

2026 Evidence of Coverage



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

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

*only zip code: 78666



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 Health Off-Exchange 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 CONTRACT 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 N. O'Connor Blvd.
Irving, TX 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.

IMPORTANT NOTICE

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 N. O'Connor Blvd. Irving, TX 75039	Toll-Free 1-844-282-3025 TTY 7-1-1
Preauthorization	Address: CHRISTUS Health Plan Attn: Preauthorization Department 5101 N. O'Connor Blvd. Irving, TX 75039	Toll-Free 1-844-282-3025 TTY 7-1-1
Claims	Address: CHRISTUS Health Plan Attn: Claims Department P.O. Box 169012 Irving, TX 75016	Toll-Free 1-844-282-3025 TTY 7-1-1
Complaints, Appeals and Grievances	Address: CHRISTUS Health Plan Attn: Complaints, Appeals & Grievances Department P.O. Box 169009 Irving, TX 75016	Toll-Free 1-844-282-0380 TTY 7-1-1
Fraud, Waste and Abuse	Email: CHRISTUSHealthSIU@CHRISTUSHealth.org	Toll-Free 1-855-771-8072 TTY 7-1-1
Website: www.CHRISTUSHealthPlan.org		
Language Access Services Toll Free 1-800-752-6096		

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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, or 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 any determination that the health care services provided or proposed to be provided to you are not medically necessary or appropriate or are experimental or investigational. Adverse determination does not mean a denial of health care services due to the failure to request prospective or concurrent utilization review.

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. The out-of-network fee schedule is the usual and customary rate based on CHRISTUS's median amount negotiated for in network services, and consistent with nationally recognized and generally accepted bundling edits and logic. 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.

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 not longer than twenty-four (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.

Appeal means the formal process by which you, an individual acting on your behalf, or your provider of record may request reconsideration of an adverse determination.

Application means the forms that each subscriber is required to complete when enrolling for our coverage.

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

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.

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

genome sequencing.

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.

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.

Clinical Trial means any research study that prospectively assigns human participants or groups of humans to one or more health-related interventions to evaluate the effects on health outcomes.

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.

Co-pay percentage is the shared financial responsibility for covered expenses between the covered person and this Plan, expressed as a percentage.

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.

Concurrent Utilization Review means a form of utilization review for ongoing health care services or for an extension of treatment beyond the previously approved health care services.

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.

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.

Deductible is part of the contribution that Members make toward the cost of their health care, also known as cost sharing. It means that amount the Member is required to pay each calendar year, directly to the practitioner/provider in connection with covered health care services before CHRISTUS Health Plan begins to pay covered benefits. The deductible may not apply to all health care services.

Department means the Texas Department of Insurance.

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.

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: (a) Ambulatory Services; (b) Emergency Care Services; (c) hospitalizations; (d) maternity and newborn services; (e) services for Behavioral Disorders, Mental Illness disorders or Substance Abuse Conditions; (f) Prescription Drugs; (g) rehabilitative and Habilitative Services and devices; (h) lab services; (i) preventive and wellness services; (j) services related to chronic disease management; (k) 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 or Investigational means a health care treatment, service, or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device, but that is not yet broadly accepted as the prevailing standard of care.

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 any facility providing health care services, including a hospital, emergency clinic, outpatient clinic, or other facility providing health care services.

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 copayments or deductibles.

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 XVIII 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 are 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 twenty-four (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.

Independent Review Organization (IRO) means an entity that is certified by the commissioner to conduct reviews. By law, an IRO must not be affiliated with the HMO which has denied a request for authorization for proposed treatment. IROs perform an administrative review of the medical necessity and appropriateness of health care services being provided or proposed to be provided to a Texas resident which has been denied twice as not medically necessary or not appropriate.

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

In-network means care received from a participating provider.

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;
- Can be omitted without adversely affecting the patient's condition or the quality of medical care pursuant to clinical analysis;
- 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. This may also be called an out-of-network provider.

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. This may also be called a network provider.

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.

PPACA means the federal Patient Protection and Affordable Care Act.

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 Health Plan or QHP means health care coverage that has been determined to meet the requirements in state and federal law.

Qualified Individual means an individual who has been determined eligible to enroll in a Qualified Health Plan.

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.

Rescission of Coverage means a cancellation or discontinuance of coverage that has retroactive effect. Prior to rescinding coverage, a group health plan must provide at least thirty (30) days advance written notice to each participant (in the individual market, primary subscriber) who would be affected. 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 twenty-four (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 wellbeing 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.

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 twenty-four (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.

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

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

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 fifty (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.

MEMBER RIGHTS AND RESPONSIBILITIES

CHRISTUS Health Plan wants to provide high-quality health care benefits to you. As a Member of the CHRISTUS Health Plan (Plan), there are rights that you are entitled to have. You also have 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.

NOTICE TO MEMBERS OF TEXAS HMO

Your HMO plan contracts with doctors, facilities, and other health care providers to treat its members. Providers that contract with your health plan are called "contracted providers" (also known as "in-network providers"). Contracted providers make up a plan's network. Your plan will only pay for healthcare you get from doctors and facilities in its network.

However, there are some exceptions, including for emergencies, when you did not pick the doctor, and for ambulance services.

Your Plan's Network

Your health plan must have enough doctors and facilities within its network to provide every service the plan covers. You should not have to travel too far or wait too long to get care. This is called network adequacy. If you cannot find the care you need, ask your health plan for help. You have the right to receive the care you need under your in-network benefit.

If you do not think the network is adequate, you can file a complaint with the Texas Department of Insurance at www.tdi.texas.gov or by calling 800-252-3439.

List of Doctors

You can get a directory of health care providers that are in your plan's network. You can get the directory online at www.christushealthplan.org or by calling 844-282-3025.

If you used your health plan's directory to pick an in-network health care provider and they turn out to be out-of-network, you might not have to pay the extra cost that out-of-network providers charge.

Bills for Health Care

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

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

Member Rights

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

- Available and accessible services for medically necessary and covered services, including twenty-four (24) hours per day, seven (7) days per week for urgent or emergency care services, and for other health care services as defined by this Contract or the *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 copayment amounts, including those for missed appointments. This also applies to any charges for non-covered benefits and services.
- 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 provider's 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.

You are responsible for understanding how the Plan works. You should carefully read this Contract and your *Schedule of Benefits*. Contact the Member Services department when you have questions about your Plan.

Electronic Communication

With your consent, we may deliver written communication to you by electronic means. Before you give consent, we will provide you notice that you may have materials or communications provided in paper or non-electronic format and how to request that information. You may

withdraw your consent at any time. Your consent will tell us if you would only like a specific transaction sent electronically or if there are identified categories of information you would like to receive electronically.

The notice will also provide you information on how to withdraw your consent and how to update your contact information with us.

ELIGIBILITY AND ENROLLMENT

Eligibility

We make eligibility decisions from the application that you submit. You are responsible for telling us about any changes that could change your eligibility. Examples of changes are adoption, a birth, addition of another dependent, or a divorce. To be eligible for covered benefits with this Contract, you must be enrolled as a Member. A Member is the person 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 sixty-five (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.

To add a newborn and other dependents to your Plan you must complete an enrollment form for the dependent and submit it to us. You must tell us any time prior to the birth of a child or within thirty-one (31) days after the birth of a child that 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. Your newborn child may receive services from non-participating providers if the newborn child is born outside the service area due to an emergency, or is born in a non-participating facility to a mother who does not have 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.

Notwithstanding notification eligibility requirements, a newborn child of the subscriber or the subscriber's spouse is entitled to coverage during the initial thirty-one (31) days following birth. You may notify CHRISTUS Health Plan, 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 twenty-five (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.

To be eligible as a Dependent, each dependent must meet the following criteria:

- Be a dependent of a Qualified Individual eligible for coverage under Texas law; AND either
- Be enrolled at the same time as the Member; OR
- Be enrolled within thirty-one (31) days of a Qualifying Event as described under the Special Enrollment Period for Dependents.

A Dependent is a Member's lawful spouse, or domestic partner, and children under age twenty-six (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.

Unless special circumstances apply, coverage of such Dependents is limited to those under the age of twenty-six (26). Dependents over the age of twenty-six (26) may qualify for continued dependent coverage if the Dependent is incapable of self-sustaining employment due to a mental or physical disability, and who is chiefly dependent upon the subscriber for support and maintenance. 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. Children subject to a Qualified Medical Child Support Order are also eligible for dental benefits under this Contract.

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

Non-custodial parents of children who are covered under a custodial parent's Contract have rights, unless those rights have been taken away by a 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

Online enrollment is available at <http://www.christushealthplan.org/>

Initial Enrollment

Coverage under this Contract shall become effective as of the date approved by CHRISTUS Health Plan.

Special and Limited Enrollment for Qualified Individuals

A Qualified Individual has sixty (60) days to enroll as a result of one of the following events:

- A Qualified Individual or Dependent suffers a loss of minimum essential coverage;
- A Qualified Individual gains a Dependent or becomes a Dependent through marriage, birth, adoption, placement for adoption, placement in foster care, or through a child support order or other court order;
- An individual, who was not previously a citizen, national, or lawfully present individual gains such status;
- A Qualified Individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the HHS, or its instrumentalities as evaluated and determined by the us. In such cases, the we may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
- A Qualified Individual or enrollee gains access to a new qualified health plan as a result of a permanent move;
- Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
- A Qualified Individual or enrollee demonstrates to us, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as we may provide.
- A Qualified Individual is one that in the case of marriage, at least one spouse must demonstrate having minimum essential coverage.
- A Qualified Individual or enrollee is a victim of domestic abuse or spousal abandonment; including a dependent or unmarried victim within a household, is enrolled in minimum essential coverage and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment.

- A Qualified Individual or enrollee applies for coverage on the Exchange during the annual open enrollment period or due to a qualifying event, is assessed by the Exchange as potentially eligible for Medicaid or the Children's Health Insurance Program (CHIP), and is determined ineligible for Medicaid or CHIP by the State Medicaid or CHIP agency either after open enrollment has ended or more than sixty (60) days after the qualifying event.

Loss of Minimum Essential Coverage means in the case of a Member who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). Loss of eligibility does not include a loss due to the failure to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan). Loss of eligibility for coverage includes, but is not limited to:

- Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the Plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
- In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside in a service area, loss of coverage because an individual no longer resides in the service area (whether or not within the choice of the individual);
- A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and
- A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.
- In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent.
- In the case of an employee or dependent that has coverage that is COBRA continuation coverage, the conditions are satisfied at the time the COBRA continuation coverage is exhausted. An individual who satisfies the conditions for special enrollment, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions.

Qualified Individuals that enroll between the first and fifteenth (15th) day of the month will have a coverage Effective Date of the first day of the following month. Qualified Individuals that enroll between the sixteenth (16th) and last day of the month will have a coverage Effective Date of the first day of the second following month.

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.

In the case of marriage, or in the case where the Qualified Individual loses minimum essential coverage, the Effective Date is the first day of the following month.

We may provide a coverage Effective Date for a Qualified Individual earlier than specified in the paragraphs above, provided that the Qualified Individual pays the entire premium for the first partial month of coverage, as well as all cost sharing.

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, that person shall be issued coverage in accordance with Texas statute.

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 CHRISTUS Health Plan when due, subject to the grace period provision of this Contract.
- After not less than thirty (30) days written notice, the Member no longer lives, resides, or works in the service area; except that CHRISTUS Health Plan 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 terminate coverage after ninety (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 the HMO in that service area, but only if coverage is discontinued uniformly without regard to health status-related factors of enrollees and dependents of enrollees who may become eligible for coverage, the HMO may cancel coverage after 180 days' written notice to the commissioner and the enrollees, in which case the HMO may not re-enter the individual market in that service area for five years beginning on the date of discontinuance at the last coverage not renewed.
- The Member is no longer a Qualified Individual and eligible for coverage;
- The Member engages in fraud or intentional misrepresentation of a material fact in the enrollment application, after not less than a fifteen (15) day written notice;
- The Member engages in fraud in the use of services or facilities, after not less than fifteen (15) days written notice;

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 tell 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 (30) 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 service area. The conversion plan will be the same form of coverage then being offered by CHRISTUS Health Plan that the original Member and his/her Dependents had, prior to conversion. Premiums must be paid on time. If the Dependent wishes to enroll on a different benefit plan, he/she may have 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. Emergency care services are covered even if the provider is not a participating provider.
- You must pay your cost sharing at the time you receive covered services. We will pay the provider the balance due for covered services. Your *Schedule of Benefits* has more 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 must make sure that preauthorization is in place when it is needed. Please read the HOW PREAUTHORIZATION WORKS section of this Contract for more details.
- Emergency care services outside the service area are covered, but other types of care may not be covered.

Primary Care Providers

A good relationship with your Primary Care Provider (PCP) will help you and your family make the most of your Plan benefits. As our 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 calling Member Services at 1-844-282-3025. We can help you choose a PCP that is a part of our provider network.

If you do not choose a PCP when you enroll, a PCP near your home will be selected for you. You do not have to use the PCP we automatically assign to you. Please call Member Services at 1-844-282-3025 to change your PCP.

PCPs can include 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. You should 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 CHRISTUS Health Plan to perform PCP duties. Contact Member Services at 1-844-282-3025 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 updated regularly.

You can see the online provider directory on our website at www.christushealthplan.org. You can also call Member Services at 1-844-282-3025 and ask about a participating provider.

ID Card

You have been sent a Plan ID card. If more cards are needed, you may download and print additional copies from your CHRISTUS Member Portal or call Member Services at 1-844-282-3025. 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. Cost sharing information can be found in your *Schedule of Benefits*.

You are entitled to Plan benefits for covered services if all premiums and copayment amounts have been paid and you are eligible to get 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 must pay for the services given to the non-Member. In addition, your Plan membership and that of your covered Dependents, may be terminated. Call Member Services at 1-844-282-3025 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, even if you paid your normal copay
 - 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 co-pay percentage, and 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.

Copay amounts paid for vision services that are not essential health benefits do not apply toward this Plan out-of-pocket maximum as well.service

The 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.

Co-pay percentage

The co-pay percentage is the percentage of costs of a covered service as shown on your *Schedule of Benefits*.

Copayments

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. Total cost of services provided will not exceed 50% copayment.

Third Party Prescription Drug Assistance

In accordance with Texas Insurance Code §1369.0542, if you receive financial assistance from a third party (including but not limited to a drug manufacturer coupon, product voucher, or charitable program) for a covered prescription drug, the amount of such assistance will be applied toward your deductible, coinsurance, copayment, or out-of-pocket maximum to the extent required by law.

Any exceptions to this policy will be clearly stated and applied only where permitted by statute, including circumstances where a medically appropriate generic equivalent is available and such application would circumvent formulary requirements.

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.

We will not impose copayment charges on you in any calendar year, when the copayments made in that calendar year total 200% of the total annual premium cost which is required to be paid by or on your behalf. This limitation applies only if you demonstrate that copayments in that amount have been paid in that calendar year.

HOW TO SEEK HEALTH CARE

The Plan has a network of doctors, healthcare facilities, labs and pharmacies. This section of the Contract explains how and where you can get 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, disfigurement to a person, or for a pregnant woman, serious jeopardy to the health of a 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.

We will pay the provider at a rate that we agree upon with the provider. If you receive a balance bill from a non-participating provider, contact us.

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 get Emergency Care Services from participating and non-participating

providers.

Emergency Care Services you get 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, except as set forth in maternity care. If you are admitted to a non-participating or out-of-network facility, you must contact the Plan for preauthorization. An authorized family member or caregiver should contact us if you are not able to do so. Preauthorization is needed 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 (844) 581-3175. 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 of 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.

A continuing-care patient means an individual who: (A) is undergoing a course of treatment for a serious and complex condition from the provider or facility; (B) is undergoing a course of institutional or inpatient care from the provider or facility; (C) is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery; (D) is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or (E) is or was determined to be terminally ill and is receiving treatment for such illness from such provider or facility.

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 ninetieth (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 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, co-pay percentage) 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, co-pay percentage. 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 copay percentage 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. The out-of-network fee schedule is the usual and customary rate based on CHRISTUS's median amount negotiated for in network services, and consistent with nationally recognized and generally accepted bundling edits and logic. 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 not balance bill you for amounts not paid by us. If you receive a balance bill from a non-participating or 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.** You can get information on our website at <https://www.christushealthplan.org/provider-resources/prior-authorization> or by calling Member Services at 1-844-282-3025.

What is Preauthorization?

Preauthorization is a clinical review process where we review your case to determine if a service is medically necessary and a covered benefit before that service is provided to you.

Our Medical Director or other clinical professionals will review the 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 Services at 1-844-282-3025.

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 make sure that we have processed a preauthorization, call Member Services at 1-844-282-3025. Please call at least fourteen (14) days before getting the services. If we do not issue a preauthorization, the claim may be denied.

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 twenty-four (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 reauthorization may be submitted sixty (60) days prior to the expiration.

What Services Require Preauthorization?

These services need preauthorization and are subject to the coverage rules in this Contract:

- All Medical Inpatient Acute Care Hospitalizations, including post-stabilization services, except as set forth in Maternity Care;
- All Inpatient Rehabilitation Hospitalizations;
- All Subacute Facility Admissions;
- All Inpatient Long Term Acute Care Hospitalization;
- Clinical Trial Services;
- Reconstructive Surgery;
- Craniomandibular Joint (CMJ) and Temporomandibular Joint Dysfunctions (TMJ);
- Dental Services;
- Durable Medical Equipment;
- Genetic Testing and counseling and treatment of Genetic Inborn Errors of Metabolism Disorders (IEM);
- Home Health Care;
- MRI, PET Scan or other nuclear 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.

Evaluation of New Technology

CHRISTUS Health Plan is committed to covering medical care and technology that are safe, effective, and supported by strong clinical evidence. This includes new medical technologies, new uses for existing treatments, and new medical devices.

Before a new technology is considered for coverage, it is reviewed by the Medical Management Committee. This review includes evaluating clinical research, medical guidelines, and

recommendations from trusted organizations such as professional medical societies and federal health agencies. Experts in the relevant medical field may also be consulted to provide additional insight.

If the technology is shown to be as safe and effective as current treatment options, improves health outcomes, and can be used reliably in real-world settings, it may be considered medically necessary and appropriate for coverage.

Preauthorization for Prescription Drugs and Intravenous Infusions

Preauthorization is needed for certain prescription drugs and intravenous infusions. Restricted drugs, other prescriptions or intravenous infusion 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.

We will not require more than one preauthorization annually for prescription drugs used to treat an autoimmune disease, hemophilia, or Von Willebrand disease. This section does not apply to:

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

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

Decisions About Preauthorizations for Prescription Drugs and Intravenous Infusions

If our clinical staff is not able to approve your preauthorization for clinical reasons or non-formulary drugs, your case will be referred to our Medical Director. The Medical Director will look at your case and review information sent to us by your provider. Our Medical Director may speak with your provider for more information.

You and your provider will be told in writing or by electronic means if preauthorization is approved. You and your provider will be told by phone or other means, depending on the 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

Standard/Non-Emergency Care Services

We will evaluate non-emergent appeal requests and notify you and your provider of our decision within seventy-two (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 twenty-four (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 twenty-four (24) hours of our receipt of a written or verbal request.

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

What If Preauthorization is Denied?

External Review by an Independent Review Organization (IRO)

You, an individual acting on your behalf, or your provider has the right to request an immediate external review of our appeal decision by An Independent Review Organization (IRO). You do not have to exhaust our appeal process before asking for an external review with An Independent Review Organization (IRO) 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 An Independent Review Organization (IRO). Expedited external review may be initiated at the same time as expedited internal appeals.

An Independent Review Organization (IRO) is required to issue an urgent care decision to us and you no later than twenty-four (24) hours from receipt of the request for external review and no later than forty-five (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 many health care services. This section gives you the details about your covered benefits and other requirements, limitations and exclusions. You must pay your co-pay percentage and copayment.

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. The exclusions section lists services that are not covered benefits under the Plan. All other benefits and services not listed as covered in this section shall be excluded, except for clinical preventative health services.

We decide whether a health care service or supply is a specifically covered benefit. When providers prescribe, order, recommend, or approve a health care service or supply it 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 us, 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 get preauthorization in order for some services to be covered services. The Plan will not pay for any of these services without preauthorization. Please read the preauthorization section of this Contract or call Member Services at 1-844-282-3025 for more information about preauthorization.

Please read your *Schedule of Benefits* or call Member Services 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 get 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.

Contact your Primary Care Physician for an appointment, before getting care from another provider. Preauthorization is usually required for follow-up care by a non-participating provider. If you think your condition is life threatening, you should seek emergency care services.

Emergency Care Services

We provide coverage for Emergency Care Services twenty-four (24) hours per day, seven 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 needed 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 than one hour from the time of the request.

We will not deny a claim for Emergency Care Services when you are sent 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. Read 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 needs preauthorization. You must pay for

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 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 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: Emergency Ambulance Services, High-Risk Ambulance Services, and Inter-facility Transfer services.

Emergency Ambulance Services

Emergency Ambulance Services are ground or air Ambulance Services delivered under reasons 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 reasons:

- 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.

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 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

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

Some services may need to be preauthorized by the Plan.

Clinical Trials

The Plan provides 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 nongovernmental 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 for a Member were receiving cancer or life threatening illness treatment;
 - (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 threatening illness
- Routine Patient Care Cost does not include
 - The cost of an investigational drug, device or procedure;
 - The cost of a non-health care service that the patient is required to receive as a result of participation in the clinical trial;
 - Costs associated with managing the research that is associated with the clinical trial;
 - Costs that would not be covered by the patient if non-investigational treatments were provided; or
 - 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 Program 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. 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,
- Nutritional supplements, non-prescription drugs or substances, medical supplies, vitamins or minerals;
- Services for physical, speech, and respiratory therapy services by licensed therapists; 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 forty-five (45), including colonoscopies and including a follow-up colonoscopy if the results of the initial colonoscopy, test, or procedure were abnormal;
- Depression screening;
- Lung Cancer 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;
- Hepatitis C virus infection screening;
- 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;
- Fall prevention in older adults, including exercise, physical therapy, and Vitamin D supplementation;
- Skin cancer;
- Behavioral counseling;
- Hepatitis B Screening;
- Tuberculosis Screening;
- Statin preventative medication: adults ages forty to seventy-five (40–75) years with no history of CVD, one or more CVD risk factors, and a calculated ten (10) year CVD event risk of 10% or greater.

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*;
- 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 forty-five and seventy-six (45 and 76), and
 - Women between the age of fifty-five to seventy-six (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;
- Preeclampsia prevention;
- Hepatitis B screening for pregnant Members at their first prenatal visit;
- 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 eighteen (18) years of age or older.
- Cervical cancer screening every three years with cervical cytology alone in women aged twenty-one to twenty-nine (21 to 29) years and for women thirty to sixty-five (30-65) years, every three (3) years with cervical cytology alone, every five (5) years with high-risk human papillomavirus (hrHPV) testing alone, or every five (5) years with hrHPV testing in combination with cytology (co-testing);
- Breast and ovarian cancer genetic counseling based on family history, any other test of 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 and screening, mammography and other breast diagnostic imaging;
- Chlamydia screening;
- Gestational diabetes mellitus screen in asymptomatic pregnant women after twenty-four (24) weeks of gestation;
- Gonorrhea screening in sexually active women age twenty-four (24) years and younger as well as in older women who are at increased risk; and
- Intimate partner violence screening for women at or above reproductive 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 eighteen (18) and twenty-four (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 three (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 seventeen (17);
- Height, weight and body mass index measurements for children;
- Hematocrit or hemoglobin screening for children;
- Hemoglobinopathies or sickle cell screening for newborns;
- Hepatitis B screening;
- HIV screening for adolescents at higher risk;
- Hypothyroidism screening for newborns;
- Immunization vaccines for children from birth to age eighteen (18) – doses, recommended ages and recommended populations vary;
- Iron supplements for children ages six to twelve (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 ten (10));
- Phenylketonuria (PKU) screening for this genetic disorder in newborns;
- Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk;
- Tobacco use interventions;
- 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; and
- Habilitative therapies for children with developmental delay as specified by an Early Childhood Intervention individualized family service plan.

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 (2) 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;
- 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 thirty-five (35) visits per calendar year maximum benefits.

Biofeedback is only covered for treatment of Raynaud's disease or phenomenon, urinary or fecal incontinence, and Acquired Brain Injury. 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 are 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

Dental services related to accidental injury are covered services regardless of age.

Pediatric Dental Benefits – Essential Health Benefit

Covered pediatric dental services are provided as part of this plan's Essential Health Benefits for Members under age 19. Covered services include:

- Diagnostic and Preventive Services (e.g., exams, cleanings, x-rays)
- Basic Services (e.g., fillings)
- Major Services (e.g., crowns)
- Medically Necessary Orthodontic Services (requires prior authorization)

These services must be obtained from participating, in-network dental providers. Balance billing is not permitted for covered in-network services.

Pediatric Dental Cost Sharing Summary

Dental Services Category	In Network Coverage
Diagnostic and Preventive Services	100%
Basic Services	100%
Major Services	100%
Medically Necessary Orthodontia	100% (Prior authorization required)

There is no deductible for in-network pediatric dental services. All cost sharing is subject to the pediatric out-of-pocket maximum, which accumulates toward the overall medical plan out-of-pocket maximum.

Adult Dental Benefit (If Applicable)

Adult dental benefits are not part of the federally defined Essential Health Benefits and are not included in this plan. If your plan includes adult dental services, those benefits are provided through a separate dental rider.

Please refer to the dental rider document for any applicable covered services, cost sharing, and waiting period details. All adult dental services must be received from participating, in-network providers. Balance billing is not permitted for covered in-network adult dental services.

Attachment B

Services, Limitations and Exclusions

Description of Dental Services for Adult Benefits (Age 19 and Older)

We will pay or otherwise discharge the Policy Benefit Level shown in Attachment A for the following services:

- **Diagnostic and Preventive Services**

- | | |
|-----------------|--|
| (1) Diagnostic: | Procedures to aid the provider in determining required dental treatment. |
|-----------------|--|

(2) Preventative: Cleanings, including scaling in presence of generalized moderate or severe gingival inflammation – full mount (periodontal maintenance is considered to be a basic service for payment purposes).

(3) Specialist Consultations: Opinion or advice requested by a general dentist.

- **Basic Services**

(1) General Anesthesia or IV Sedation: When administered by a provider for covered oral surgery or selected endodontic and periodontal surgical procedures.

(2) Periodontal Cleanings: Periodontal maintenance.

(3) Palliative: Emergency treatment to relieve pain.

(4) Restorative: Amalgam and resin-based composite restorations (fillings) and prefabricated restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).

- **Major Services**

(1) Crowns and inlays/onlays: Treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composites.

(2) Prosthodontics: Procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges; implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.

(3) Oral Surgery: Extractions and certain other surgical procedures (including pre- and post-operative care).

(4) Endodontics: Treatment of diseases and injuries of the tooth pulp.

(5) Periodontics: Treatment of gums and bones supporting teeth.

(6) Denture Repairs: Repair to partial or complete dentures, including rebase procedures and relining.

- **Note on additional benefits during pregnancy**

When a Member is pregnant, we will pay for additional services to help improve the oral health of the Member during the pregnancy. The additional services each calendar year while the Member is covered under the Contract include one (1) additional oral exam and either one (1) additional routine cleaning; one (1) additional periodontal scaling and root planing per quadrant; or one (1) additional periodontal maintenance procedure. Written confirmation of the pregnancy must be provided by the Member or the Member's Provider when the claim is submitted.

- **Teledentistry Services**

Teledentistry services are dental services delivered by a dentist acting within the scope of the dentist's license, or by a health professional acting under the dentist's delegation and supervision and within the scope of the health professional's license or certification.

Teledentistry services use telecommunications and information technology to deliver the services to a Member in one physical location while the dentist or health professional is located in a different physical location.

Limitations for Adult Benefits (Age 19 and Older)

- (1) Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures.

Examples of Optional Services:

- a) a composite restoration instead of an amalgam restoration on posterior teeth;
- b) a crown where a filling would restore the tooth;
- c) an inlay/onlay instead of an amalgam restoration; or
- d) porcelain, resin or similar materials for crowns placed on a maxillary second or third molar, or on any mandibular molar (an allowance will be made for a porcelain fused to high noble metal crown).

If a Member receives Optional Services, an alternate benefit will be allowed, which means we will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Member will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

- (2) If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under this Contract. If the provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.
- (3) We will pay for oral examinations (except after hours exams and exams for observation) no more than twice in a calendar year.
- (4) We will pay for cleanings, including scaling in presence of generalized moderate or severe gingival inflammation (including periodontal maintenance or any combination thereof) no more than twice in a calendar year. A full mouth debridement is allowed once in a lifetime, when the Member has no history of prophylaxis, scaling and root planing, periodontal surgery, or periodontal maintenance procedures within three years, and counts toward the cleaning frequency in the year provided. Note that periodontal maintenance, procedure codes that include periodontal maintenance, and full mouth debridement are covered as a Basic Benefit, and routine cleanings including scaling in presence of generalized moderate or severe gingival inflammation are covered as a Diagnostic and Preventive Benefit. See note on additional benefits during pregnancy.
- (5) A caries risk assessment is allowed once in twelve (12) months.

- (6) Full mouth debridement is not allowed when performed by the same dentist/dental office on the same day as evaluation procedures.
- (7) Application of caries arresting medicament is limited to twice per tooth per calendar year.
- (8) X-ray limitations:
 - a) We will limit the total reimbursable amount to the provider's accepted fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the accepted fee for a complete intraoral series.
 - b) When a panoramic film is submitted with supplemental film(s), we will limit the total reimbursable amount to the provider's accepted fee for a complete intraoral series.
 - c) If a panoramic film is taken in conjunction with an intraoral complete series, we consider the panoramic film to be included in the complete series.
 - d) A complete intraoral series and panoramic film are each limited to once every 60 months.
 - e) Bitewing x-rays are limited to one (1) time each calendar year. Bitewings of any type are not billable to the Member or us within 12 months of a full mouth series unless warranted by special circumstances.
 - f) Image capture procedures are not separately allowable services.
- (9) Pulp vitality tests are allowed once per day when definitive treatment is not performed.
- (10) Specialist Consultations are limited to once per lifetime per provider and count toward the oral exam frequency. Screenings of patients or assessments of patients reported individually when covered, are limited to only one in a 12-month period and included if reported, with any other examination on the same date of service and provider office.
- (11) We will not cover to replace amalgam and resin-based composite restorations (fillings) and prefabricated restorations within 24 months of treatment if the service is provided by the same provider/provider office. Replacement restorations, including reattachment of a tooth fragment, within 24 months are included in the fee for the original restoration.
- (12) Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.
- (13) Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only and is considered palliative treatment for permanent teeth.
- (14) Pulpal debridement and partial pulpotomy for apexogenesis are limited to once per lifetime.
- (15) Pulpal therapy (resorbable filling) is limited to once in a lifetime. Retreatment of root canal therapy by the same provider/provider office within 24 months is considered part of the original procedure.
- (16) Hemisection (including any root removal), not including root canal therapy, root amputation per root, internal root repair of perforation defects and incomplete

- endodontic therapy; inoperable, unrestorable or fractured tooth, are limited to once in a lifetime.
- (17) Retreatment of apical surgery by the same provider/provider office within twenty-four (24) months is considered part of the original procedure.
 - (18) Pin retention is covered not more than once in any twenty-four (24) month period.
 - (19) Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required x-rays or select diagnostic procedures.
 - (20) Periodontal limitations:
 - a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every twenty-four (24) month period. In the absence of supporting documentation, no more than two quadrants of scaling and root planing will be benefited on the same date of service. See note on additional benefits during pregnancy.
 - b) Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing performed within 36 months by the same dentist/dental office.
 - c) Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.
 - d) Guided tissue regeneration and/or bone grafts are not benefited in conjunction with soft tissue grafts in the same surgical area.
 - e) Periodontal surgery is subject to a 30-day wait following periodontal scaling and root planing in the same quadrant.
 - f) Cleanings (regular and periodontal) and full mouth debridement are subject to a 30-day wait following periodontal scaling and root planing if performed by the same provider office.
 - g) When implant procedures are a covered benefit, scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surface, without flap entry and closure is covered as a Basic Benefit and are limited to once in a twenty-four (24) month period.
 - (21) Oral Surgery services are covered once in a lifetime except removal of benign odontogenic cysts or tumors, excision of benign lesions and incision and drainage procedures, which are covered once in the same day.
 - (22) General anesthesia, intravenous moderate (conscious) sedation is a benefit only when provided by a dentist in conjunction with covered oral surgery procedures or selected endodontic and periodontal surgical procedures.
 - (23) Crowns and inlays/onlays are covered not more often than once in any 60-month period except when We determine the existing crown or inlay/onlay is not satisfactory and

- cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.
- (24) Core buildup, including any pins, is covered not more than once in any 60-month period.
 - (25) Post and core services are covered not more than once in any 60-month period.
 - (26) Crown and inlay/onlay repairs are covered not more than once in any 60-month period. crowns, inlays/onlays and fixed bridges include repairs for twenty-four (24) months following installation.
 - (27) When allowed within six (6) months of a restoration, the benefit for a crown, inlay/onlay or fixed prosthodontic service will be reduced by the benefit paid for the restoration.
 - (28) Denture Repairs are covered not more than once in any six (6) month period except for fixed denture repairs which are covered not more than once in any 60-month period.
 - (29) Prosthodontic appliances, implants and/or implant supported prosthetics that were provided under any Delta Dental program will be replaced only after 60 months have passed, except when we determine that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Delta Dental program will be made if we determine it is unsatisfactory and cannot be made satisfactory. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Our payment for implant removal is limited to one (1) for each implant in 60 months whether provided under Delta Dental or any other dental care plan. Implant/abutment supported removable dentures and fixed dentures will receive a benefit allowance for the corresponding conventional removable appliances. The Member is responsible for the difference in the fee for an implant/abutment supported denture and the fee for a conventional prosthodontic appliance.
 - (30) Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments, are covered once in 36 months.
 - (31) Debridement of a peri-implant defect or defects surrounding a single implant (with or without osseous contouring), and surface cleaning of the exposed implant surfaces, including flap entry and closure, are covered once in 36 months.
 - (32) When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a benefit.
 - (33) Recementation of crowns, inlays/onlays, indirectly fabricated or prefabricated post and core, or bridges is included in the fee for the crown, inlay/onlay or bridge when performed by the same provider/provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a lifetime by the same provider/provider office.
 - (34) The initial installation of a prosthodontic appliance and/or implants is not a benefit unless the prosthodontic appliance and/or implant, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Member was under a Delta Dental plan.

- (35) Occlusal adjustment - limited, is allowed once in a 60-month period.
- (36) We limit payment for dentures to a standard partial or complete denture (Member copays apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post-delivery care including any adjustments and relines for the first six (6) months after placement.
 - a) Denture rebase is limited to one (1) per arch in a 24-month period and includes any relining and adjustments for six (6) months following placement.
 - b) Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments are limited to two (2) per arch in a calendar year and relining is limited to one (1) per arch in a six (6) month period. Immediate dentures, and immediate removable partial dentures include adjustments for three (3) months following installation. After the initial three (3) months of an adjustment or reline, adjustments are limited to two (2) per arch in a calendar year and relining is limited to one (1) per arch in a six (6) month period.
 - c) Tissue conditioning is limited to two (2) per arch in a 12-month period. However, tissue conditioning is not allowed as a separate benefit when performed on the same day as a denture reline or rebase service.
 - d) Recementation of fixed partial dentures is limited to once in a lifetime.
- (37) Frenulectomy is only considered in cases of ankyloglossia (tongue-tie) interfering with feeding or speech as diagnosed and documented by a physician, or if there is a papilla penetrating frenum interfering with closure of a diastema.

Exclusions for Adult Benefits (Age 19 and Older)

We do not pay Benefits for:

- (1) treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- (2) cosmetic surgery or procedures for purely cosmetic reasons.
- (3) maxillofacial prosthetics.
- (4) provisional and/or temporary restorations.
- (5) services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn children for medically diagnosed congenital defects or birth abnormalities.
- (6) treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration,

- periodontal splinting, complete occlusal adjustments or night guards/occlusal guards and abfraction.
- (7) any single procedure provided prior to the date the Member became eligible for services under this plan.
 - (8) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.
 - (9) charges for anesthesia, other than general anesthesia and IV sedation administered by a provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures.
 - (10) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
 - (11) interim implants.
 - (12) indirectly fabricated resin-based inlays/onlays.
 - (13) charges by any hospital or other surgical or treatment facility and any additional fees charged by the provider for treatment in any such facility.
 - (14) treatment by someone other than a provider or a person who by law may work under a provider's direct supervision.
 - (15) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments are not separately payable procedures.
 - (16) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
 - (17) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
 - (18) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for benefits provided under the Contract, will be the responsibility of the Member and not a covered benefit.
 - (19) amounts over plan maximums and/or any service not covered under the dental plan.
 - (20) services covered under the dental plan but exceed benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.
 - (21) the initial placement of any prosthodontic appliance or implants, unless such placement is needed to replace one or more natural, permanent teeth extracted while the Member is covered under the Contract or was covered under any dental care plan with Delta Dental. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.
 - (22) services for orthodontic treatment (treatment of malocclusion of teeth and/or jaws) including orthodontic related services such as cephalometric x-rays, oral/facial

photographic images and diagnostic casts, surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth and surgical repositioning of teeth.

- (23) services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues.
- (24) endodontic endosseous implants.
- (25) services or supplies for sealants, fluoride, space maintainers, apexification and transseptal fiberotomy/supra crestal fiberotomy.
- (26) missed and/or cancelled appointments.
- (27) actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.
- (28) the fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.
- (29) dental case management motivational interviewing and patient education to improve oral health literacy.
- (30) non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.
- (31) extra-oral – 2D projection radiographic image and extra-oral posterior dental radiographic image.
- (32) diabetes testing.
- (33) corticotomy (specialized oral surgery procedure associated with orthodontics).
- (34) antigen or antibody testing.
- (35) counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use.

Description of Dental Services for Pediatric Benefits (Under Age 19)

We will pay or otherwise discharge the Policy Benefit Level shown in Attachment A for Essential Health Benefits when provided by a provider and when necessary and customary under generally accepted dental practice standards and for medically necessary orthodontic services. Orthodontic treatment is a benefit of this dental plan only when medically necessary as evidenced by a severe handicapping malocclusion and when a prior authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health. Benefits for medically necessary orthodontics will be provided in periodic payments based on continued enrollment.

- **Diagnostic and Preventive Services**

- (1) Diagnostic: procedures to aid the provider in determining required dental treatment.

- (2) Preventive: cleanings, including scaling in presence of generalized moderate or severe gingival inflammation - full mouth (periodontal maintenance is considered to be a Basic Benefit for payment purposes), topical application of fluoride solutions, space maintainers.
- (3) Sealants: topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.
- (4) Specialist Consultations: opinion or advice requested by a general dentist.

- **Basic Services**

- (1) General Anesthesia or IV Sedation: When administered by a provider for covered oral surgery or selected endodontic and periodontal surgical procedures.
- (2) Periodontal Cleanings: Periodontal maintenance.
- (3) Palliative: Emergency treatment to relieve pain.
- (4) Restorative: Amalgam and resin-based composite restorations (fillings) and prefabricated restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).

- **Major Services**

- (1) Crowns and Onlays/Inlays: Treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composites.
- (2) Prosthodontics: Procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges; implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.
- (3) Oral Surgery: extractions and certain other surgical procedures (including pre-and post-operative care).
- (4) Endodontics: treatment of diseases and injuries of the tooth pulp.
- (5) Periodontics: treatment of gums and bones supporting teeth.
- (6) Denture Repairs: repair to partial or complete dentures, including rebase procedures and relining.
- (7) Night Guards/Occlusal Guards: intraoral removable appliances provided for treatment of harmful oral habits.

- **Note on additional benefits during pregnancy**

When a Member is pregnant, we will pay for additional services to help improve the oral health of the Member during the pregnancy. The additional services each calendar year while the Member is covered under the Contract include one (1) additional oral exam and either one (1) additional routine cleaning; one (1) additional periodontal scaling and root planing per quadrant; or one (1) additional periodontal maintenance procedure. Written confirmation of the pregnancy must be provided by the Member or the Member's provider when the claim is submitted.

- **Teledentistry Services**

Teledentistry services are dental services delivered by a dentist acting within the scope of the dentist's license, or by a health professional acting under the dentist's delegation and supervision and within the scope of the health professional's license or certification.

Teledentistry services use telecommunications and information technology to deliver the services to a Member in one physical location while the dentist or health professional is located in a different physical location.

We cover teledentistry services the same as services provided in an in-office visit.

Limitations for Pediatric Benefits (Under Age 19)

- (1) Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures.

If a Member receives Optional Services, an alternate benefit will be allowed, which means we will base benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Member will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.
- (2) Claims shall be processed in accordance with our standard processing policies. The processing policies may be revised from time to time; therefore, we shall use the processing policies that are in effect at the time the claim is processed. We may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis.
- (3) If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under this Contract. If the provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.
- (4) Exam and cleaning limitations:
 - a) We will pay for oral examinations (except after hours exams and exams for observation) and routine cleanings, including scaling in presence of generalized moderate or severe gingival inflammation (or any combination thereof) no more than once every six (6) months. Periodontal maintenance are limited to four (4) times in a 12-month period. Up to four (4) periodontal maintenance procedures and up to two (2) routine cleanings, including scaling in presence of generalized moderate or severe gingival inflammation (or any combination thereof) not to exceed four (4) procedures in a 12-month period. See note on additional benefits during pregnancy.

- b) A full mouth debridement is allowed once in a lifetime, when the Member has no history of prophylaxis, scaling and root planing, periodontal surgery, or periodontal maintenance procedures within three years, and counts toward the cleaning frequency in the year provided.
 - c) Note that periodontal maintenance, procedure codes that include periodontal maintenance, and full mouth debridement are covered as a Basic Benefit, and routine cleanings including scaling in presence of generalized moderate or severe gingival inflammation are covered as a Diagnostic and Preventive Benefit. Periodontal maintenance is only covered when performed following active periodontal therapy.
 - d) Caries risk assessments are allowed once in twelve (12) months.
 - e) Full mouth debridement is not allowed when performed by the same dentist/dental office on the same day as evaluation procedures.
- (5) Application of caries arresting medicament is limited to twice per tooth per calendar year.
- (6) X-ray limitations:
 - a) We will limit the total reimbursable amount to the provider's accepted fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the accepted fee for a complete intraoral series.
 - b) When a panoramic film is submitted with supplemental film(s), We will limit the total reimbursable amount to the provider's accepted fee for a complete intraoral series.
 - c) If a panoramic film is taken in conjunction with an intraoral complete series, we consider the panoramic film to be included in the complete series.
 - d) A complete intraoral series and panoramic film are each limited to once every 60 months.
 - e) Bitewing x-rays are limited to once every six (6) months. Bitewings of any type are not billable to the Member or us within 12 months of a full mouth series unless warranted by special circumstances.
 - f) Image capture procedures are not separately allowable services.
- (7) The fee for pulp vitality tests are included in the fee for any definitive treatment performed on the same date.
- (8) Topical application of fluoride solutions is limited to twice within a 12-month period.
- (9) A distal shoe space maintainer - fixed - unilateral is limited to children 8 and younger and is limited to once per quadrant per lifetime. A separate/additional space maintainer can be allowed after the removal of a unilateral distal shoe. The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different provider/provider's office.
- (10) Sealants are limited as follows:
 - a) once in 36 months to permanent molars if they are without caries (decay) or

restorations on the occlusal surface.

- b) repair or replacement of a sealant on any tooth within 24 months of its application is included in the fee for the original placement.

- (11) Preventive resin restorations in a moderate to high-risk caries risk patient - permanent tooth are limited to once per tooth in 36 months.
- (12) Specialist Consultations count toward the oral exam frequency. Screenings of patients or assessments of patients reported individually when covered, are limited to only one in a 12-month period and included if reported, with any other examination on the same date of service and provider office.
- (13) We will not cover replacement of an amalgam or resin-based composite restorations (fillings) within 24 months of treatment if the service is provided by the same provider/provider office. Prefabricated crowns are limited to once per Member per tooth in any 60-month period. Replacement restorations within 24 months are included in the fee for the original restoration.
- (14) Protective restorations (sedative fillings) are allowed when definitive treatment is not performed on the same date of service. The fee for protective restorations is included in the fee for any definitive treatment performed on the same date.
- (15) Prefabricated stainless steel crowns are allowed on baby (deciduous) teeth and permanent teeth through age 14. Replacement restorations within 24 months are included in the fee for the original restoration.
- (16) Therapeutic pulpotomy is limited to baby (deciduous) teeth only; an allowance for an emergency palliative treatment is made when performed on permanent teeth.
- (17) Pulpal therapy (resorbable filling) is limited to once in a lifetime and to primary incisor teeth for Members up to age six (6) and for primary molars and cuspids up to age eleven (11). Retreatment of root canal therapy by the same provider/provider office within 24 months is considered part of the original procedure.
- (18) Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation.
- (19) Retreatment of apical surgery by the same provider/provider office within 24 months is considered part of the original procedure.
- (20) Fees for additional pins on the same tooth on the same date are considered a component of the initial pin placement.
- (21) Palliative treatment is covered per visit, not per tooth, and the fee for palliative treatment provided in conjunction with any procedures other than x-rays or select Diagnostic procedures is considered included in the fee for the definitive treatment.
- (22) Periodontal limitations:
 - a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. In the absence of supporting documentation, no more than two quadrants of scaling and root planing will be benefited on the same date of service. See note on additional benefits during pregnancy.

- b) Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing performed within 36 months by the same dentist/dental office.
 - c) Periodontal services, including graft procedures are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.
 - d) Bone grafts are not benefited in conjunction with soft tissue grafts in the same surgical area.
 - e) Periodontal surgery is subject to a 30-day wait following periodontal scaling and root planing in the same quadrant.
 - f) Cleanings (regular and periodontal) and full mouth debridement are subject to a 30-day wait following periodontal scaling and root planing if performed by the same provider office.
 - g) When implant procedures are a covered benefit, scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure is covered as a Basic Benefit and are limited to once in a 24-month period.
- (23) Collection and application of autologous blood concentrate product are limited to once every 36 months.
- (24) Crowns and inlays/onlays are covered not more often than once in any 60-month period except when We determine the existing crown or inlay/onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues. Services will only be allowed on teeth that are developmentally mature.
- (25) Core buildup, including any pins, is covered not more than once in any 60-month period.
- (26) Prefabricated post and core, in addition to crown is covered once per tooth every 60-month period.
- (27) Resin infiltration of incipient smooth surface lesions is covered once in any 36-month period.
- (28) When allowed within six (6) months of a restoration, the benefit for a crown, inlay/onlay or fixed prosthodontic service will be reduced by the benefit paid for the restoration.
- (29) Prosthodontic appliances, implants and/or implant supported prosthetics (except for implant/abutment supported removable dentures) that were provided under any Delta Dental program will be replaced only after 60 months have passed, except when we determine that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Delta Dental program will be made if we determine it is unsatisfactory and cannot be made satisfactory. Services will only be allowed on teeth that are developmentally mature. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Our payment for implant removal is limited to one (1) for each implant within a 60-month period whether provided under Delta Dental or any other dental care plan.

- (30) Debridement and/or osseous contouring of a peri-implant defect, or defects surrounding a single implant, and includes surface cleaning of the exposed implant surface, including flap entry and closure is allowed once every 60-month period.
- (31) An implant is a covered procedure of the plan only if determined to be a dental necessity. If an arch can be restored with a standard prosthesis or restoration, no benefits will be allowed for the individual implant or implant procedures. Only the second phase of treatment (the prosthodontic phase-placing of the implant crown, bridge denture or partial denture) may be subject to the alternate Benefit provision of the plan.
- (32) When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a benefit.
- (33) Recementation of crowns, inlays/onlays or bridges is included in the fee for the crown, inlay/onlay or bridge when performed by the same provider/provider office within six (6) months of the initial placement.
- (34) The initial installation of a prosthodontic appliance and/or implants is not a benefit unless the prosthodontic appliance and/or implant, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Member was under a Delta Dental plan.
- (35) We limit payment for dentures to a standard partial or complete denture (Member copays apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post-delivery care including any adjustments and relines for the first six (6) months after placement.
 - a) Denture rebase is limited to one (1) per arch in a 36-month period and includes any relining and adjustments for six (6) months following placement.
 - b) Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, relining is limited to one (1) per arch in a 36-month period. Immediate dentures, and immediate removable partial dentures include adjustments for three (3) months following installation. After the initial three (3) months of an adjustment or reline, adjustments are limited to two (2) per arch in a calendar year and relining is limited to one (1) per arch in a 36-month period.
 - c) Tissue conditioning is not allowed as a separate benefit when performed on the same day as a denture reline or rebase service.
- (36) Occlusal guards are covered by report for Members age 13 or older when the purpose of the occlusal guard is for the treatment of bruxism or diagnoses other than temporomandibular joint dysfunction (TMJD). Occlusal guards are limited to one (1) per 12 consecutive month period. We will not cover the repair or replacement of any appliances for night guard/occlusal guard. Adjustment of an occlusal guard is allowed once in 12 months following six months from initial placement.
- (37) Limitations on Orthodontic Services:
 - a) Services are limited to medically necessary orthodontics when provided by a provider. Orthodontic treatment is a benefit of this dental plan only when medically necessary as

evidenced by a severe handicapping malocclusion and when a prior authorization is obtained.

- b) Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index or one of the automatic qualifying conditions below exist.
- c) The automatic qualifying conditions are:
 - i) Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
 - ii) A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
 - iii) A crossbite of individual anterior teeth causing destruction of soft tissue,
 - iv) Severe traumatic deviation.
- d) The following documentation must be submitted with the request for prior authorization of services by the provider:
 - i) ADA 2006 or newer claim form with service code(s) requested;
 - ii) Diagnostic study models (trimmed) with bite registration; or OrthoCad equivalent;
 - iii) Cephalometric radiographic image or panoramic radiographic image;
 - iv) HLD score sheet completed and signed by the orthodontist; and
 - v) Treatment plan.
- e) The allowances for comprehensive orthodontic treatment procedures (D8080, D8090) include all appliances, adjustments, insertion, removal and post treatment stabilization (retention). No additional charge to the Member is permitted.
- f) Comprehensive orthodontic treatment includes the replacement, repair and removal of brackets, bands and arch wires by the original provider.
- g) Orthodontic procedures are benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for Members under the age of 19 and shall be prior authorized.
- h) Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the Member is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.
- i) All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.
- j) When specialized orthodontic appliances or procedures chosen for aesthetic considerations are provided, we will make an allowance for the cost of a standard orthodontic treatment. The Member is responsible for the difference between the

allowance made towards the standard orthodontic treatment and the dentist's charge for the specialized orthodontic appliance or procedure.

- k) Repair and replacement of an orthodontic appliance inserted under this dental plan that has been damaged, lost, stolen, or misplaced is not a covered service.
- l) Orthodontics, including oral evaluations and all treatment, must be performed by a licensed dentist or their supervised staff, acting within the scope of applicable law. The dentist of record must perform an in-person clinical evaluation of the patient (or the telehealth equivalent where required under applicable law to be reimbursed as an alternative to an in-person clinical evaluation) to establish the need for orthodontics and have adequate diagnostic information, including appropriate radiographic imaging, to develop a proper treatment plan. Self-administered (or any type of "do it yourself") orthodontics are not covered.
- m) The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

Exclusions for Pediatric Benefits (Under Age 19)

We do not pay Benefits for:

- (1) services that are not Essential Health Benefits.
- (2) treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- (3) cosmetic surgery or procedures for purely cosmetic reasons.
- (4) maxillofacial prosthetics.
- (5) provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under). Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed service.
- (6) services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to children for medically diagnosed congenital defects or birth abnormalities.
- (7) treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, or complete occlusal adjustments.
- (8) any single procedure provided prior to the date the Member became eligible for services under this plan.
- (9) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.
- (10) charges for anesthesia, other than general anesthesia and IV sedation administered by a

provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures. Local anesthesia and regional/or trigeminal bloc anesthesia are not separately payable procedures.

- (11) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
- (12) laboratory processed crowns for teeth that are not developmentally mature.
- (13) endodontic endosseous implants.
- (14) indirectly fabricated resin-based inlays/onlays.
- (15) charges by any hospital or other surgical or treatment facility and any additional fees charged by the provider for treatment in any such facility.
- (16) treatment by someone other than a provider or a person who by law may work under a provider's direct supervision.
- (17) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments are not separately payable procedures.
- (18) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
- (19) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
- (20) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for benefits provided under the Contract, will be the responsibility of the Member and not a covered benefit.
- (21) any service not covered under the dental plan.
- (22) services covered under the dental plan but exceed benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.
- (23) the initial placement of any prosthodontic appliance or implant, unless such placement is needed to replace one or more natural, permanent teeth extracted while the Member is covered under the Contract or was covered under any dental care plan with Delta Dental. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.
- (24) services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues.
- (25) services for orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except medically necessary orthodontics provided a prior authorization is obtained.
- (26) missed and/or cancelled appointments.
- (27) actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.

- (28) the fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.
- (29) dental case management motivational interviewing and patient education to improve oral health literacy.
- (30) non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.
- (31) extra-oral – 2D projection radiographic image and extra-oral posterior dental radiographic image.
- (32) diabetes testing.
- (33) corticotomy (specialized oral surgery procedure associated with orthodontics).
- (34) antigen or antibody testing.
- (35) counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use.

Diabetes Services

When used to treat insulin dependent diabetes, non-insulin dependent diabetes, or 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;
- 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 reeducation;
- 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 thirty (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 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)
- Biomarker testing

The Plan covers biomarker testing for the purpose of diagnosing, treating, managing, or monitoring an enrollee's disease or condition when the test provides clinical utility.

Coverage will be provided if the use of the test for the enrollee's specific condition is:

- Evidence-based and scientifically valid;
- Informs the patient's clinical management or outcome; and
- Addresses the condition for which the test is being ordered.

The Plan will provide this coverage in a manner that minimizes disruptions to care, including reducing the need for repeat biopsies or biospecimen collections. Prior authorization will not be required for biomarker testing that meets these criteria in accordance with Texas Insurance Code §1372.003

Some Diagnostic Services require preauthorization. Refer to the Preauthorization section for more information. We will provide coverage for these diagnostic services in a manner that limits disruption in care, including, limiting the number of biopsies and biospecimen samples.

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 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 five (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 will equal 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 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. 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.
- We follow 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.
- 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.

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; any treatment relating to hearing aids, including coverage for habilitation and rehabilitation as necessary for educational gain. Hearing aid means durable medical equipment that is of a design and circuitry to optimize audibility and listening skills. 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 up to a maximum of \$2000 per device. If your hearing aid exceeds the maximum of \$2000 per device, we will not deny your claim, you will simply pay the difference in cost.

Medically or audilogically necessary cochlear implants for each ear with internal replacement are covered under this Plan for individuals eighteen (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 results in metabolism problems. It is present at birth and can result in death if untreated. 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.

Covered services for genetic Inborn Errors of Metabolism include the treatments 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.

Coverage is subject to applicable to copayments, for low protein food products for treatment of inherited metabolic diseases, if the low protein food products are medically necessary and, if applicable, are obtained from a source approved by the health insurance issuer, provided coverage will not be denied if the health insurance issuer does not approve a source.

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.

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. There is a limit of sixty (60) number of home health visits per Member during a calendar year. Please review your *Schedule of Benefits* for details.

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; and
- Private duty nursing for extended care services.

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 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;
- Three 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).

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 substance abuse detoxification, partial hospitalization. Rehabilitation does not include residential treatment centers or other facilities using a social model to provide rehabilitation. Inpatient services require preauthorization and all 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 supports and supplements require preauthorization; please refer to the Preauthorization section for more information.

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 Medication

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 seventeen (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. Primary care and specialist office visits could be subject to co-pays. Please see your *Schedule of Benefits and Coverage* or call Member Services at 1-844-282-3025 if you have any questions.

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 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. Periodically, the *Formulary* is reviewed and updated to assure that the most current and clinically appropriate drug therapies are being used. If there is any modification of the *Formulary*, the Plan will send Members a sixty (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. 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 the *Schedule of Benefits*.

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 one (1) year (365 days) following the date of service. The claim must contain an itemized statement of expenses.

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 twenty-first (21st) day after the date a prescription for a thirty (30)-day supply of eye drops is dispensed;
- Not earlier than the forty-second (42nd) day after the date a prescription for a sixty (60)-day supply of eye drops is dispensed; or
- Not earlier than the sixty-third (63rd) day after the date a prescription for a ninety (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*.

Upon request we will provide information regarding a covered prescription drug to you or your provider. The information provided will include our drug formulary for the prescription drug and any formulary alternative.

We will not deny, delay, or restrict a request for information from you or your provider regarding your prescription drugs. No penalization will be enforced on you or your provider for drug information or for choosing an alternative, clinically appropriate, medication.

Step Therapy Protocol for Prescription Drugs to Treat Serious Mental Illnesses

This section applies only to a drug prescribed for treatment of a diagnosis of a serious mental illness for members 18 years of age or older.

Coverage for prescription drugs to treat a serious mental illness will not require that you:

- fail to successfully respond to more than one different drug for each drug prescribed, excluding the generic or pharmaceutical equivalent of the prescribed drug; or
- prove a history of failure of more than one different drug for each drug prescribed, excluding the generic or pharmaceutical equivalent of the prescribed drug.

We may implement a step therapy protocol to require a trial of a generic or pharmaceutical equivalent of a prescribed prescription drug as a condition of continued coverage of the prescribed drug only:

- once in a plan year; and
- if the generic or pharmaceutical equivalent drug is added to the plan's drug formulary.

Clinician-Administered Drugs

We will not, for an enrollee with a chronic, complex, rare, or life-threatening medical condition:

- require clinician-administered drugs to be dispensed only by certain pharmacies or only by pharmacies participating in our network;
- if a clinician-administered drug is otherwise covered, limit or exclude coverage for such drugs based on your choice of pharmacy or because the drug was not dispensed by a pharmacy that participates in our network;
- require a physician or health care provider participating in our network to bill for or be reimbursed for the delivery and administration of clinician-administered drugs under the pharmacy benefit instead of the medical benefit without:
 - informed written consent of the patient; and
 - a written attestation by the patient's physician or health care provider that a delay in the drug's administration will not place the patient at an increased health risk;
 or
- require that you pay an additional fee, higher copay, second copays, or any other price increase for clinician-administered drugs based on your choice of pharmacy or because the drug was not dispensed by a pharmacy that participates in our network.

The section above only applies if the patient's physician or health care provider determines that:

- a delay of care would make disease progression probable; or
- the use of a pharmacy within the health benefit plan issuer's network would:
 - make death or patient harm probable;
 - potentially cause a barrier to your adherence to or compliance with the plan of care; or
 - because of the timeliness of the delivery or dosage requirements, necessitate delivery by a different pharmacy.

Nothing in this section may be construed to:

- authorize a person to administer a drug when otherwise prohibited under the laws of this state or federal law; or
- modify drug administration requirements under the laws of this state, including any requirements related to delegation and supervision of drug administration.

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 nineteen (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.

Reconstructive Surgeries for Craniofacial Abnormalities

The Plan covers “reconstructive surgery for craniofacial abnormalities,” which is 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.

Rehabilitation Therapy

Rehabilitation therapy includes physical, speech, occupational, 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, 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. The term recipient is defined to include a Member receiving authorized transplant-related services during any of the following:

- evaluation,
- candidacy,
- transplant event, or
- post-transplant care.

Coverage is subject to the conditions and limitations outlined 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 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.

Coverage Prohibited

We may not cover a human organ transplant or post-transplant care if:

- The transplant operation is performed in China or another country known to have participated in forced organ harvesting, as designated by the commissioner of state health services; or
- The human organ to be transplanted was procured by a sale or donation originating in China or another country known to have participated in forced organ harvesting, as designated by the commissioner of state health services.

Vision Care

- One wellness eye exam per year for children, one wellness eye exam every twenty-four (24) months for adults.
- One pair of glasses per year for children, one every twenty-four (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.
- Birth control:
 - a one-time, three-month supply of the covered prescription contraceptive drug the first time the Member obtains the drug; and
 - a 12-month supply of the covered prescription contraceptive drug at one time each subsequent time the Member obtains the same drug, regardless of whether you enrolled in the health benefit plan the first time the enrollee you obtained the drug. A Member may obtain only one 12-month supply of a covered prescription contraceptive drug during each 12-month period.

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. Inpatient covered services may require preauthorization by the Plan before services are provided; provided however, that no preauthorization is required for:

- Forty-eight (48) hours of inpatient care following a vaginal delivery or ninety-six (96) hours of inpatient care following a Cesarean section or
- Post-Partum care.

Prenatal Maternity Care

Coverage for Prenatal care includes:

- A minimum of one prenatal office visit per month during the first two (2) trimesters of pregnancy;
- A minimum of two office visits per month during the seventh (7th) and eighth (8th) months; and
- A minimum of one office visit per week during the ninth (9th) 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, preeclampsia, 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 (3) 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 manual breast pump. One replacement manual breast pump is allowed for each following birth. A replacement set of associated supplies is allowed per Member per year. 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, supplies, and support services are covered during the antenatal, perinatal, and postpartum periods, consistent with United States Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA) guidelines. There is no time limit; coverage is based on medical necessity and clinical recommendations.

Alpha-fetoprotein IV Screening

The alpha-fetoprotein IV screening test for pregnant women 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:

- the ninetieth (90th) day after the effective date of termination from the provider network;
- if the Member has been diagnosed with a terminal illness at the time of termination, the expiration of the nine (9) month period after the effective date of the termination; or
- if the Member is pregnant at the time of termination, through delivery of the child, immediate post-partum care and the six (6) 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.

Direct abortion is not a covered benefit.

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your Contract with us.

Mastectomy or Lymph Node Dissection

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

- Forty-eight (48) hours following a mastectomy, and
- Twenty-four (24) hours following a lymph node dissection.

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

Prohibitions: We may not:

- deny any covered person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours;
- provide money payments or rebates to encourage any covered person to accept less than the minimum inpatient hours;
- reduce or limit the amount paid to the attending physician, or otherwise penalize the physician, because the physician required a covered person to receive the minimum inpatient hours; or
- provide financial or other incentives to the attending physician to encourage the physician to provide care that is less than the minimum hours.

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy-Enrollment

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

- all stages of the reconstruction of the breast on which mastectomy has been performed;
- surgery and reconstruction of the other breast to achieve a symmetrical appearance; and

- prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

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

Prohibitions: We may not:

- offer the covered person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above;
- condition, limit, or deny any covered person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above; or
- reduce or limit the amount paid to the physician or provider, nor otherwise penalize, or provide a financial incentive to induce the physician or provider to provide care to a covered person in a manner inconsistent with the coverage and/or benefits shown above.

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy-Annual

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

Examinations for Detection of Prostate Cancer

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

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

Coverage and/or Benefits for Fertility Preservation for Cancer Patients

CHRISTUS shall cover fertility preservation services for a covered individual who has been diagnosed or undergoes a medical treatment for cancer that may directly or indirectly cause iatrogenic infertility. We will cover the cost associated with storage of oocytes and sperm for a minimum of three (3) years.

Inpatient Stay following Birth of a Child

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

- Forty-eight (48) hours following an uncomplicated vaginal delivery, and
- Ninety-six (96) hours following an uncomplicated delivery by cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to give birth in a hospital or other health care facility or to remain in a hospital or other health care facility for the minimum number of hours following birth of the child

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

Prohibitions: We may not:

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

Coverage for Tests for Detection of Colorectal Cancer

Benefits are provided, for each person enrolled in the plan who is forty-five (45) years of age or older include coverage for all colorectal cancer exams, preventative services, and lab tests with an "A" or "B" grade from the USPSTF for average-risk individuals. Benefits include:

- an initial colonoscopy or other medical test or procedure for colorectal cancer screening, and
- a follow-up colonoscopy if the results of the initial colonoscopy, test, or procedure are abnormal.

Coverage of Tests for Detection of Human Papillomavirus, Ovarian Cancer, and Cervical Cancer

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

- a CA 125 blood test;
- and, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the FDA, alone or in combination with a test approved by the FDA for the detection of the human papillomavirus and;
- any other test or screening approved by the United States Food and Drug Administration for the detection of ovarian cancer.

If any person covered by this plan has questions concerning the above, please call us at 1-844-282-3025, or write us at:

CHRISTUS Health Plan
Attn: Member Service Department
5101 N. O'Connor Blvd.
Irving, Texas 75039

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 Contract or after the effective date of termination of Coverage.
- **Clinical Trials**
 - Any 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 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 which is not exempt from having an investigational new drug application.
 - Costs associated with managing the research associate with the Clinical Trial.
 - Costs of tests necessary for the research of the Clinical Trial.
 - Costs paid for or not charged by the 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.
- **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 as well as the coverage of cosmetic procedures for the conditions noted above to correct function and approve appearance or restore form (even if it doesn't restore function) due to the defect incurred in the injury, disease, or congenital defect.
- **Circumcisions**
 - Performed other than for newborn stays, unless medically necessary.
- **Dental Services**
 - There is no routine dental coverage for adults. Dental services related to accidental injury are COVERED BENEFITS.
 - Dental care and dental x-rays are allowable for children only as specified under the COVERED BENEFITS.
- **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**
 - Fertility preservation coverage and benefits are included for covered individuals who have been diagnosed with or undergoing medical treatment for cancer that may directly or indirectly cause iatrogenic infertility.
- **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, unless the request comes from a qualified healthcare provider.
 - 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, microphlebectomy, 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, includes 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 four (4) consecutive months, additional therapy is considered long-term therapy or rehabilitation.
- For information regarding treatment of chronic conditions such as, but not limited to, muscular dystrophy, Down syndrome, and cerebral palsy, contact the Plan to discuss potential coverage.
- **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.
- **Sex Dysfunction**
 - Treatment for sexual dysfunction, including medication, counseling and clinics.
- **Skilled Nursing Facility Care**
 - Custodial or domiciliary care.
- **Speech Therapy**
 - Therapy for stuttering.
 - Additional benefits beyond those listed in COVERED BENEFITS.
- **Smoking Cessation (except as specified in COVERED BENEFITS)**
 - Hypnotherapy for smoking cessation counseling
 - Over the counter drugs, unless listed on the *Formulary*.
 - Acupuncture for smoking cessation purposes.
- **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 twenty **(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 twenty (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 fifteen (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.

We will notify you of the acceptance or rejection of a claim no later than the fifteenth (15th) business day after receipt of all items.

Payment of Claims

Benefits payable under this Contract will be paid within five (5) days of notice of acceptance of your claim. 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.

No additional fee will be charged to the payor because the payee elects to receive the payment by paper check instead of by an automated clearinghouse transaction or other electronic funds transfer.

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 N. O'Connor Blvd.
Irving, TX 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 75016-9001

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 (90) days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety (90) 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 plan, excluding disability income protection coverage;
- Individual and group health maintenance organization evidences of coverage; individual accident and health insurance plan;
- Individual and group preferred provider benefit plans and exclusive provider benefit plans;
- Group contracts, individual 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 plan;
- Uninsured arrangements of group or group-type coverage;
- The medical benefits coverage in automobile 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 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 contract that is designed to fully integrate with other policies through a variable deductible.

Each contract for coverage under (a)(1) or (a)(2) is a separate 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:

- (1) The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the health plans provides coverage for private hospital room expenses.
- (2) 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.

- (3) 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.
- (4) 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.
- (5) 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:
 - I. The health plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

- II. 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 deductible any amounts it would have credited to its deductible 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.

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 the Plan's COB contractor 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, the Plan's COB contractor 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. The Plan's COB contractor 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 the Plan's COB contractor 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.

CONSUMER EXPLANATORY BOOKLET COORDINATION OF BENEFITS (COB)

IMPORTANT NOTICE

This is a summary of only a few of the provisions of your health plan to help you understand COB, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language contained in your contract, which determines your benefits.

Double Coverage

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one health plan, state law permits your insurers to follow a procedure called “coordination of benefits” to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

COB is complicated and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, read your evidence of coverage or contact the Texas Department of Insurance.

Primary or Secondary?

You will be asked to identify all the plans that cover members of your family. We need this information to determine whether we are the “primary” or “secondary” benefit payer. The primary plan always pays first when you have a claim. Any plan that does not contain Texas’ COB rules will always be primary unless the provisions of both plans state that the complying plan is primary.

When This Plan is Primary

If you or a family member is covered under another plan in addition to this one, we will be primary when:

- Your Own Expenses
 - The claim is for your own health care expenses, unless you are covered by Medicare and both you and your spouse are retired
- Your Spouse’s Expenses
 - The claim is for your spouse, who is covered by Medicare, and you are not both retired.
- Your Child’s Expenses
 - The claim is for the health care expenses of your child who is covered by this plan and:
 - You are married and your birthday is earlier in the year than your spouse’s, or you are living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other

- individual's birthday. This is known as the "birthday rule"; or
- You are separated or divorced and you have informed us of a court order that makes you responsible for the child's health care expenses; or
- There is no court order, but you have custody of the child.

Other Situations

We will be primary when any other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary

When we are the primary plan, we will pay the benefits in accord with the terms of your contract, just as if you had no other health care coverage under any other plan.

When This Plan is Secondary

We will be secondary whenever the rules do not require us to be primary.

How We Pay Claims When We Are Secondary

When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay part or all of the allowable expenses left unpaid, as explained below. An "allowable expense" is a health care expense, including copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the person.

If there is a difference between the amount the plans allow, we will usually base our payment on the higher amount. However, if one plan has a contract with the health care provider or physician and the other does not, our combined payments will not be more than the contracted amount. Health maintenance organizations and preferred provider organizations usually have contracts with their providers.

We may reduce our payment by any amount so that, when combined with the amount paid by the primary plan, the total benefits paid equal 100 percent of the total allowable expense for your claim. We will credit any amount we would have paid in the absence of your other health care coverage. We will not pay an amount the primary plan did not cover because you did not follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain prior authorization as required by that plan, we will not pay the amount of the reduction, because it is not an allowable expense.

Vision and Eye Care Benefits

When you are covered by multiple plans with vision benefits, each providing coverage for the same eye care services, the primary plan will pay up to its coverage limit and the secondary plan will cover any remaining expenses not covered by the primary plan up to its own coverage limit. We will not reduce or exclude eye care benefits if another plan pays these benefits, unless the total paid exceeds the provider's usual and customary billed charges.

Questions About COB?

Contact the Texas Department of Insurance

1-800-252-3439

In Austin Call 512-463-6515

COMPLAINTS AND APPEALS 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 decisions, 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.

CHRISTUS Health Plan has 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 a complaint or appeal.

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. Accordingly, we treat a rescission of coverage as an adverse benefit determination. 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 an Independent Review Organization (IRO). If you have a life-threatening condition, you are entitled to an immediate appeal to an Independent Review Organization (IRO) 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 thirtieth (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 seventy-two (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 seventy-two (72) hours for an appeal concerning an acquired brain injury.

If we receive a standard internal review 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 thirty (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 one business day 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 an Independent Review Organization (IRO); notice of the external review process; a copy of a request for an external review by an Independent Review Organization (IRO); 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 An Independent Review Organization (IRO)

You, an individual acting on your behalf, or your provider has the right to request an immediate review of our appeal decision with an Independent Review Organization (IRO). 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 an Independent Review Organization (IRO). An Independent Review Organization (IRO) is required to issue an urgent care decision to us and you no later than seventy-two (72) hours from receipt of the request for external review and no later than forty-five (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, 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 needed because you or your provider have to submit information necessary to reach a decision 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 (5th) 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 the 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 the complaint. Our letter will include our complaint procedures and time frames for resolution. We will resolve your complaint no later than the thirtieth (30th) calendar day after the date. 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 complaint, 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 no 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 will 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 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 forty-five (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 submit your complaint online at:

www.tdi.texas.gov/consumer/health-complaints.html

The commissioner shall investigate a complaint against us to determine compliance within sixty (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.

Culturally and Linguistically Appropriate Manner of Notice

When we send you information, we will make sure 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;
- provide, upon request, a notice in any applicable non-English language;
- 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; and
- send notices in any non-English language that is spoken by more than ten percent (10%) of our service population. We use the standard issued by the department of Health and Human Services (HHS). The standard is found at <http://cciio.cms.gov/resources/factsheets/clas-data.html>.

PAYMENT OF PREMIUM

Payment of Premium

You are responsible for paying your premium on time. The first premium is due with the enrollment application. Other premiums are due on the first day of the 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 defined below, 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 thirty (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 thirty (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.

We will notify you of the nonpayment of premiums, as well as providers of the possibility of denied claims when you are in the second and third month of the grace period.

Changes in Premium Payments

We reserve the right to annually change the premium payment amount for the covered benefits. We will provide at least sixty (60) days' advance notice in writing of any change to the premium payment.

Your rate may change. A few examples of why are:

- A change of residence;
- The addition of a Dependent due to a qualifying event; 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 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.

The right of recovery belongs to us alone. It is used at our sole discretion. If we tell 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 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 with 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 three 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, endorsements, or riders 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 of material fact from your application and/or you provided fraudulent 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 if you are not satisfied with it for any reason, you are permitted to return it within ten days of receiving it and receive a refund of the premium paid. If services are rendered or claims paid during the ten 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. In any case where termination resulted from failure to make timely payment of premium, CHRISTUS will allow reinstatement within thirty (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 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 twenty-four (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.

SERVICE AREA MAP

Network Analysis

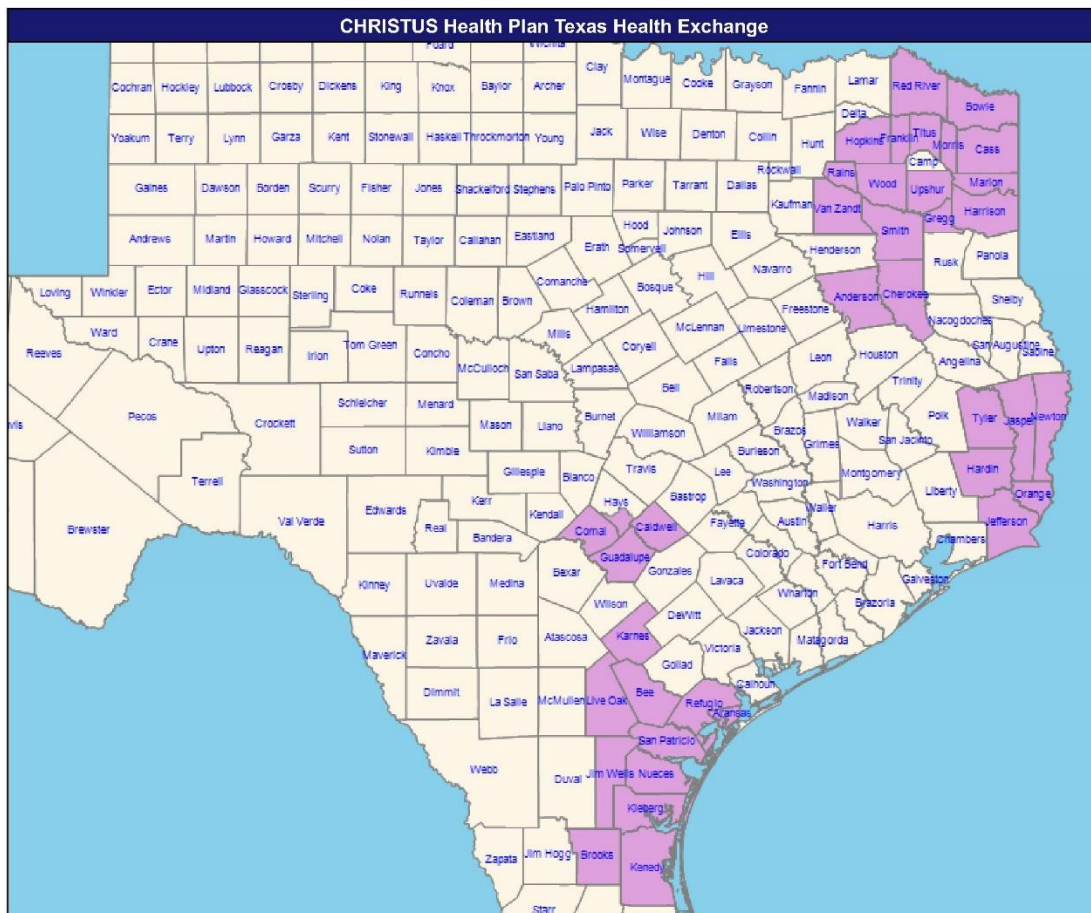
Map

May 13, 2024

Service Areas

CHRISTUS Health Plan Texas
Health Exchange

78.55 miles





844.282.3025, TTY 711

Monday – Friday, 8 a.m. – 5 p.m., local time

CHRISTUShealthplan.org