources of liability other than this Contract.

We are subrogated to all of the rights of the Member against any party liable for the Member's injury or illness; or is or may be liable for the payment for the medical treatment of such injury or occupational illness (including any insurance carrier), to the extent of the value of the medical benefits that may have been paid by Us. We may assert this right without consent from the Member.

This right includes, but is not limited to, the Member's rights under uninsured and underinsured motorist coverage; any no-fault insurance; medical payment coverage (auto, homeowners or otherwise); Workers' Compensation coverage; or other insurance, as well as the Member's rights under the Plan to bring an action to clarify his or her rights under that insurance.

We are not obligated in any way to pursue this right independently or on behalf of the Member, but may choose to pursue Our rights to reimbursement at Our sole discretion.

The Member is obligated to cooperate with Us and its agents in order to protect Our subrogation rights. Cooperation with Us means You will:

- provide Us with any relevant information requested;

- sign and deliver such documents as reasonably requested by Us to secure the subrogation Claim;
- obtain Our consent of the Plan or its agents before releasing any party from liability for payment of medical expenses.

If the Member enters into litigation or settlement negotiations regarding the obligations of other parties, the Member must not prejudice Our subrogation rights. If a Member fails to obtain prior written consent from Us and agrees to a settlement or releases any party from liability for payment of medical expenses, or otherwise fails to cooperate with this provision, including executing any documents required herein, the Member will be required to repay CHP for the value of any benefits that were paid under Us.

If You are in an accident and another person or entity may be legally liable to You, notify the Plan's Subrogation Services immediately at:

CHRISTUS Health Plan
Attn: COB, Subrogation and Recovery Department
PO Box 169001
Irving, Texas 75039-9001

Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this contract provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Indemnities payable under this contract for any loss other than loss for which this contract provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this contract provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

The Plan may pursue recovery against underinsured/uninsured motorist coverage or medical payments coverage only if the covered individual or the covered individual’s immediate family did not pay the premiums for the coverage.

COORDINATION OF THIS CONTRACT'S BENEFITS WITH OTHER BENEFITS

This section of the Contract applies when a person has health care coverage under more than one health plan. “Health plan” is defined below.

The rules in this section govern the order in which each health plan, including this Plan, will pay a claim for benefits. The order process is called “COB.”

The health plan that pays first is called the primary plan. The primary plan must pay benefits in accord with its contract terms without regard to the possibility that another health plan may cover some expenses.

The health plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans equal 100 percent of the total allowable expense.

Definitions

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

(1) Health plan includes:

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

(2) Health plan does not include:

- disability income protection coverage;
- the Texas Health Insurance Pool;
- workers' compensation insurance coverage;

- hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage;
- supplemental benefit coverage;
- accident only coverage;
- specified accident coverage;
- school accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis;
- benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
- Medicare supplement policies;
- a state plan under Medicaid;
- a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan; or
- an individual accident and health insurance contract that is designed to fully integrate with other policies through a copayment.

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

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

The "**Order of Benefit Determination Rules**" below determine whether this Plan is a primary plan or secondary plan when a Member has health care coverage under more than one health plan. When this Plan is primary, it determines payment for its benefits first before those of any other health plan without considering any other health plan's benefits. When this Plan is secondary, it determines its benefits after those of another health plan and may reduce the benefits it pays so that all health plan benefits equal 100 percent of the total allowable expense.

(c) "Allowable expense" is a health care expense, including copayments, that is covered at least in part by any health plan covering the Member. When a health plan provides benefits in the form of services, such as this Plan, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any health plan covering the Member is not an allowable expense. In addition, any expense that a health care provider or physician by law or in accord with a contractual agreement is prohibited from charging the Member is not an allowable expense.

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

- The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the health plans provides coverage for private hospital room expenses.
- If a Member is covered by two or more health plans that do not have negotiated fees and compute their benefit payments based on the usual and customary fees, allowed amounts, or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.
- If a Member is covered by two or more health plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
- If a Member is covered by one health plan that does not have negotiated fees and that calculates its benefits or services based on usual and customary fees, allowed amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another health plan that provides its benefits or services based on negotiated fees, the primary plan's payment arrangement must be the allowable expense for all health plans. However, if the health care provider or physician has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the health care provider's or physician's contract permits, the negotiated fee or payment must be the allowable expense used by the secondary plan to determine its benefits.
- The amount of any benefit reduction by the primary plan because a Member has failed to comply with the primary plan’s provisions is not an allowable expense. Examples of these types of provisions include second surgical opinions, prior authorization of admissions, and preferred health care provider and physician arrangements.

(d) "Allowed amount" is the amount of a billed charge that a health plan determines to be covered for services provided by a non-preferred health care provider or physician. The allowed amount includes both the health plan’s payment and any applicable copayment amounts for which the Member is responsible.

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

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

Order of Benefit Determination Rules
When a Member is covered by two or more health plans, the rules for determining the order of benefit payments are as follows:

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

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

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

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

(e) If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan must pay or provide benefits as if it were the primary plan when a covered person uses a non-contracted health care provider or physician, except for emergency services or authorized referrals that are paid or provided by the primary plan.

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

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

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

1. Nondependent or Dependent. The health plan that covers the Member other than as a dependent, for example as an employee, member, contract holder, Subscriber, or retiree, is the primary plan, and the health plan that covers the Member as a dependent is the

secondary plan. However, if the Member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the health plan covering the Member as a dependent and primary to the plan covering the Member as other than a dependent, then the order of benefits between the two health plans is reversed so that the health plan covering the Member as an employee, member, contract holder, Subscriber, or retiree is the secondary plan and the other health plan is the primary plan. An example includes a retired employee.

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

A. For a dependent child whose parents are married or are living together, whether or not they have ever been married: (A) The health plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or (B) If both parents have the same birthday, the health plan that has covered the parent the longest is the primary plan.

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

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

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

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

iv. if there is no court order allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows: (I) the health plan covering the custodial parent; (II) the health plan covering the spouse of the custodial parent; (III) the health plan covering the noncustodial parent; then (IV) the health plan covering the spouse of the noncustodial parent.

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

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

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

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

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

5. Longer or Shorter Length of Coverage. The health plan that has covered the person as an employee, member, contract holder, Subscriber, or retiree longer is the primary plan, and the health plan that has covered the person the shorter period is the secondary plan.

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

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

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

Compliance with Federal and State Laws Concerning Confidential Information
Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other health plans.

HMS, the Plan's COB contractor, will comply with federal and state law concerning confidential information for the purpose of applying the rules in this section and determining benefits payable under this Plan and other health plans covering the person claiming benefits.

Each Member claiming benefits under this Plan must give HMS any facts it needs to apply these rules and determine benefits.

Facility of Payment
A payment made under another health plan may include an amount that should have been paid under this Plan.

If it does, HMS may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. HMS will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery
If the amount of the payments made by HMS is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

APPEALS AND COMPLAINT PROCESS

You have a right to Appeal any determination We make that denies payment on Your claim or Your request for coverage of a health care service or treatment. You have the right to:

- appeal an Adverse Determination to Us;
- to External Review; and/or
- to file a Complaint.

We have a department that takes care of Appeals and Complaints. If You disagree with Our decision, You may ask for a review by filing an Appeal or Complaint. We will never retaliate against a Member in any way for filing an Appeal or Complaint.

Confidentiality
CHRISTUS Health Plan, the Commissioner, independent co-hearing officers, and all others who acquire access to identifiable medical records and information of members when reviewing Complaints shall treat and maintain such records and information as confidential except as otherwise provided by federal and Texas law.

We have procedures to ensure the confidential treatment and maintenance of identifiable medical records and information submitted as part of any Complaint.

Who Can Help You
Member Services can help You. If You have a Concern about a person, a service, the quality of Your care, or Your benefits, You can contact the Member Services toll-free at 1-844-282-3025.

Member Services will make every effort to resolve Your Complaint or Concern the first time it is brought to our attention. If the Member Services representative is not able to resolve Your Complaint or Concern, You can file an appeal or complaint within 180 days of receiving your EOB or Adverse Determination.

Appeal from an Adverse Determination (Treatment or Service)
If We find that the requested Health Care Service is not covered by the health benefits plan, We will not address the issue of medical necessity. If We determine that Health Care Services provided or proposed to be provided to You are not Medically Necessary or appropriate or are experimental or investigational, We will notify You, an individual acting on Your behalf and Your Provider of Record, including the Provider who provided the Health Care Service, of Our determination, along with Your right to Appeal the Adverse Determination and the process for requesting that Appeal. We will always mail or otherwise transmit notice of Our review within the second working day of the request for Utilization Review and We receive all information necessary to complete the review.

An Adverse Determination is a determination by Us that the health care services provided or proposed to be provided are not medically necessary or appropriate, or are experimental or

investigational. It does not mean a denial of Health Care Services due to the failure to request prospective or Concurrent Utilization Review.

We will notify You, an individual acting on Your behalf, and Your Provider of Record of an Adverse Determination by telephone or electronic transmission within the time period appropriate to the circumstances relating to the delivery of the Health Care Services and Your condition, but in no case to exceed one hour after the time of the request when denying post-stabilization care subsequent to emergency treatment as requested by a treating Health Care Professional or other Provider or if You are hospitalized, within one working day. If the Health Care Service is denied based on Medical Necessity or because it is experimental or investigational, You are entitled to an Appeal for external review by MAXIMUS Federal Services. If You have a life-threatening Condition, You are entitled to an immediate Appeal to MAXIMUS Federal Services and are not required to comply with Our procedures for an internal review.

We shall provide You notice of an Adverse Determination for a Concurrent Utilization Review for the provision of prescription drugs or intravenous infusions for which You are receiving health benefits no later than the 30th day before the date on which the prescription drug or intravenous infusions will be discontinued.

You, an individual acting on Your behalf, or Your Provider of Record may appeal the Adverse Determination and may ask for an expedited Appeal for emergency care denials, denials of care for life-threatening Conditions, and denials of continued stays for hospitalization. The expedited review will be a review by a health care Provider who has not previously reviewed the case and who is of the same or similar specialty as the health care Provider that typically manages the medical condition, procedure, or treatment under review.

Your expedited Appeal will be completed based on the immediacy of Your Condition, the procedure, or treatment, but in no event will exceed one working day from the date all information necessary to complete the appeal is received.

Our determination in an expedited Appeal may be provided by telephone or electronic transmission within one working day, but will be followed with a letter within 72 hours after the plan receives the initial telephone or electronic notification. We will provide notification of Our determination through a direct telephone contact to the individual making the request within 72 hours for an Appeal concerning an acquired brain injury.

If We receive a standard internal review request of pre-service or post-service, We will send to the appealing party within five (5) working days from receipt of the Appeal a letter acknowledging the date We received the Appeal. Our letter will include a list of relevant documents that must be submitted by the appealing party to Us, and if the Appeal was received orally, a one-page Appeal form to be filled out by the appealing party. Our letter will also include the Appeal procedures and the time frames required for resolution.

In any instances in which the Medical Necessity or appropriateness or the experimental or investigational nature of the Health Care Services is in question prior to issuance of an Adverse Determination, We will afford the Provider of Record a reasonable opportunity to discuss the plan of treatment for You with a Physician. This discussion will include, at a minimum, the clinical basis for Our decision.

After review of the Appeal, We will issue a response letter to You, an individual acting on Your behalf, and the Provider of Record, explaining the resolution of the Appeal as soon as practical, in no case later than 30 calendar days after We receive the Appeal. If the Appeal is for Emergency Care, or denial of a continued stay for Hospitalization, the time frame for resolution will be completed based on the immediacy of Your Condition, the procedure, or treatment, but may not exceed 72 hours from the date that CHRISTUS Health receives the request.

Our response letter will contain a statement of the specific medical, dental, or contractual reasons for the resolution; the clinical basis for the decision; a description of or the source of the screening criteria that were utilized in making the determination; the professional specialty of the Physician who made the determination; notice of the appealing party's right to seek review of the Adverse Determination with MAXIMUS Federal Services; notice of the external review process; a copy of a request for an external review by MAXIMUS Federal Services ; and procedures for filing a complaint.

If the Appeal of an Adverse Determination is denied and, within ten (10) working days from the denial, the Appeal denial will be reviewed by a Participating Provider in the same or similar specialty that typically manages the medical, dental or specialty condition, procedure, or treatment under discussion for review of the Adverse Determination. This specialty review will be completed within fifteen (15) business days of receipt of the request.

External Review by MAXIMUS Federal Services
You, an individual acting on Your behalf, or Your Provider has the right to request an immediate review of Our Appeal decision with MAXIMUS Federal Services. You do not have to exhaust Our Appeal process before asking for an external review if the Appeal process timelines are not met or if You have an urgent care situation. Our notice of determination of the Appeal will include a form for making a request for an external review with MAXIMUS Federal Services. MAXIMUS Federal Services is required to issue an urgent care decision to Us and You no later than 72 hours from receipt of the request for external review and no later than 45 days for Standard request. There is no cost to You for the external review.

Retrospective Utilization Review
If a retrospective Utilization Review is conducted and results in an Adverse Determination, the We will notify You and Your Provider of the Adverse Determination within a reasonable period, but not later than thirty (30) days after the date when the claim was received.

The thirty (30) day period may be extended for another fifteen (15) days if We determine that an extension is necessary due to matters beyond Our control and You and Your Provider are notified of the extension with expected determination date within thirty (30) days of when the claim was received.

If an extension is necessary due to a failure of You or Your provider to submit information necessary to reach a determination on the request, the notice will specifically describe the required information necessary to make the determination and will give You and Your Provider at least forty-five (45) days from the date of the receipt of the notice of extension to provide the specified information.

Complaint Process

If You notify Us with an oral or written Complaint, We will send You, not later than the fifth business day after the date of receiving the Complaint, a letter acknowledging the date We received the Complaint. If Your Complaint was received orally, We will enclose a one-page Complaint form with a complaint acknowledgement letter. You do not have to return the complaint form but we ask that You send it back because the form will help us resolve Your complaint. We will resolve Your Complaint not later than the thirtieth (30th) calendar day after the date We receive Your written Complaint or Oral Complaint. If Your Complaint concerns an emergency or a denial of continued hospitalization, We shall investigate and resolve Your Complaint in accordance with the immediacy of Your Condition, but in no event later than one business day after We receive Your Complaint. After We have reviewed Your Compliant, We will issue You a response letter that:

- explains the resolution of the complaint,
- states the specific medical or contractual reasons for the resolution,
- states the specialization of any physician or provider consulted, and
- contains a complete description of the process for appealing the decision, along with the deadlines for the appeals process and the deadlines for the final decision on the appeal.

Appeals from a Complaint

If Your Complaint is not resolved to Your satisfaction, You have the right to either appear in person before a complaint appeal panel in a location in which You normally receive Health Care Services or another location to which You find agreeable, or to address a written Appeal to the complaint appeal panel. We will complete the complaint appeal process not later than the thirtieth (30th) calendar day after the date of the receipt of Your request for Appeal. If Your Appeal of a Complaint relates to an ongoing emergency or denial of continued hospitalization, the resolution shall be concluded in accordance with the immediacy of Your case and not later than one business day after Your request for Appeal is received.

Composition of Complaint Appeal Panel

We shall appoint members to the complaint appeal panel, which will advise Us on the resolution of the dispute. The appeal panel will be composed of an equal number of the Plan staff, Physicians or other Providers, and Plan enrollees. A member of a complaint appeal panel may

not have been previously involved in the disputed decision. The Physicians or other Providers on a complaint appeal panel must have experience in the area of care that is in dispute and must be independent of any Physician or Provider who made any previous determination.

If specialty care is in dispute, the complaint appeal panel must include a person who is a specialist in the field of care to which the appeal relates. The enrollee members of a complaint appeal panel may not be employees of the Plan.

We shall provide You or Your designated representative within five (5) business days any documentation to be presented to the complaint appeal panel by Our staff; the specialization of any Physicians or Providers consulted during the investigation; and the name and affiliation of each Plan representative on the complaint appeal panel.

You or your designated representative has the right to:

- appear in person before the complaint appeal panel;
- present alternative expert testimony; and
- request the presence of and question any person responsible for making the disputed decision that resulted in the appeal.

Our notice of the final decision on an Appeal shall include a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision, along with the toll-free telephone number and address of TDI.

We shall maintain a Complaint and Appeal log for each Complaint. You are entitled to a copy of the record of Your Complaint and any proceeding relating to that Complaint. If We decide in favor of paying for the Health Care Services, We will provide payment within 45 days after the day of the final decision.

Filing Complaints with the Texas Department of Insurance

Any person, including persons who have attempted to resolve a Complaint through Our Appeals and Complaint Process and who are dissatisfied with the resolution, may complain to the Texas Department of Insurance by calling toll-free to 1-800-252-3439. If You would like to make Your request in writing, send it to:

Texas Department of Insurance
P.O. Box 12030
Austin, Texas 78711-2030

If You can access the internet, You can send Your complaint in an email to:
www.tdi.texas.gov/consumer/complfrm.html

The commissioner shall investigate a complaint against Us to determine compliance within 60 days after the Texas Department of Insurance's receipt of the complaint and all information

necessary for the Department to determine compliance. The commissioner may extend the time necessary to complete an investigation in the event any of the following circumstances occur:

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

Exhaustion of Remedies

You must complete levels of Our Appeal and Complaint Process applicable to You and any regulatory/statutory review process available to You under state or federal law before You file a legal action. Completion of these administrative and regulatory processes assures that both You and We have a full and fair opportunity to resolve any disputes regarding the terms and conditions contained in this Contract.

If exhaustion of internal appeals is required prior to external review, exhaustion must be unnecessary and the internal appeals process will be deemed exhausted if:

- We waive the exhaustion requirement;
- We are considered to have exhausted the internal appeals process by failing to comply with the requirements of the internal appeals process; or
- You request an expedited internal appeal and an expedited internal appeal and an expedited external review at the same time.

Exception to exhaustion requirement.

The internal claims and appeals process will not be deemed exhausted based on violations by the health care plan that are *de minimus* and do not cause, and are not likely to cause, prejudice or harm to the Complainant, so long as the health care plan demonstrates that the violation was for good cause or due to matters beyond the control of the health care plan, and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the Complainant. This exception is not available if the violation is part of a pattern or practice of violations by the health care plan.

You may request a written explanation of the violation from Us. We must provide such explanation within 10 days. We must include a specific description of Our basis, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted.

If an external reviewer or a court rejects Your request for immediate review under this section on the basis that We met the standards for the exception of this section, You have the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), We must provide You with notice of the opportunity to resubmit and pursue the internal

appeal of the claim. Time periods for re-filing the claim shall begin to run upon Complainant receipt of such notice.

Culturally and Linguistically Appropriate Manner of Notice
As We work with You under this Section, We will ensure that We provide a culturally and linguistically appropriate manner of notice, which means notice to You will meet the following requirements:

- We provide oral language services (such as a telephone customer assistance hotline) that includes answering questions in any applicable non-English language and providing assistance with filing claim and appeals (including external review) in any applicable non-English language;
- We provide, upon request, a notice in any applicable non-English language; and
- We include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the health care plan.

With respect to an address in any Texas county to which a notice is sent, a non-English language is an applicable non-English language if ten percent (10%) or more of the population residing in the county is literate only in the same non-English language, as determined by the department of health and human services (HHS); the counties that meet this ten percent (10%) standard, as determined by HHS, are found at http://cciio.cms.gov/resources/factsheets/clas-data.html and any necessary changes to this list are posted by HHS annually.

PAYMENT OF PREMIUM

Payment of Premium
You are responsible for the timely prepayment of all Premiums. The first premium is due with the enrollment application. Subsequent premiums are due on the first day of month for the coverage provided during that month Premium period means monthly. All premiums are payable to Us.

You must pay the required premium to Us as it becomes due. If We do not receive Your premium on time, or within the Grace Period We will terminate coverage in accordance with the TERMINATION OF COVERAGE section of this Contract. We will not be financially responsible for any services rendered after that date.

Grace Period
A grace period of 30 days will be granted for the payment of each premium due after the first premium. During the grace period, coverage shall continue in force. If payment is not received within the 30 day grace period, coverage will be terminated as of the last day of the month before the grace period began.

Example: April payment is due April 1. If payment is not received by April 30, coverage is terminated retroactive to the last day of March.

Changes in Premium Payments
CHRISTUS Health Plan reserves the right to change the Premium Payment amount for the Covered Benefits upon at least 60 days' advance notice in writing. Your rate may change. A few examples of why are:

- A change of residence;
- The addition of a Dependent due to a Qualifying Event;
- A request to change benefits that is approved by the Underwriting department; or
- Termination of a Dependent on a family Contract.

Recovery of Excess Benefit Overpayments
We have the right to recover any overpayments that We have made. Recovery may be sought from one or more of the following: any person to, for, or with respect to whom such services were provided or such payments were made; any third party payor; any health care plan or other organization. If We notify You (or Your legal representative if You are a minor or legally incompetent) that We are pursuing the recovery of these benefits, We ask that You cooperate with Us to secure these recovery rights.

GENERAL PROVISIONS

Amendments
Your Contract may be changed at any time. We will give You sixty (60) days' notice prior to any change. You will receive an amendment to Your Contract showing any change.

Assignment
We specifically reserve the right to pay You directly and to refuse to honor an assignment of benefits in any circumstances. No person may execute any power of attorney to interfere Our right to pay You instead of anyone else.

Availability of Provider Services
We do not guarantee that a Hospital, Health Care Facility, Physician, or other Provider will be available in the Provider Network.

Circumstances Beyond Our Control
If a disaster occurs, We will make a good faith effort to help You get Covered Services, and We will remain responsible for payment for Covered Services; however, We will not be liable for damages resulting from delays, or failures due to a lack of facilities or personnel that are beyond Our control. Examples of disasters are earthquakes, epidemics, war, and riots.

Clerical Error
A clerical error in record keeping will not void coverage otherwise validly in force, nor will it continue coverage otherwise validly terminated. Upon discovery of the error an equitable adjustment of premium shall be made.

Computation of Time
Whenever the Texas regulation requires that an action be taken within a certain period of time from receipt of a request or document, the request or document shall be deemed to have been received within 3 working days of the date it was mailed.

Conformity with State Statutes
Any provision which, on its Effective Date, is in conflict with the statutes of the state in which You reside, is hereby amended to conform to the minimum requirements of such statutes and shall not be rendered invalid but shall be construed and applied as if it were in full compliance with all applicable laws.

Disclaimer of Liability
We have no control over the diagnosis, treatment, care, or other service provided to a You by any facility or Provider, whether a Participating or Non-Participating Provider. We are not liable for loss or injury caused by any health care Provider by reason of negligence or otherwise.

Entire Contract
This Contract and Evidence of Coverage, together with the *Schedule of Benefits* and *Formulary*; the Application; and any supplements; amendments; or endorsements collectively constitute the Entire Contract between Us and You. No change in this Contract is valid unless it is in writing and is approved by one of Our executive officers. You will be notified of any such changes. No agent may change this Evidence of Coverage or waive any of its provisions.

Execution of a Contract – Application for Coverage
All statements, in the absence of fraud or the intentional misrepresentation of a material fact, made by any applicant (You and/or Your Dependents) shall be deemed representations and not warranties. No such statements shall void Coverage or reduce benefits unless contained in a written Application that is signed by the Subscriber and that has been furnished to the Subscriber or their representative.

Federal and State Health Care Reform
This Contract shall comply with all applicable state and federal laws, rules and regulations. Upon the compliance date of any change in law, or the promulgation of any final rule or regulation which directly affects Our obligations under this Contract, this Contract will be modified and submitted for appropriate state and/or federal approval. We will notify You when this happens.

Fraud
We are required to cooperate with government, regulatory and law enforcement agencies in reporting suspicious activity. This includes both Provider and Member activity.

Governing Law
The Contract is issued in the State of Texas and shall be interpreted under the laws of the State of Texas and applicable federal rules and regulation.

Hospitalization on the Effective Date of Coverage
If You are confined in a Hospital on the Effective Date of Your coverage, You must notify the Plan of the hospitalization within two (2) days; or as soon as reasonably possible thereafter.

Identification Cards
We issue Identification (ID) Cards to You for identification purposes only. Possession of Our ID Card confers no rights to services or other benefits under this Contract. To be entitled to such services or benefits, the holder of the ID Card must, in fact, be a Member on whose behalf all applicable Contract charges have actually been paid. If You or any family member permits the use of Your ID Card by any other person, all Your rights and those of other members of Your family pursuant to this Contract may be immediately terminated at Our discretion. Any person receiving services or other benefits to which he or she is not then entitled pursuant to the provisions of this Contract shall be charged therefore at the rates generally charged in the area for medical, Hospital and other Health Care Services.

Independent Contractors
Participating Providers are not employees, representatives or agents of the Plan. They are independent contractors. The Plan is not liable or responsible for their actions or failure to act. You are encouraged to contact Member Services at 1-844-282-3025 if You are not satisfied with Your care.

Legal Actions
No legal action shall be brought to recover on this Plan by the Group or Member prior to the expiration of sixty (60) days after written proof of loss has been furnished, in accordance with the requirements of state law. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

Member Activity
Anyone who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and subject to fines and confinement in state prison. We may terminate enrollment for any Member for any type of fraudulent activity. Some examples of fraudulent activity are:

- Falsifying enrollment information;
- Allowing someone else to use Your ID Card;
- Forging or selling prescriptions; or
- Misrepresenting a medical condition in order to receive Covered benefits to which You would not normally be entitled.

Misrepresentation of Information
If, in the first two (2) years from the effective date of Your and/or Your Dependents Coverage, You intentionally omitted information from Your Application and/or You provided fraudulent or false information, the Coverage for You and/or Your Dependent shall be null and void from the effective date. In the case of fraud, no time limits shall apply and You will be required to pay for all benefits that We have provided. We will furnish You a signed copy of the enrollment application.

If the age of the Member has been misstated all amounts payable under this Contract shall be adjusted to reflect the premium that would have been paid for the correct age.

Misstatements
All statements made 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 a Member’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.

This Contract may only be contested because of fraud or intentional misrepresentation of material fact made on the enrollment application.

Notice
If We are required or permitted by this Contract to give any Notice to You, it shall be given appropriately if it is in writing and delivered personally or deposited in the United States mail with postage prepaid and addressed to You at the address of record on file at Our principal office. You are solely responsible for ensuring the accuracy of Your address of record on file with Us.

Opportunity to Examine the Plan Document
The Subscriber to whom the contract is issued may examine it and You are not satisfied with it for any reason, You are permitted to return it within 10 days of receiving it and receive a refund of the premium paid. If services are rendered or claims paid during the 10 day examination period, You are responsible for repaying Us for such services or claims. This consideration, including premiums, application fee, and any other amounts to be paid for coverage will be expressed in the agreement or in the application.

Policies and Procedures
We may adopt reasonable policies, procedures, rules, and interpretations for the purposes of promoting the orderly and efficient administration of the Contract.

Practitioner/Provider Activity
If You suspect that a Practitioner, pharmacy, Hospital, facility or other Health Care Professional has done any of the items listed below, please call the Practitioner or Provider and ask for an explanation, as there may be an error.

- Charged for services that You did not receive
- Billed more than one time for the same service
- Billed for one type of service, but gave You another service (such as charging for one type of equipment but delivering another less expensive type)
- Misrepresented information to You (such as changing Your diagnosis or changing the dates that You were seen in the office)

If You are unable to resolve the issue with the Provider, or if You suspect any other suspicious activity, please contact Our Member Services.

Reinstatements
We may reinstate this Contract after termination without the execution of a new Application or the issuance of a new Identification Card or any notice to You. In any case where termination resulted from failure to make timely payment of premium, CHRISTUS will allow reinstatement within 30 days after termination was applied, if the member can prove that the original payment, or a payment attempt, was made before the original invoice due date. In such a case, the member must also pay all owed premium, both prior month(s) and current month, in order for

reinstatement to be applied. There shall not be any gaps in coverage as a result of a reinstatement. If reinstatement is applied, the original Evidence of Coverage will be in effect.

Time Limit on Certain Defenses
You must fully and accurately complete the enrollment application on behalf of Yourself and any eligible dependents that You wish to enroll in the Plan. All statements, in the absence of fraud, made by the applicant on the enrollment application shall be deemed representations and not warranties. No such statements shall be used to void coverage or to reduce benefits unless contained in a written application of this Contract. In the event that a misstatement in an application is made that was NOT fraudulent or willful, We may prospectively rate and collect from You the premium that would have been charged at the time coverage was effect had such misstatement not been made.

Waiver by Agents
No agent or other person, except an officer of CHRISTUS Health Plan, has the authority to waive any conditions or restrictions of this Contract, to extend the time for making payment, or to bind CHRISTUS Health Plan, by making promise or representation or by giving or receiving any information. No such waiver, extension, promise, or representation shall be valid or effective unless evidenced by an Endorsement or amendment in writing to this Contract or a Letter of Agreement signed by a CHRISTUS Health Plan officer.

Workers' Compensation Insurance
This Contract is not in lieu of and does not affect any requirement for Coverage by the Texas Workers Compensation Act. However, an employee of a professional or business corporation may affirmatively elect not to accept the provisions of the Texas Workers Compensation Act if they are an executive officer of that professional or business corporation and owns ten percent (10%) or more of the outstanding stock of the professional business corporation.

For purposes of the Texas Workers Compensation Act, an executive officer means the chairman of the board, president, vice-president, secretary or treasurer of a professional or business corporation.

In the event that an employee chooses to opt out of worker's compensation coverage, and meets the criteria stated above, We will provide 24-hour health care Coverage to those employees, subject to the eligibility requirements for Coverage with Us.

In addition to meeting all of Our eligibility requirements, documentation indicating that the aforementioned criteria have been met will be required in order for Coverage with Us to become effective.

DEFINITIONS

Unless specifically defined elsewhere, wherever used in this Contract, the following terms have the meanings given below:

Accidental Injury means a bodily injury caused solely by external, traumatic, and unforeseen means. Accidental Injury does not include disease or infection, hernia or cerebral vascular accident. Dental injury caused by chewing, biting, or malocclusion is not considered an Accidental Injury.

Acquired Brain Injury means an injury to the brain that occurs after birth, is non-congenital and non-degenerative and prevents the normal function of the brain. Brain injuries may be mild, moderate or severe and may result in memory loss, change in personality, behavior dysfunction, difficulty managing anger, impaired judgment, loss of judgment.

Acupuncture means the use of needles inserted into and removed from the body and the use of other devices, modalities and procedures at specific locations on the body for the prevention, cure or correction of any disease, Illness, injury, pain or other Condition by controlling and regulating the flow and balance of energy and functioning of the person to restore and maintain health.

Administrative Complaint means an oral or written complaint submitted by or on behalf of a Complainant regarding any aspect of a health benefits plan other than a request for Health Care Services, including but not limited to:

- administrative practices of the health care plan that affects the availability, delivery, or quality of Health Care Services;
- claims payment, handling or reimbursement for Health Care Services; and
- termination of coverage.

Adverse Determination means a determination by a health maintenance organization or a utilization review agent that health care services provided or proposed to be provided to an enrollee are not medically necessary or are not appropriate.

Alcoholism means alcohol dependence or alcohol abuse meeting the criteria as stated in the Diagnostic and Statistical Manual IV for these disorders.

Allowable Charge is the amount that We have determined to be the maximum amount payable for a Covered Service. For Covered Services provided by Non-Participating Providers, the amount payable will be either a rate agreed upon by Us and the Non-Participating Provider, or based upon Our out-of-network fee schedule. Our out-of-network fee schedule is based on generally accepted industry standards and practices for determining the customary billed charge for a service, and fairly and accurately reflects market rates, including geographic differences in

costs, and is consistent with nationally recognized and generally accepted bundling edits and logic. Allowable Charge does not apply to contracted Providers.
Ambulance is a vehicle which is licensed solely as an Ambulance by the local regulatory body to provide Emergency transportation to a Hospital or transportation from one Hospital to another Health Care Facility for those individuals who are unable to travel to receive medical care by any other means or the Hospital cannot provide the needed care. Air Ambulance charges are payable only for transportation from the site of an Emergency to the nearest Hospital that is equipped to treat the Condition instead of local Ambulance service.

Ambulatory Services are Health Care Services delivered at a Provider's office, clinic, medical center, or Ambulatory Surgical Facility in which the patient's stay is no longer than 24 hours.

Ambulatory Surgical Facility means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and which is duly licensed by the appropriate state and local authority to provide Ambulatory Services.

Annual Out-of-pocket Maximum means a specified dollar amount of Covered Services received in a Calendar Year that is the most the Member will pay (Cost Sharing responsibility) for that Calendar Year.

Application means the forms, including required medical underwriting questionnaires, if any, that each Subscriber is required to complete when enrolling for Our Coverage.

Autism Spectrum Disorder is a Condition that meets the diagnostic criteria for the pervasive developmental disorders published in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision, also known as DSM-IV-TR, published by the American Psychiatric Association, including autistic disorder; Asperger's disorder; pervasive development disorder not otherwise specified; Rett's disorder; and childhood disintegrative disorder.

Bariatric Surgery means surgery that modifies the gastrointestinal tract with the purpose of decreasing calorie consumption and therefore decreasing weight.

Behavioral Disorder is a disability characterized by displayed behaviors of sufficient duration, frequency, and intensity over a long period of time which significantly deviates from socially acceptable norms for a person's age and situation.

Biofeedback means therapy that provides visual, auditory or other evidence of the status of certain body functions so that a person can exert voluntary control over the functions, and thereby alleviate an abnormal bodily condition.

Biologicals are medical compounds that are prepared from living organisms and/or their products.

Calendar Year is the period of time beginning January 1 and ending December 31 of any given year. The initial Calendar Year period is from a Member's Effective Date of coverage and ends on December 31, which may be less than 12 months.

Cancer Clinical Trial means a course of treatment provided to a Member for the purpose of prevention or reoccurrence, early detection of treatment of cancer that is being provided in Texas.

Certification means a decision by a health plan that a Health Care Service requested by a Provider or Grievant has been reviewed and, based upon the information available, meets the health care plan's requirements for coverage and medical necessity, and the requested Health Care Service is therefore approved.

Certified Nurse Midwife is any person who is licensed by the board of nursing as a Registered Nurse and who is licensed by the Texas Department of Health as a Certified Nurse Midwife.

Certified Nurse Practitioner is a Registered Nurse endorsed by the Board of Nursing for the expanded practice as a Certified Nurse Practitioner. A Certified Nurse Practitioner's name and pertinent information is entered on the list of Certified Nurse Practitioners maintained by the Texas Board of Nursing.

Codependency means a popular term referring to all the effects that people who are dependent on alcohol or other substances have on those around them, including the attempts of those people to affect the dependent person.

Commissioner means the Texas Commissioner of Insurance.

Complainant means an enrollee, or a physician, provider, or other person designated to act on behalf of an enrollee, who files a complaint.

Complaint means any dissatisfaction expressed orally or in writing by a complainant to a health maintenance organization regarding any aspect of the health maintenance organization's operation. The term includes dissatisfaction relating to plan administration, procedures related to review or appeal of an adverse determination under Section 843.261, the denial, reduction, or termination of a service for reasons not related to medical necessity, the manner in which a service is provided, and a disenrollment decision. 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 enrollee; or a provider's or enrollee's oral or written expression of dissatisfaction or disagreement with an adverse determination.

Condition is a group of related diagnoses dealing with the same organ, system, or disease process.

Copayment is the amount that Members are required to pay to a Participating Provider or other authorized provider in connection with the provision of Health Care Services. The Copayments for this Plan are shown on the *Schedule of Benefits*.

Cosmetic Surgery means surgery that is performed primarily to improve appearance and self-esteem, which may include reshaping normal structures of the body.

Cost Sharing means any contribution Members make towards the cost of their Covered Health Care Services as defined in their Contract. This includes Copayments.

Coverage/Covered means benefits extended under this Contract, subject to the terms, conditions, Limitations, and Exclusions of this Contract.

Covered Benefit or Covered Service(s) means a benefit or service incurred by or on behalf of a Member for those services or supplies which are:

- Administered or ordered by a Physician or other qualified Provider;
- Medically Necessary to the diagnosis and treatment of an Injury or Illness;
- Not excluded by any provision of the Contract; and
- Incurred while the Member's coverage is in force under the Contract.

A Covered Service is deemed to be incurred on the date such service or supply which gave rise to the expense or charge was rendered or obtained.

Craniomandibular means the joint where the jaw attaches to the skull. Also refer to Temporomandibular Joint (TMJ).

Custodial Care means any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of a Member's Condition. Custodial Care also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine drugs, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.).

Custom-fitted Orthotics means an Orthosis which is individually made for a specific patient starting with the basic materials including, but not limited to, plastic, metal, leather, or cloth in the form of sheets, bars, etc. It involves substantial work such as cutting, bending, molding, sewing, etc. It may involve the incorporation of some prefabricated components. It involves more than trimming, bending, or making other modifications to substantially prefabricated item.

Dependent has the meaning set forth on page 12 of this Contract.

Diagnostic Service means procedures ordered by a Practitioner/Provider to determine a definite condition or disease or review the medical status of an existing condition or disease.

Division means the Texas division of insurance.

Durable Medical Equipment means equipment or supplies prescribed by a Practitioner/Provider that is Medically Necessary for the treatment of an Illness or Accidental Injury, or to prevent the Member's further deterioration. This equipment is designed for repeated use, generally is not useful in the absence of Illness or Accidental Injury, and includes items such as oxygen equipment, wheelchairs, Hospital beds, crutches, and other medical equipment.

Effective Date is 12:01 a.m. of the date on which the Member's coverage begins.

Emergency Care or **Emergency Care Services** are health care services provided in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize Emergency Medical Conditions.

Emergency Medical Condition is a severe Injury or a medical Condition of a recent onset and severity, including severe pain. The Injury or medical Condition must be one that would lead a prudent layperson with an average knowledge of medicine and health to believe that failure to get immediate medical care could: (a) place such person's life or health in serious jeopardy; (b) result in serious impairment to bodily functions; (c) result in serious impairment to a bodily organ or part; or (d) result in serious disfigurement; (e) or for a pregnant woman, result in serious jeopardy to the health of a fetus.

Essential Health Benefits are determined by HHS under PPACA and are subject to change, but currently include the following general categories of service: Ambulatory Services; Emergency Care Services; hospitalizations; maternity and newborn services; services for Behavioral Disorders, Mental Illness disorders or Substance Abuse Conditions; Prescription Drugs; rehabilitative and Habilitative Services and devices; lab services; preventive and wellness services; services related to chronic disease management; and pediatric services, including oral and vision care.

Excluded Services means Health Care Services that are not Covered Services and that We will not pay for.

Experimental, Investigational or **Unproven** means any treatment, procedure, facility, equipment, drug, device, or supply that is not accepted as standard medical practice in the state where services are provided. In addition, if a federal or other governmental agency approval is required for use of any items and such approval was not granted at the time services were administered, the service is Experimental. To be considered standard medical practice and not Experimental or Investigational, treatment must meet all five of the following criteria:

- A technology must have final approval from the appropriate regulatory government bodies;
- The scientific evidence as published in evidence-based, peer-reviewed literature must permit conclusions concerning the effect of the technology on health outcomes;
- The technology must improve the net health outcome;
- The technology must be as beneficial as any established alternatives; and
- The improvement must be attainable outside the Investigational settings.

External Review means external appeal

Follow-up Care is the contact with, or re-examination of a patient at prescribed intervals following diagnosis or during a course of treatment.

Formulary is a listing of covered drug products selected by Us in consultation with a team of health care Providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. You may obtain Your *Formulary* by calling the telephone number on Your ID card.

Genetic Inborn Errors of Metabolism (IEM) means a rare, inherited disorder that is present at birth and results in death or mental retardation if untreated and requires consumption of special medical foods.

Habilitative Services means Health Care Services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include Physical and Occupational Therapy, speech-language pathology, and other services for people with disabilities in a variety of Inpatient and/or outpatient settings.

Health Benefits Plan means a health plan or a Contract, contract, certificate or agreement offered or issued by a health care plan or plan administrator to provide, deliver, arrange for, pay for, or reimburse the costs of Health Care Services.

Health Care Facility means an institution providing Health Care Services, including a hospital or other licensed inpatient center; an ambulatory surgical or treatment center; a skilled nursing center; a residential treatment center; a home health agency; a diagnostic, laboratory or imaging center; and a rehabilitation or other therapeutic health setting.

Health Care Plan means a person that has a valid certificate of authority in good standing to act as a health maintenance organization, nonprofit health care plan or prepaid dental plan.

Health Care Professional means a physician or other health care practitioner, including a pharmacist, who is licensed, certified or otherwise authorized by the state to provide Health Care Services consistent with state law.

Health Care Services means, to the extent offered by the Plan, services, supplies, and procedures for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury, or disease, and includes, to the extent offered by the health benefits plan, physical and mental health services, including community-based mental health services, and services for developmental disability or developmental delay.

Health Maintenance Organization means any person who undertakes to provide or arrange for the delivery of basic Health Care Services to enrollees on a prepaid basis, except for enrollee responsibility for cost sharing.

HHS means the United States Department of Health and Human Services.

Home Health Agency means an agency or organization that:

- Specializes in giving nursing care or therapeutic services in the home;
- Is licensed to provide such care or services by the appropriate licensing agency where services are performed or is certified as a Home Health Agency under Title XVlll of the Social Security Act of 1965, as amended;
- Is operating within the scope of its license of certification; and
- Maintains a complete medical record for each patient.

Home Health Agency does not mean any other similar service or agency which does not meet this definition, even if the service or agency meets some of the above requirements or provides some or all of the services which may be provided by a Home Health Agency.

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

- Drugs and IV solutions;
- Pharmacy compounding and dispensing services;
- All equipment and ancillary supplies necessitated by the defined therapy;
- Delivery services;
- Patient and family education; and
- Nursing services.

Hospice Care Program means an organization duly licensed to provide Hospice Care Program Services. An approved Hospice must be licensed when required, Medicare-certified as a Hospice, or accredited by the Joint Commission on Accreditation of Healthcare Organization (JCAHO) as a Hospice.

Hospice Care Program Services means a centrally administered program designed to provide for the physical, psychological and spiritual care for dying persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort

while maintaining dignity and a quality of life. Hospice Care Program Services is available in the home, in a Skilled Nursing Facility, or in a special hospice care unit.

Hospital is an institution licensed, accredited or certified by the State providing Health Care Services under the care of a Physician which:

- Provides 24-hour nursing service by licensed Registered Nurses (R.N.);
- Mainly provides diagnostic and therapeutic care under the supervision of Physicians while Hospital Confined; and
- Maintains permanent surgical facilities or has an arrangement with another surgical facility supervised by a staff of one or more Physicians.

Hospital also includes certain tax-supported institutions, which may not be required to maintain surgical facilities. Hospital does not mean health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, custodial homes of the aged or similar institutions.

Illness means a sickness or disease, including all related Conditions and occurrences, requiring Health Care Services.

In-network means care received from a Participating Provider.

Injury is bodily injury due to an accident which results solely, directly and independently of disease, bodily infirmity, or any other causes.

Inpatient means You are a registered bed patient and are treated as such in a Hospital.

Licensed Practical Nurse (LPN) means an individual who has received specialized nursing training and practical nursing experience and is duly licensed to perform nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such service.

Mammography and other breast diagnostic imaging means an imaging examination using mammography, ultrasound imaging, or magnetic resonance imaging that is designed to evaluate:

- a subjective or objective abnormality detected by a physician or patient in a breast;
- an abnormality seen by a physician on a screening mammogram;
- an abnormality previously identified by a physician as probably benign in a breast for which follow-up imaging is recommended by a physician; or
- an individual with a personal history of breast cancer or dense breast tissue.

Managed Care means a system or technique(s) generally used by third party payers or their agents to affect access to and control payment for Health Care Services. Managed care techniques most often include one or more of the following:

- Prior, concurrent, and retrospective review of the medical necessity and appropriateness of services or site of services;
- Contracts with selected health care providers;
- Financial incentives or disincentives for enrollees to use specific providers, services, or service sites;
- Controlled access to and coordination of services by a case manager; and
- Payer efforts to identify treatment alternatives and modify benefit restrictions for high cost patient care.

Maternity means Coverage for prenatal, intrapartum, perinatal or postpartum care.

Medicaid means Title XIX and/or Title XXI of the Social Security Act and all amendments thereto.

Medical Director is a Physician who serves to manage the provision of Health Care Services to Our Members.

Medically Necessary means a treatment, drug, device, procedure, supply or service that is necessary and appropriate for the diagnosis or treatment of an Illness or Injury in accordance with generally accepted standards of medical practice in the United States at the time it is provided.

A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if it:

- Is Experimental, Investigational or Unproven or for research purposes;
- Is provided solely for educational purposes or the convenience of the patient, the patient's family, Physician, Hospital, or any other Provider;
- Exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or preventive care;
- Could have been omitted without adversely affecting the patient's Condition or the quality of medical care;
- Involves treatment of or the use of a medical device, drug, or substance not formally approved by the U.S. Food and Drug Administration (FDA); or
- Involves a service, supply, or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual.

We may require You or Your Provider to furnish peer-reviewed, evidence-based scientific literature that demonstrates that the service is required for the health of the Member.

Medicare means Title XVIII of the Social Security Act and all amendments thereto.

Member is an individual:

- who meets each of the enrollment and eligibility requirements described in this Contract;
- who has been properly enrolled in coverage with Us; and
- for whom We have received any required Premium for the enrolled coverage.

Mental Illness/Disorder is any Condition listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV, or current edition), and/or Mental Disorders Section of the International Classification of Disease.

Non-Participating Provider means a Provider that is not a Participating Provider and that offers out-of-area services.

Nutritional Support means the administration of solid, powder or liquid preparations provided either orally or by enteral tube feedings. It is Covered only when enteral tube feedings are required.

Obstetrician/Gynecologist (OB/GYN) is a Physician that is board eligible or certified by the American Board of Obstetricians and Gynecologists, or by the American College of Osteopathic Obstetricians and Gynecologists.

Occupational Therapy means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function and improve a Member's functional ability to perform activities of daily living.

Orthotic Appliances/Devices/Orthosis means an individualized rigid or semi-rigid supportive device constructed and fitted by a licensed orthopedic technician which supports or eliminates motion of a weak or diseased body part.

Out-of-Network Services means Health Care Services Obtained from a Non-Participating Provider.

Outpatient Hospital is a place to receive Covered Services while not an Inpatient. Services considered Outpatient include, but are not limited to, services in an Emergency room regardless of whether You are subsequently admitted as an Inpatient in a Hospital.

Participating Provider is a Physician, Provider, Hospital or Health Care Facility that has an agreement with Us to accept Our rates and payments as payment in full when providing Health Care Services to Members.

PPACA means the federal Patient Protection and Affordable Care Act.

Physical Therapy is therapy for the preservation, enhancement, or restoration of movement and physical function impaired or threatened by Illness or Injury that utilizes therapeutic exercise,

physical modalities (as massage and electrotherapy), assistive devices, and patient education and training.

Physician is one of the following:

- A doctor of medicine, surgery, or osteopathy;
- A doctor of podiatry or a doctor of chiropractic; or
- Any other licensed Provider who is required to be recognized as a Physician by state law and acts within the scope of his/her license to treat an Illness or Injury.

Physician Assistant is a person who has graduated from a nationally-recognized physician assistant or assistant surgeon program; or who is currently certified by the national commission of Physician Assistants. A Physician Assistant must be licensed to practice medicine under the supervision of a licensed Physician in the state in which they practice.

Plan means the health benefit plan established by CHRISTUS Health Plan and selected by the Member to provide Health Care Services to Members, as it exists on the Effective Date of this Contract or as subsequently amended as provided herein.

Preauthorization means a decision by a Health Care Plan that a Health Care Service requested by a Practitioner/Provider or Covered Person has been reviewed and, based upon the information available, meets the Health Care Plan's requirements for Coverage and Medical Necessity, and the requested Health Care Service is therefore approved.

Prescription Drugs are drugs for which sale or legal dispensing requires the order of a Provider with legal authority to prescribe drugs.

Primary Care Physician or **Primary Care Provider** or **PCP** is the Physician or other Provider You see first for most health problems. Your PCP makes sure You get the care You need to keep You healthy. Your PCP also may talk with other Physicians and Providers about Your care and refer You to them. PCPs include, but are not limited to family practice Physicians; general practitioners; internists; pediatricians; Obstetricians and/or Gynecologists (OB/GYNs). Your PCP is responsible for providing Your Primary Care Services. These include annual examinations; routine immunizations; and treatment of non-emergency acute illnesses and injuries.

Primary Care Services are services provided by a PCP or primary Provider of Health Care Services.

Provider means a duly licensed Hospital, Physician, or other practitioner of the healing arts that is authorized to render Health Care Services within the scope of their license.

Provider Network means a list of the Providers that are Participating Providers.

Qualified Medical Child Support Order is an order from a State or Federal government agency or court. It requires a person to provide health care coverage for specific dependents.

Reconstructive Surgery for Craniofacial Abnormalities means surgery 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, infections, or disease.

Rescission of Coverage means a cancellation or discontinuance of coverage that has retroactive effect; a cancellation or discontinuance of coverage is not a rescission if:

- the cancellation or discontinuance of coverage has only a prospective effect; or
- the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Registered Nurse is an individual who has received specialized nursing training, is authorized to use the designation of (R.N.) and who is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

Rehabilitation means care for restoration (including by education or training) of a Member's prior ability to function at a level of maximum therapeutic benefit. This type of care must be acute Rehabilitation, sub-acute Rehabilitation, or intensive day Rehabilitation, and it includes Rehabilitation Therapy and pain management programs. An Inpatient Hospitalization will be deemed to be for Rehabilitation at the time the Member has been medically stabilized and begins to receive Rehabilitation Therapy or treatment under a pain management program.

Rehabilitation Therapy means Physical Therapy, Occupational Therapy, Speech Therapy, or Respiratory Therapy.

Residential Treatment Center means a non-acute level facility that is credentialed and provides overnight lodging that is monitored by medical personnel, has a structured treatment program, and has staff available 24 hours a day.

Respiratory Therapy means a medically supervised, individualized, physical conditioning program designed and adapted to promote and improve the lung and breathing health and well-being of a Member and would include simple breathing exercises and advice on posture and the use of supplementary devices that aid in removing mucus from the airways and improve the strength of the lungs. Respiratory therapists train You in bronchial hygiene, proper use of inhalers, and proper breathing.

Schedule of Benefits means the written materials required by NMSA 1978 Section 59A-57-4 to be given to the Grievant by the health care plan or group contract holder.

Screening Mammography, or "low-dose mammography", means the x-ray examination of the breast using equipment dedicated specifically for mammography, including an x-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one radiation mid-breast, with two views for each breast.

Second Opinions provide an opportunity or requirement to obtain a clinical evaluation by a Provider other than the one originally making a recommendation for a proposed health service to assess the Medical Necessity and appropriateness of the initial proposed health service.

Service Area is the geographical area that CHRISTUS Health Plan is authorized by law to serve. CHRISTUS Health Plan's Service Area map is provided in this booklet.

Skilled Nursing Care refers to services ordered by a Physician which require the clinical skills and professional personnel of a Registered Nurse (RN) or Licensed Practical Nurse (LPN). Skilled Care is provided directly by or under the supervision of such personnel to a patient who needs those services twenty-four (24) hours a day, along with other treatment, for recovery from illness or injury. Skilled Care does not include Custodial Care.

Skilled Nursing Facility means a place that:

- Is legally operated as a Skilled Nursing Facility;
- Primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Care under the supervision of a Physician;
- Provides continuous 24 hours a day nursing service by or under the supervision of a Licensed Practical Nurse;
- Maintains a daily medical record on each patient; and
- Provides Rehabilitation services, such as Physical, Occupational and Speech therapy, and may provide other multidisciplinary services, such as Respiratory Therapy, dietician/nutrition services, and medical social work.

Skilled Nursing Facility does not include any facility that is primarily a rest home, a facility for the care of the aged, or for treatment of drug abuse, Mental Disorder, tuberculosis, or for intermediate, custodial or educational care.

Specialist is a Physician who provides Covered Services for a specific disease or part of the body. Examples include internists who care for diseases of internal organs in adults; oncologists who care for patients with cancer; cardiologists who care for patients with heart Conditions; and orthopedists who care for patients with certain bone, joint, or muscle Conditions and psychiatrists care for Members with Behavioral Disorders or Mental Illness/Disorders.

Speech Therapy is the treatment and exercises for treating voice and speech and swallowing disorders due to diagnosed Illness or Injury provided by a qualified Provider.

Subluxation means misalignment, demonstrable by x-rays or Chiropractic examination, which produces pain and is correctible by manual manipulation

Subscriber means an individual who is the contract holder and is responsible for payment of premiums to CHRISTUS Health Plan.

Substance Abuse means alcohol, drug, or chemical abuse, overuse, or dependency.

Teledentistry means a health care service delivered by a dentist, or a health professional acting under the delegation and supervision of a dentist, acting within the scope of the dentist's or health professional's license or certification to a patient at a different physical location than the dentist or health professional using telecommunications or information technology.

Termination Date is 11:59 pm on the last day of the month for which premiums were paid and the date that the Member's coverage ends.

Termination of Coverage means the cancellation or non-renewal of coverage provided by a health care plan to a Grievant but does not include a voluntary termination by a Grievant or termination of a health benefits plan that does not contain a renewal provision;

Tertiary Care Facility is a Hospital unit that provides specialized care for high-risk patients. The facility provides and coordinates transport, communication, education and data analysis systems for the geographic area that it serves.

Uniform Standards means all generally accepted practice guidelines, evidence-based practice guidelines or practice guidelines developed by the federal government or national and professional medical societies, boards and associations, and any applicable clinical review criteria, policies, practice guidelines, or protocols developed by the health care plan consistent with the federal, national, and professional practice guidelines that are used by a health care plan in determining whether to certify or deny a requested Health Care Service.

Urgent Care means Medically Necessary Health Care Services provided in emergencies or after a Primary Care Provider's normal business hours for unforeseen Conditions due to Illness or Injury that are not life-threatening but require prompt medical attention.

Urgent Illness is a non-life-threatening illness that requires prompt medical attention. Some examples of urgent situations are sprains; a rising fever despite having taken medication; new ear pain; an asthma attack where medications are not helping; an animal bite; an object in the eye or eye infection; a cut that may need stitches; a child with severe vomiting or diarrhea; a possible broken bone; shortness of breath; a sore throat; flu symptoms; a urinary tract infection; or a migraine headache where medicines are not relieving the pain.

Utilization Review or **Utilization Management** is the process of reviewing and managing a Member's medical Conditions so that the Member receives the right care, by the right Provider, at the right time. This process maximizes benefits and ensures quality health care.

Workers' Compensation refers to the workers' compensation plan of any of the 50 United States, the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands; as well as the systems provided under the Federal Employees' Compensation Act and the Longshoreman's and Harbor Workers' Compensation Act; and any other federal, state, county, or municipal workers' compensation; occupational disease or other employer liability laws; or other legislation of similar purpose or intent.

We, Our, Us, and **CHRISTUS** refers to CHRISTUS Health Plan.

You, Your, and **Yours** refers to the Member.

Network Analysis

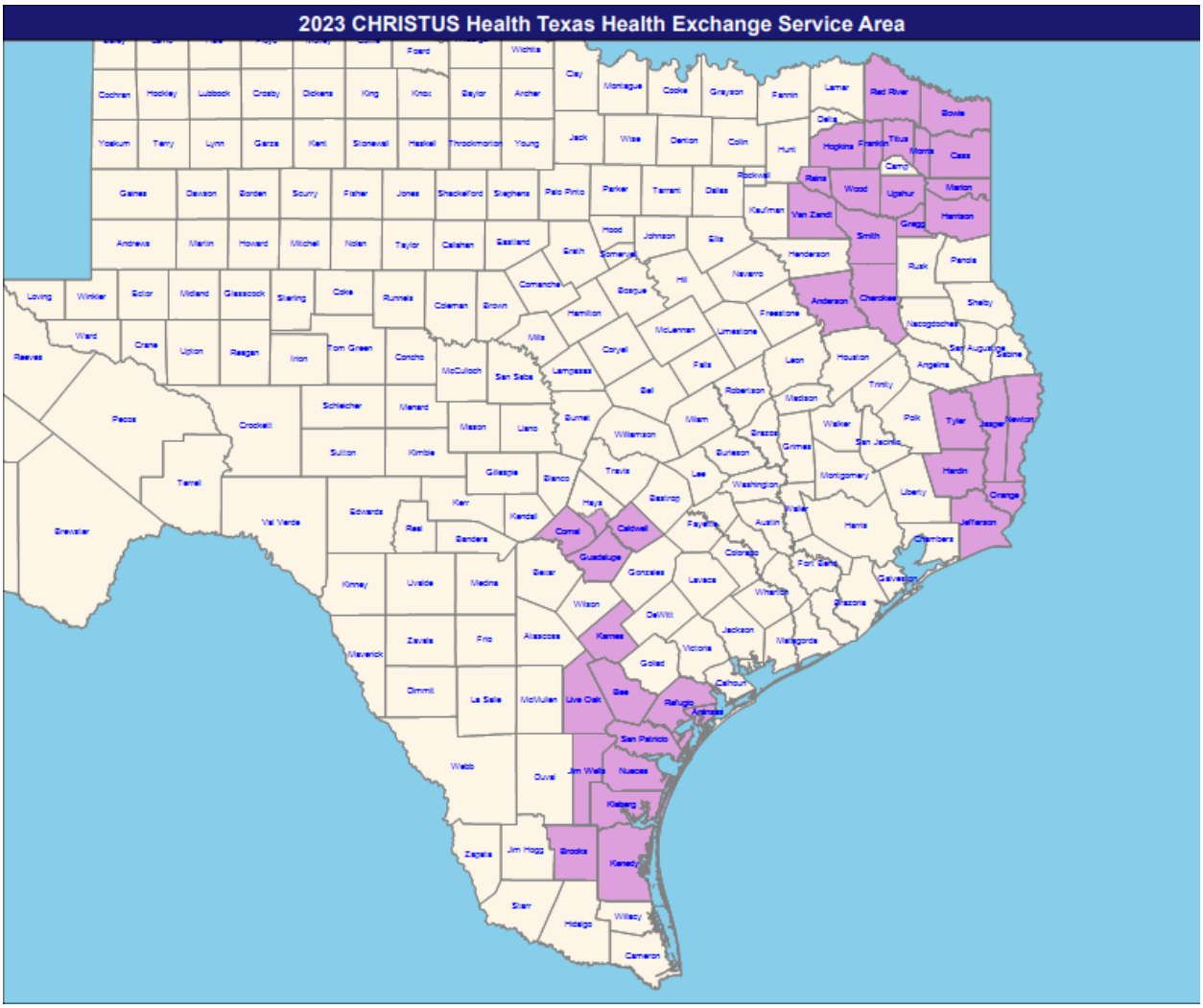
Map

June 22, 2023

Service Areas

TDI_EOC 2023

87.54 miles



CHRISTUS® Health Plan

844.282.3025 | TTY 711

Oct. 1 – Mar. 31, 7 days a week, 8 a.m. – 8 p.m., local time

Apr. 1 – Sept. 30, Mon. – Fri., 8 a.m. – 8 p.m., local time

CHRISTUShealthplan.org

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