CHRISTUS Health Plan

TEXAS HEALTH EXCHANGE ELITE

SMALL GROUP OFF-EXCHANGE

2026 Evidence of Coverage

CHRISTUS HEALTH PLAN TEXAS HEALTH EXCHANGE ELITE SMALL GROUP OFF-EXCHANGE COVERS MEMBERS IN THE FOLLOWING COUNTIES:

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

*only zip code: 78666

CHRISTUS Elite
EVIDENCE OF COVERAGE

Texas Health Off - Exchange
Small Group Coverage

This Consumer Choice of Benefits Health Maintenance Organization health care plan, either in whole or in part, does not provide state-mandated health benefits normally required in evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas.

Please consult your insurance agent to discover which state-mandated health benefits are excluded in this evidence of 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 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.

This Evidence of Coverage ("EOC") is part of the Group Agreement ("Group Agreement") between the Group and CHRISTUS Health Plan (HMO). The Group Agreement determines the terms and conditions of coverage. Provisions of this EOC include the **Schedule of Benefits and Coverage** and any amendments, riders, or attachments, which may be delivered with the EOC or added later.

HMO agrees to provide You coverage for benefits in keeping with the conditions, rights, and privileges set forth in this EOC. Your coverage under this EOC is subject to all the conditions and provisions of the Group Agreement.

This EOC describes Your covered health care benefits. Coverage for services or supplies is provided only iffurnished while You are a Member and this coverage is in force. Except as shown in **GENERAL PROVISIONS**:**COBRA Continuation Coverage** and **State Continuation Coverage**, coverage is not provided for any services received before coverage starts or after coverage ends.

Certain words have specific meanings in this EOC. Defined terms are capitalized and shown in the appropriate provision or in the **DEFINITIONS** section and in the amendments or attachments to this EOC, if applicable.

The Group Agreement relating to this EOC is not a workers' compensation insurance contract. Ask Your employer if they subscribe to the workers' compensation system. This EOC is governed by applicable federal law and the laws of Texas.

Please read this entire EOC carefully, as it describes Your rights and obligations and those of the HMO. It is Your Group's and Your responsibility to understand these terms and conditions, because in some circumstances, certain medical services are not covered or may require Preauthorization by HMO.

This EOC covers no services if current Premiums have not been paid. If the Group Agreement is terminatedfor non-payment of Premium, You are responsible for the cost of services received during the Grace Perioddescribed in **HOW THE PLAN WORKS.**

This EOC applies only to Your HMO coverage. It does not limit Your ability to receive health care servicesthat are not Covered Services.

No Participating Provider or other Provider, institution, facility or agency is an agent or employee of HMO.

THIS EOC IS NOT A MEDICARE SUPPLEMENT CONTRACT.

CHRISTUS HEALTH PLAN
CHRISTUS Elite
5101 N. O'Connor Blvd.
Irving, TX 75039
Toll-Free Phone Number: 1-844-856-0826
www.christushealthplan.org

CHRISTUS®
Health Plan

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DEFINITIONS

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

Allowable Amount means the maximum amount determined by HMO to be eligible for consideration of payment for a particular service, supply or procedure rendered by a Participating Provider. The Allowable Amount is based on the provisions of the Participating Provider contract and the payment methodology in effect on the date of service, whether diagnostic related grouping (DRG), capitation, relative value, fee schedule, per diem or other.

Autism Spectrum Disorder means a Neurobiological Disorder that includes autism, Asperger's syndrome, or pervasive developmental disorder--not otherwise specified. "Neurobiological Disorder" means an illness of the nervous system caused by genetic, metabolic, or other biological factors.

Basic Health Care Services means health care services that the commissioner determines an enrolled population might reasonably need to be maintained in good health.

Calendar Year means the period beginning January 1 of any year and ending December 31 of the same year.

Chemical Dependency means the abuse of or psychological or physical dependence on or addiction to alcohol or a Controlled Substance.

Chemical Dependency Treatment Center means a facility that provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved by HMO or its designated behavioral health administrator. The facility must be:

- affiliated with a Hospital under a contractual agreement with an established system for patient Referral;
- accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations;
- licensed, certified or approved as a Chemical Dependency treatment program or center by an agency of the state of Texas having legal authority to so license, certify or approve; or
- if outside Texas, licensed, certified or approved as a Chemical Dependency treatment program or center by the appropriate agency of the state in which it is located having the legal authority to so license, certify or approve.

Clinical Ecology means the inpatient or outpatient diagnosis or treatment of allergic symptoms by:

- cytotoxicity testing (testing the result of food or inhalant by whether or not it reduces or kills white blood cells);
- urine auto injection (injecting one's own urine into the tissue of the body);
- skin irritation by Rinkel method;
- subcutaneous provocative and neutralization testing (injecting the patient with allergen); or
- sublingual provocative testing (droplets of allergenic extracts are placed in mouth).

Coinsurance means the percentage of the Allowable Amount required to be paid by You or on Your behalf at the time of service to a Participating Provider in connection with Covered Services provided as described in **COVERED SERVICES AND BENEFITS**.

Complications of Pregnancy means conditions, requiring Hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsis, 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.

Contract Month means the period of each succeeding month beginning on the Group Agreement effective date

Controlled Substance means an abusable volatile chemical as defined in the Texas Health and Safety Code, or a substance designated as a Controlled Substance in the Texas Health and Safety Code.

Copayment or **Copay** means the dollar amount required to be paid by You or on Your behalf at the time of service to a Participating Provider in connection with Covered Services provided as described in **COVERED SERVICES AND BENEFITS**.

Cosmetic, Reconstructive or Plastic Surgery means surgery that can be expected or is intended to improve Your physical appearance, is performed for psychological purposes, or restores form but does not correct or materially restore a bodily function.

Covered Services means those Medically Necessary health services specified and described in **COVERED SERVICES AND BENEFITS.**

Crisis Stabilization Unit means a twenty-four (24) hour residential program that is usually short-term in nature and provides intensive supervision and highly structured activities to Members who show signs of an acute demonstrable psychiatric crisis of moderate to severe proportions.

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 Your condition. Custodial Care Services 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 nonprofessional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.).

Deductible means the dollar amount required to be paid by You or on Your behalf to a Participating Provider before benefits are available in connection with Covered Services provided as described in **COVERED SERVICES AND BENEFITS** and **PHARMACY BENEFITS**.

Dependent(s) means the Subscriber's family members who meet the eligibility requirements of this EOC and have been enrolled by the Subscriber.

Dietary and Nutritional Services means Your education, counseling, or training (including printed material) regarding diet, regulation or management of diet, or the assessment or management of nutrition.

Domestic Partner means a person with whom You have entered into a domestic partnership in accordance with the Group's guidelines and who has been determined eligible for coverage by HMO. Note: Domestic Partner coverage is available at Your employer's discretion. Contact Your employer for information on whether Domestic Partner coverage is available for Your Group and if COBRA-like benefits are available.

Durable Medical Equipment (DME) means equipment that can withstand repeated use, is primarily and usually used to serve a medical purpose, is generally not useful to a person in absence of illness or injury, and is appropriate for use in the home.

Effective Date of Coverage means the commencement date of coverage under this EOC as shown on the records of HMO.

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

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

Environmental Sensitivity means the inpatient or outpatient treatment of allergic symptoms by controlling environment, sanitizing the surroundings (removal of toxic materials), or use of special nonorganic, non-repetitive diet techniques.

Experimental/Investigational means the use of any treatment, procedure, facility, equipment, drug, device or supply not accepted as Standard Medical Treatment of the condition being treated or any of such items requiring federal or other governmental agency Approval not granted at the time services were provided. "Approval" by a federal agency means that the treatment, procedure, facility, equipment, drug, device or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient. Medical treatment includes medical, surgical or dental treatment. "Standard Medical Treatment" means the services or supplies that are in general use in the medical community in the United States, and:

- have been demonstrated in peer-reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- are appropriate for the Hospital or Participating Provider; and

- the Health Care Professional has had the appropriate training and experience to provide the treatment or procedure.

HMO shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational, and will consider the guidelines and practices of Medicare, Medicaid, or other government-financed programs in making its determination.

Although a Health Care Professional may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, such services or supplies still may be considered to be Experimental/Investigational within this definition. Treatment provided as part of a clinical trial or a research study is Experimental/Investigational.

Grace Period means a period of thirty (30) days after all but the first Premium due date, during which period Premiums may be paid to HMO without lapse of coverage occurring. If payment is not received within thirty (30) days, coverage will be terminated after the 30th day and You will be liable for the cost of services received during the Grace Period.

Group means the employer or party that has entered into a Group Agreement with HMO under which HMO will provide for or arrange health services for eligible Members of the Group who enroll.

Group Open Enrollment Period means those periods of time (at least thirty-one (31) days) established by Group and HMO from time to time, but no less frequently than once in any twelve (12) consecutive months, during which eligible persons who have not previously enrolled with HMO may do so.

Health Benefit Plan means a group, blanket, or franchise insurance contract, a EOC issued under a group contract, a group Hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services.

Health Care Professional(s) means Physicians, nurses, audiologists, Physician assistants, nurse first assistants, acupuncturists, clinical psychologists, pharmacists, occupational therapists, physical therapists, speech and language pathologists, surgical assistants and other professionals engaged in the delivery of health services who are licensed, practice under an institutional license, or certified, or practice under authority of a Physician or legally constituted professional association, or other authority consistent with state law.

HMO (Health Maintenance Organization) means CHRSITUS Health Plan.

Hospice means an organization, licensed by appropriate regulatory authority or certified by Medicare as a supplier of Hospice care, which has entered into an agreement with HMO to render Hospice care to Members. **Hospital** means an acute care institution which:

- is duly licensed by the state in which it is located and must be accredited by the Joint Commission on Accreditation of Healthcare Organizations or certified under Medicare;
- is primarily engaged in providing, on an inpatient basis, medical care and treatment of sick and injured persons through medical, diagnostic, and major surgical facilities;
- provides all services on its premises under the supervision of a staff of Physicians;
- provides twenty-four (24) hour a day nursing and Physician service; and
- has in effect a Hospital utilization review plan.

Hospital Services (except as expressly limited or excluded in this EOC) means those Medically Necessary Covered Services that are generally and customarily provided by acute general Hospitals; and prescribed, directed or authorized by the PCP.

Infertility means the condition of a presumably healthy Member who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual sexual intercourse. This does not include conditions for male Members when the cause is a vasectomy or orchiectomy or for female Members when the cause is a tubal ligation or hysterectomy.

Infusion Therapy involves the administration of medication through a needle or catheter. It is prescribed when a patient's condition is so severe that it cannot be treated effectively by oral medications. Typically, "infusion therapy" means that a drug is administered intravenously, but the term also may refer to situations where drugs are provided through other non-oral routes, such as intramuscular injections and epidural routes (into the membranes surrounding the spinal cord). Infusion therapy in most cases requires health care professional services for the safe and effective administration of the medication.

Life-Threatening Disease or Condition means, for the purposes of a clinical trial, any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Limited Provider Network means a subnetwork within an HMO delivery network in which contractual relationships exist between Physicians, certain Providers, independent Physician associations and/or Physician groups which limit Your access to only the Physicians and Providers in the subnetwork.

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.

Marriage and Family Therapy means the provision of professional therapy services to individuals, families, or married couples, singly or in groups, and involves the professional application of family systems theories and techniques in the delivery of therapy services to those persons. The term includes the evaluation and remediation of cognitive, affective, behavioral, or relational dysfunction within the context of marriage or family systems.

Medical Director means a Physician of HMO, or his designee, who is responsible for monitoring the provision of Covered Services to Members.

Medical Social Services means those social services relating to the treatment of a Member's medical condition. Such services include, but are not limited to assessment of the:

- social and emotional factors related to Member's illness, need for care, response to treatment and adjustment to care; and
- relationship of Member's medical and nursing requirements to the home situation, financial resources, and available community resources.

Medically Necessary means services or supplies (except as limited or excluded herein) that are:

- essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, or bodily malfunction;
- provided in accordance with and consistent with generally accepted standards of medical practice in the United States;
- not primarily for Your convenience, or the convenience of Your Participating Provider; and
- the most economical supplies or levels of service appropriate for Your safe and effective treatment.

When applied to hospitalization, this further means that You require acute care as an inpatient due to the nature of the services rendered or Your condition, and You cannot receive safe or adequate care as an outpatient. In determining whether a service is Medically Necessary, HMO may consider the views of the state and national medical communities and the guidelines and practices of Medicare, Medicaid, or other government-financed programs and peer reviewed literature. Although a Participating Provider may have prescribed treatment, such treatment may not be Medically Necessary within this definition. This definition applies only to the HMO's determination of whether health care services are Covered Services under this EOC.

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

Member means a Subscriber or Dependent(s) covered under HMO. This EOC may refer to a Member as You or Your.

Mental Health Care means any one or more of the following:

1. The diagnosis or treatment of a mental disease, disorder, or condition listed in the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association*, as revised, or any other diagnostic coding system as used by HMO or its designated behavioral health administrator, whether or not the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin;
2. The diagnosis or treatment of any symptom, condition, disease, or disorder by a Participating Provider when the Covered Service is:
    - individual, group, family, or conjoint psychotherapy,
    - counseling,
    - psychoanalysis,
    - psychological testing and assessment,
    - the administration or monitoring of psychotropic drugs, or
    - Hospital visits (if applicable) or consultations in a facility listed in **item 5**, below;
3. Electroconvulsive treatment;
4. Psychotropic drugs;
5. Any of the services listed in **items 1-4**, above, performed in or by a Hospital (if applicable), or other licensed facility or unit providing such care.

Mental Health Treatment Facility means a facility that:

- meets licensing standards;
- mainly provides a program for diagnosis, evaluation and treatment of acute mental or nervous disorders;
- prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs;
- provides all normal infirmary level medical services or arranges with a Hospital for any other medical services that may be required;
- is under the supervision of a psychiatrist; and
- provides skilled nursing care by licensed nurses who are directed by a registered nurse.

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

Obstetrician/Gynecologist means a Participating Physician contracted by HMO as an Obstetrician and/or Gynecologist who may be selected by a female to provide:

- well-woman exams;
- obstetrical care;
- care for all active gynecological conditions; and
- diagnosis, treatment, and Referral for any disease or condition within the scope of the professional practice of the Obstetrician/Gynecologist.

Out-of-Area means not within the Service Area.

Participating describes a Provider that has entered into a contractual agreement with HMO for the provision of Covered Services to Members.

Physician means a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is properly licensed or certified to provide medical care (within the scope of his license) under the laws of the state where the individual practices.

Post-Delivery Care means postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments, including parent education, assistance and training in breast and bottle feeding, and the performance of necessary and appropriate clinical tests.

Preauthorization means a determination by HMO that health care services proposed to be provided to a patient are Medically Necessary and appropriate. Preauthorization processes will be conducted in accordance with the laws in the state of Texas.

Premium means the amount the Group or You are required to pay to HMO to continue coverage.

Primary Care Physician or PCP means the Participating Physician who is primarily responsible for

providing, arranging and coordinating all aspects of Your health care. You and Your Dependents must each select a PCP from those listed by HMO to provide primary care services. You may choose a PCP who is a family practitioner, internist, pediatrician and/or Obstetrician/Gynecologist.

Professional Services means those Medically Necessary Covered Services rendered by Physicians and other Health Care Professionals in accordance with this EOC. All services must be performed, prescribed, directed, or authorized in advance by the PCP.

Prosthetic Appliances means artificial devices including limbs or eyes, braces or similar prosthetic or orthopedic devices, which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (dental appliances and the replacement of cataract lenses are not considered Prosthetic Appliances).

Provider means any duly licensed institution, Physician, Health Care Professional or other entity which is licensed to provide health care services.

Psychiatric Day Treatment Facility means an institution that is appropriately licensed and is accredited by the Joint Commission on Accreditation of Healthcare Organizations as a Psychiatric Day Treatment Facility for the provision of Serious Mental Illness services to Members for periods of time not to exceed eight hours in any 24-hour period. Any treatment in such facility must be certified in writing by the attending Physician to be in lieu of hospitalization.

Reconstructive Surgery for Craniofacial Abnormalities means surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Referral means specific directions or instructions from Your PCP, in conformance with HMO's policies and procedures that direct You to a Participating Provider for Medically Necessary care.

Research Institution means an institution or Provider (person or entity) conducting a phase I, phase II, phase III, or phase IV clinical trial.

Residential Treatment Center means a facility setting (including a Residential Treatment Center for Children and Adolescents) offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, wilderness programs, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities. Patients are medically monitored with 24 hour medical availability and 24 hour onsite nursing service for Mental Health Care and/or treatment of Chemical Dependency. HMO requires that any Mental Health Treatment Facility, Residential Treatment Center and/or Chemical Dependency Treatment Center must be licensed in the state where it is located, or accredited by a national organization that is recognized by HMO as set forth in its current credentialing contract, and otherwise meets all other credentialing requirements set forth in such contract.

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

Routine Patient Care Costs means the costs of any Medically Necessary health care service for which benefits are provided under the Health Benefit Plan, without regard to whether the Member is participating in a clinical trial.

Routine patient care costs do not include:

- The investigational item, device or service, itself;
- Items and services that are provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Serious Mental Illness means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

- schizophrenia;
- paranoid and other psychotic disorders;
- bipolar disorders (hypomanic, manic, depressive and mixed);
- major depressive disorders (single episode or recurrent);
- schizo-affective disorders (bipolar or depressive);
- obsessive-compulsive disorders;
- depression in childhood or adolescence.

Service Area means the geographical area served by HMO and approved by state regulatory authorities. The applicable Service Area includes the area shown and described in **SERVICE AREA**.

Skilled Nursing Facility means an institution or distinct part of an institution that is licensed or approved under state or local law, and primarily provides skilled nursing care and related services as a Skilled Nursing Facility, extended care facility or nursing care facility approved by the Joint Commission on Accreditation of Health Care Organizations, the Bureau of Hospitals of the American Osteopathic Association or as otherwise determined by HMO to meet the reasonable standards applied by either of those authorities.

Specialist means a duly licensed Physician, other than a PCP.

Subscriber means a person who meets all applicable eligibility and enrollment requirements of this EOC, and whose enrollment application and Premium payment have been received by HMO.

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 Services means a health service, other than a Telemedicine Medical Service or a teledentistry dental service, delivered by a licensed or certified health Professional Provider acting within the scope of the Health Care Professional Provider's license or certification who does not perform a Telemedicine

Medical Service that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

- compressed digital interactive video, audio, or data transmission;
- clinical data transmission using computer imaging by way of still-image capture and store and forward; and
- other technology that facilitates access to health care services or medical specialty expertise.

Telemedicine Medical Services means a health care service initiated by a Physician or provided by a health professional Provider acting under Physician delegation and supervision for purposes of patient assessment by a health professional, diagnosis, or consultation by a Physician, treatment or the transfer of medical data that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

- compressed digital interactive video, audio or data transmission;
- clinical data transmission using computer imaging by way of still-image capture and store and forward; and
- other technology that facilitates access to health care services or medical specialty expertise.

Tobacco User means a person who is permitted under state and federal law to legally use tobacco, with tobacco use (other than religious or ceremonial use of tobacco), occurring on average four or more times per week that last occurred within the past six months (or such other meaning required or permitted by applicable law). Tobacco includes, but is not limited to, cigarettes, cigars, pipe tobacco, smokeless tobacco, snuff, etc. For additional information, please call customer service at the toll-free number on the back of Your identification card or visit the website at www.christushealthplan.org.

Urgent Care means medical or health care services provided in a situation other than an emergency that are typically provided in a setting such as an Urgent Care Provider's office or Participating Urgent Care center, as a result of an acute injury or illness that is severe or painful enough to lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the person's condition, illness, or injury is of such a nature that failure to obtain treatment within a reasonable period of time would result in serious deterioration of the condition of the person's health.

Urgent Care Provider means a Participating Provider that has entered into a contractual agreement with HMO for the provision of Covered Services for Urgent Care to Members.

You and **Your** means any Member, including Subscriber and Dependents.

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.

WHO GETS BENEFITS

Eligibility

No eligibility rules or variations in Premium will be imposed based on your health status, medical condition, claims experience, receipt of care, medical history, genetic information, evidence of insurability, disability, or other health status related factor. Coverage under this EOC is provided regardless of Your race, color, national origin, disability age, sex gender identity or sexual orientation. Variations in the administration, processes or benefits of this EOC are based on clinically indicated, reasonable medical management practices, or are part of permitted wellness incentive; disincentives and/or other programs do not constitute discrimination.

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

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

Subscriber Eligibility. To be eligible to enroll as a Subscriber, a person must:

1. reside, live or work in the Service Area; and

2. be a bona fide employee of Group entitled to participate in the health care benefit program arranged by Group or be entitled to coverage under a trust agreement or employment contract;and

3. satisfy any probationary or waiting period requirements established by Group.

   Note: No such waiting period may exceed 90 days unless permitted by applicable law. If our records show that Your Group has a waiting period that exceeds the time period permitted by applicable law, then HMO reserves the right to begin Your coverage on a date that we believe is within the required period. Regardless of whether we exercise that right, Your Group is responsible for Your

waiting period**.** If You have questions about Your waiting period, please contact Your Group.

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

1. meet all Dependent eligibility criteria established by Group; and

2. be Subscriber's spouse or Domestic Partner. Subscriber may be required to submit a certified copy of a marriage license or declaration of informal marriage with Dependent's enrollment application/change form before coverage will be extended; or

3. be a Dependent child, which hereafter means a natural child, eligible foster child, a stepchild, an adopted child (including a child for who the Subscriber or Subscriber's spouse is a part in a suit in which the adoption of the child is sought) or a Dependent child of a Domestic Partner under twenty-six years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage or any combination of those factors. To be eligible for coverage, a child of a Subscriber's child must also be dependent upon Subscriber for federal income tax purposes at the time application for coverage is made.

   In addition, a Dependent shall include a child for whom Subscriber or Subscriber's spouse or Domestic Partner is a court-appointed legal guardian, provided proof of such guardianship is submitted with the prospective Dependent's enrollment application/change form; or

4. be a child of any age who is and continues to be incapable of sustaining employment by reason of mental retardation or physical handicap and is chiefly dependent upon Subscriber for economic support and maintenance. Subscriber must provide HMO with a Dependent Child's Statement of Disability form, including a medical certification ofdisability, within thirty-one (31) days of the date of such medical certification after the child's attainment of the limiting age and subsequently as may be required by HMO, but not more often than once per year. HMO's determination of eligibility shall be conclusive; or

6. have a court order for coverage to be provided for a spouse or minor child under Subscriber's Health Benefit Plan and a request for enrollment shall be made within thirty-one (31) days after issuance of the court order.

7. be a grandchild of the insured or group member if the grandchild is:

   - unmarried;
   - younger than 25 years of age; and
   - a dependent of the insured or group member for federal income tax purposes at the time application for coverage of the grandchild is made; and

Coverage of Subscriber shall be a condition precedent to coverage of eligible Dependents, and no Dependent shall be covered hereunder prior to Subscriber's Effective Date of Coverage.

Loss of Eligibility. You must notify HMO of any changes that will affect Your eligibility, or that of Your Dependents, for services or benefits under this EOC within thirty-one (31) days of the change.

Enrollment and Effective Date of Coverage

No person meeting Subscriber or Dependent eligibility requirements will be refused enrollment or re-enrollment by HMO because of health status, age, requirements for health services, or the existence of a pre-existing physical or mental condition, including pregnancy. No person, however, is eligible to re-enroll who had coverage terminated under **GENERAL PROVISIONS, Termination of Coverage.** Your coverage shall not be terminated by HMO due to health status or health care needs.

Initial Enrollment. Each eligible employee of Group shall be entitled to apply for coverage for himself and eligible Dependents during the initial Group Open Enrollment Period. All persons included for coverage must be listed on the enrollment application/change form. No proof of insurability is required. The Effective Date of Coverage is the first day of the month after the enrollment period, unless otherwise specified and agreed upon by Group and HMO.

Group Open Enrollment Period. A Group Open Enrollment Period will be held at least annually at which time eligible employees and/or Dependents may enroll as Members of HMO. No proof of insurability shall be required. The Effective Date of Coverage is the first day of the month after the enrollment period, unless otherwise specified and agreed upon by Group and HMO.

Other Enrollment Events. Coverage under this EOC for persons becoming eligible at times other than initial enrollment or the Group Open Enrollment Period will become effective as stated in **items 1-6** below, only if HMO receives completed enrollment application/change form and applicable Premium payments

timely. “Timely” means within thirty-one (31) days from the date of the event, unless otherwise specified and agreed upon by Group and HMO.

1. **Newly Eligible Employee**. Each new employee of Group who becomes eligible for coverage at a time other than the initial enrollment or Group Open Enrollment Period may enroll himself and eligible Dependents. If application is not made Timely, the newly eligible employee may not be added until the next Group Open Enrollment Period. The Effective Date of Coverage is the first day of the month following the date employee becomes eligible, unless otherwise specified and agreed upon by Group and HMO.

2. **Newly Eligible Dependents.** Subscriber may enroll any person who becomes newly eligible as a Dependent by completing and submitting to HMO an enrollment application/change form within thirty-one (31) days after attaining eligibility. No proof of insurability shall be required. The Effective Date of Coverage will be the date of the event, i.e., marriage, entry into a domestic partnership, birth, adoption, becoming a party in a suit for adoption or guardianship, unless otherwise specified and agreed upon by Group and HMO. Newly eligible Dependents not added to coverage within thirty-one (31) days after the event will become effective in accordance with the provisions for late enrollees.

3. **Newborn Children Coverage**. Coverage will be automatic for Subscriber or Subscriber’s spouse’s or Domestic Partner’s newborn child for the first thirty-one (31) days following the date of birth. Coverage will continue beyond the thirty-one (31) days only if the child is an eligible Dependent and You notify HMO (verbally or in writing) or submit an Enrollment Application/Change Form to HMO Timely and make or agree to make any additional Premium payments in accordance with this EOC. The Effective Date of Coverage for newborn children shall be the newborn’s date of birth. The Enrollment Application/Change Form can be found on our website at www.christushealthplan.org.

4. **Newly Adopted Children**. Coverage will be automatic for a newly-adopted child of Subscriber for the first thirty-one (31) days from the date Subscriber is a party in a suit for adoption or thirty-one (31) days from the date the adoption is final. Coverage will continue beyond the thirty-one (31) days only if the child is an eligible Dependent and You submit an Enrollment Application/Change Form to HMO within thirty-one (31) days after the date Subscriber becomes a party in a suit for adoption, the date the adoption becomes final, and You make or agree to make any required Premium payments in accordance with this EOC. The Effective Date of Coverage for newly-adopted children shall be the date You become a party in a suit for adoption or the date the adoption is final. The Enrollment Application/Change Form can be found on our website at www.christushealthplan.org.

5. **Court-Ordered Dependents.** Dependent children for whom Subscriber has received a court order requiring Subscriber to provide health coverage will be covered for an initial period of thirty-one (31) days from the date Group receives notification of the court order. Coverage will continue beyond the thirty-one (31) days only if You submit to HMO appropriate Enrollment Application/Change Form within thirty-one (31) days of the date of receipt of the court order by Group and make or agree to make any additional Premium payments in accordance with this EOC. The Effective Date of Coverage for court-ordered Dependents will be the date the court order is

received by Group. The Enrollment Application/Change Form can be found on our website at www.christushealthplan.org.

Coverage for a Dependent spouse for whom Subscriber has received a court order requiring You to provide health coverage will be effective on the first day of the month after HMO receives the appropriate enrollment application/change form and applicable Premium payments, if HMO receives such form and payments within thirty-one (31) days after issuance of the court order.

6. **Late Enrollees; Special Enrollment Events.** Eligible Subscribers or Dependents initially or newly eligible for enrollment who do not enroll within thirty-one (31) days after eligibility are late enrollees and may only be enrolled during a subsequent Group Open Enrollment Period. An eligible Subscriber or Dependent is not a late enrollee in the following situations:

   a. **Family Additions.** In the event of marriage, entry into a domestic partnership, birth, adoption, becoming a party in a suit for adoption or receipt of a court order to provide coverage for a Subscriber's (or individual eligible as a Subscriber) spouse or child(ren), a Subscriber who did not enroll when initially eligible, may enroll himself and any person becoming eligible to be a Dependent, as set forth below. No proof of insurability is required. If enrollment application/change form and applicable Premium payments are not Timely, these individuals are late enrollees and may only be enrolled in a subsequent Group Open Enrollment Period.

      (1) **Marriage or Domestic Partnership**. Subscriber may enroll Subscriber and Subscriber's spouse or Domestic Partner within thirty-one (31) days after the date of marriage or entry into a domestic partnership. The Effective Date of Coverage is the first day of the month following the date of the event unless otherwise specified and agreed upon by Group and HMO.

      (2) **Birth or Adoption.** Subscriber may enroll Subscriber, Subscriber's spouse or Domestic Partner, and/or Subscriber's newborn or newly-adopted child(ren). The effective date of coverage will be the date of birth, adoption, or becoming a party in a suit for adoption.

      (3) **Court-Ordered Dependents.** Subscriber may enroll the spouse and/or child(ren) for whom You have received a court order requiring You to provide health coverage.

         (a) **Court-ordered child(ren)**: A Subscriber may enroll himself, if not already covered, and such child(ren) subject to the court order. The Effective Date of Coverage is as of the date Group receives notice of the court order if HMO receives enrollment application/change form(s) within thirty-one (31) days after the date Group receives a court order or notice of a court order, and You make or agree to make any additional Premium payments.

         (b) **Court-ordered spouse**: The Effective Date of Coverage is the first day of the month after HMO receives enrollment application/change form, if HMO receives application/change form within thirty-one (31) days after issuance of the court order and You make or agree to make any additional Premium payments.

b. **Loss of Other Coverage.** Any individual eligible as a Subscriber or Dependent who did not enroll when initially eligible may enroll if each of the following is true, and if HMO receives completed enrollment application/change forms and applicable Premium payments within thirty-one (31) days after the date coverage ends or after a claim is denied due to reaching the lifetime limit under another Health Benefit Plan, self-funded employer Health Benefit Plan, or other health insurance coverage (collectively referred to in this subsection as "Prior Health Benefit Plan"):

(1) You or any eligible Dependent was covered under a Prior Health Benefit Plan at the time You were initially eligible to enroll;

(2) You declined enrollment, in writing, for Yourself and/or Your Dependent(s) at the time of initial eligibility, stating that coverage under a Prior Health Benefit Plan was the reason for declining enrollment; and

(3) You or any eligible Dependent lost coverage under a Prior Health Benefit Plan as a result of:

(a) termination of employment;
(b) a reduction in the number of hours of employment;
(c) termination of Your Prior Health Benefit Plan coverage;
(d) You or Your Dependent incurring a claim that would meet or exceed a lifetime limit on all benefits under Prior Health Benefit Plan coverage;
(e) the Prior Health Benefit Plan no longer offering any benefits to the class of similarly situated individuals that include You or Your Dependent(s);
(f) if coverage was through a health maintenance organization, You or Your Dependent(s) no longer residing, living, or working in the service area of the health maintenance organization and no other benefit option being available;
(g) termination of contribution toward the premium made by the former employer;
(h) dependent status ending (for example, due to death of a spouse, divorce, legal separation or reaching the maximum age to be eligible as a dependent child under the Prior Health Benefit Plan); or
(i) expiration of the continuation of coverage period of the Prior Health Benefit Plan under Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, or under the continuation provisions of the Texas Insurance Code.

The Effective Date of Coverage under this subsection is the day after prior coverage terminated.

c. **Dependent Loss of Governmental Coverage.** An individual who is eligible to enroll and who has lost coverage under Medicaid (Title XIX of the Social Security Act), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s) or under the Texas Children's Health Insurance Program (CHIP), Chapter 62, Health and Safety Code, is not a late enrollee provided appropriate enrollment application/change forms and applicable Premium payments are received by HMO within sixty (60) days after the date on which such individual loses coverage. Coverage will be effective the day after prior coverage terminated.

d. **Health Insurance Premium Payment (HIPP) Reimbursement Program.** An individual who is eligible to enroll and who is a recipient of medical assistance under the state of Texas Medicaid Program or enrolled in CHIP, and who is a participant in the state of Texas HIPP Reimbursement Program may enroll with no enrollment period restrictions. If the individual is not eligible unless a family member is enrolled, both the individual and family member may enroll. The Effective Date of Coverage is on the first day of the month after HMO receives (i) written notice from the Texas Health and Human Services Commission, or (ii) enrollment forms, from You, provided such forms and applicable Premium payments are received by HMO within sixty (60) days after the date the individual becomes eligible for participation in the HIPP Reimbursement Program.

HOW THE PLAN WORKS

Provider Information

You are entitled to medical care and services from Participating Providers including Medically Necessary medical, surgical, diagnostic, therapeutic and preventive services that are generally and customarily provided in the Service Area. Some services may not be covered. To be covered, a service that is Medically Necessary must also be described in **COVERED SERVICES AND BENEFITS.** Even though a Physician or other Health Care Professional has performed, prescribed or recommended a service does not mean it is Medically Necessary or that it is covered under **COVERED SERVICES AND BENEFITS.** Some Covered Services may also require Preauthorization by HMO. Preauthorization processes will be conducted in accordance with the laws in the state of Texas.

Only services that are performed, prescribed, directed or authorized in advance by the PCP or HMO are covered benefits under this EOC except Emergency Care, Urgent Care or Covered Services provided to female Members, who may directly access an Obstetrician/Gynecologist in the same Limited Provider Network as their PCP for: 1) well woman exams; 2) obstetrical care; 3) care for all active gynecological conditions; and 4) diagnosis, treatment, and Referral for any disease or condition within the scope of the professional practice of the Obstetrician/Gynecologist. PCPs in a Limited Provider Network will be identified in the HMO provider directory or You can call customer service at the toll-free telephone number on the back of Your identification card.

HMO and Participating Providers do not have any financial responsibility for any services You seek or receive from a non-Participating Provider or facility, except as set forth below, unless both Your PCP and HMO have made prior Referral authorization arrangements.

Selecting a PCP

At the time You enroll, You must choose a PCP. If any Member is a minor or otherwise incapable of selecting a PCP, the Subscriber should select a PCP on Member's behalf. If Your Dependents enroll, You and Your Dependents must choose a PCP from HMO's directory of Participating Providers in order to receive Covered Services. For the most current list of Participating Providers visit the website at www.christushealthplan.org. You may also refer to Your Provider directory or call customer service at the toll-free telephone number on the back of Your identification card. You may also request a written copy ofthe Participating Provider directory, which is updated quarterly, by calling customer service. Each directoryidentifies those Providers who are accepting existing patients only. HMO may assign a PCP if one has not been selected.

Female enrollee are allowed to select, in addition to a primary care physician, an obstetrician or gynecologist to provide the Member with health care services that are within the scope of the professional specialty practice of a properly credentialed obstetrician or gynecologist.

Members who have been diagnosed with a chronic, disabling or life threatening illness may request approval to choose a Participating Specialist as a PCP using the process described in **Specialist as PCP.**

Your PCP

Your PCP coordinates Your medical care, as appropriate, either by providing treatment or by issuing Referrals to direct You to Participating Providers. The PCP can also order lab tests and x-rays, prescribe medicines or therapies, and arrange hospitalization.

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

If Your PCP performs, suggests, or recommends a course of treatment for You that includes services that are not Covered Services, the entire cost of any such non-Covered Services will be Your responsibility.

Changing Your PCP

You may change Your PCP by calling the customer service toll-free telephone number listed on Your identification card to make the change or to request a change form or assistance in completing that form. The change will become effective on the first day of the month following HMO's receipt and approval of the request.

In the event of termination of a Participating Provider of any kind, HMO will use best efforts to provide reasonable advance notice to Members receiving care from such Participating Provider that termination is imminent. Special circumstances may render You eligible to continue receiving treatment from a Participating Provider after the effective date of termination, which is fully described in **Continuity of Care**.

Continuity of Care

If You are under the care of a Participating Provider who stops participating in HMO's network, HMO will continue coverage for that Provider's Covered Services if all the following conditions are met:

- You have a disability, acute condition, life-threatening illness, scheduled to undergo non-elective surgery (including receipt of postoperative care) or are pregnant; and
- the Provider agrees to continue accepting the same reimbursement that applied when participating in HMO's network, and not to seek payment from You for any amounts for which You would not be responsible if the Provider were still participating in HMO's network.

Continuity coverage shall not extend for more than ninety (90) days (or more than nine (9) months if You have been diagnosed with a terminal illness) beyond the date the Provider's termination takes effect. If You are pregnant when the Provider's termination takes effect, coverage may be extended through delivery, immediate postpartum care and the follow-up check-up within the first six (6) weeks of delivery.

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.

Specialist as PCP

If You have been diagnosed with a chronic, disabling, or life-threatening illness, You may contact customer service at the toll-free telephone number on Your identification card to get information to submit for approval from the HMO Medical Director to choose a Participating Specialist as Your PCP. The Medical Director will require both You and the Participating Specialist interested in serving as Your PCP to sign a certification of medical need, to submit along with all supporting documentation. The Participating Specialist must meet HMO's requirements for PCP participation and be willing to accept the coordination of all Your healthcare needs. If Your request is denied, You may appeal the decision as described in **COMPLAINT AND APPEAL PROCEDURES.** If Your request is approved, the Specialist's designation as Your PCP will not be effective retroactively. As used herein, **"**life threatening**,"** means a disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Availability of Providers

HMO cannot guarantee the availability or continued participation of a particular Provider. Either HMO or any Participating Provider may terminate the Provider contract or limit the number of Members that will be accepted as patients. If the PCP initially selected cannot accept additional patients, You will be given an opportunity to make another PCP selection. You must then cooperate with HMO to select another PCP.

Facility Based Physician or Provider Disclosure

In accordance with Texas Insurance Code §1451.501(1-a) and §1451.504, CHRISTUS Health Plan maintains a provider directory that clearly identifies facility-based physicians or providers. The directory includes separate headings for facility-based provider types, including:

- Radiologists
- Anesthesiologists
- Pathologists
- Neonatologists
- Assistant surgeons
- Hospitalists
- Intensivists

CHRISTUS Health Plan is not required to list in the directory any facility-based physician or provider who is employed by the facility. Members may access the most up to date provider directory online at www.christushealthplan.org or may request a printed copy by contacting Member Services.

Out-of-Network Services

You may obtain Covered Services from Providers who are not part of HMO's network of Participating Providers when receiving Emergency Care. Also, court-ordered Dependents living outside the Service Area may use non-Participating Providers.

If Covered Services are not available from Participating Providers within the access requirements established by law and regulation, HMO will allow You to use a non-Participating Provider for medically necessary covered services, other than emergency care, as approved by the HMO. This process is done through a Referral request, which will be approved within five business days. When services are rendered by an out-of-network facility based physician in an in-network facility, non-network diagnostic imaging Provider, laboratory service Provider, or if you You are not given the choice of a network physician or provider, the Plan will fully reimburse the out-of-network physician at the usual and customary rate. If You receive a balance bill from a Non-Participating Provider, contact Us.

Inpatient Care by Non-PCP

During an inpatient stay at a Participating Hospital, Skilled Nursing Facility or other Participating facility, it may be appropriate for a Physician other than Your PCP to direct and oversee Your care, if Your PCP does not do so. However, upon discharge, You must return to the care of Your PCP or have Your PCP coordinate care that may be Medically Necessary.

Emergency Medical Services: Non-Network Ground Providers

In accordance with the Texas Insurance Code §38.006 and related statutes, CHRISTUS Health Plan provides coverage for emergency ground transportation and emergency medical services rendered by a non-network emergency medical services provider. This applies when services are provided by an emergency medical services provider as defined by Texas Health and Safety Code §773.003(11).

When services are provided by a non-network ground emergency medical services provider:

- The enrollee's financial responsibility is limited to the applicable in-network copayment, coinsurance, and deductible
- The plan will reimburse the provider based on rates established by the applicable political subdivision, if submitted to the Texas Department of Insurance under TIC §38.006
- If no such rates are submitted, reimbursement will follow the plan's allowed amount methodology, subject to applicable law
- The plan will comply with the required payment timeframes under TIC §§1271.159 and 1275.054.

This section does not apply to air ambulance services.

Provider Communication

HMO will not prohibit, attempt to prohibit or discourage any Provider from discussing or communicating to You or Your designee any information or opinions regarding Your health care, any provisions of the

Health Benefit Plan as it relates to Your medical needs or the fact that the Provider's contract with HMO has terminated or that the Provider will no longer be providing services under HMO.

Your Responsibilities

- You shall complete and submit an application or other forms or statements that may be reasonably requested. You agree that all information contained in the applications, forms and statements submitted to HMO due to enrollment under this EOC or the administration herein shall be true, correct, and complete to the best of Your knowledge and belief.
- You shall notify HMO immediately of any change of address for You or any of Your covered Dependents.
- You understand that HMO is acting in reliance upon all information You provided at time of enrollment and afterwards and represents that information so provided is true and accurate.
- By electing coverage pursuant to this EOC, or accepting benefits hereunder, all Members who are legally capable of contracting, and the legal representatives of all Members who are incapable of contracting, at time of enrollment and afterwards, represent that all information so provided is true and accurate and agree to all terms, conditions and provisions hereof.
- You are subject to and shall abide by the rules and regulations of each Provider from which benefits are provided.

Refusal to Accept Treatment

You may, for personal reasons, refuse to accept procedures or treatment by a Participating Provider. Participating Providers may regard such refusal to accept their recommendations as incompatible with continuance of the Provider-patient relationship and as obstructing the provision of proper medical care. Participating Providers shall use their best efforts to render all necessary and appropriate Professional Services in a manner compatible with Your wishes, insofar as this can be done consistent with the Participating Provider's judgment as to the requirements of proper medical practice. If You refuse to follow a recommended treatment or procedure, and the Participating Provider informed You of his belief that no professionally acceptable alternative exists, neither HMO nor any Participating Provider shall have any further responsibility to provide care for the condition under treatment.

Premium Payment

On or before the Premium due date, Group or its designated agent shall remit payment to HMO on behalf of each Subscriber and Dependents the amount specified by HMO.

Failure to Render Payments

Only if HMO receives Your stipulated payment, shall You be entitled to health services covered hereunder and then only for the Contract Month for which such payment is received. If any required payment is not received by the Premium due date of the Contract Month, then You will be terminated at the end of the Grace Period of the Contract Month. You will be responsible for the cost of services rendered to You during the Grace Period of the Contract Month in the event that Premium payments are not made by Group.

Change in Premium Rates

HMO reserves the right to establish a revised schedule of Premium payments on each anniversary date of this EOC upon sixty (60) days written notice to Group.

A Tobacco User may be subject to a Premium increase of up to 1.5 times the rate applicable to those who are not Tobacco Users, to the extent permitted by applicable law, provided that HMO will provide an opportunity to offset such Premium variation through participation in a wellness program to prevent or reduce Tobacco Use, if required by applicable law.

Member Complaint Procedure

Any problem or claim between You and HMO or between You and a Participating Provider must be dealt with using the process described in **COMPLAINT AND APPEAL PROCEDURES**. Complaints may concern non-medical or medical aspects of care as well as this EOC, including its breach or termination.

Identification Card

Cards issued to Members under this EOC are for identification only. The identification card confers no rightto services or other benefits under this EOC. To be entitled to any services or benefits, the holder of the identification card must be a Member on whose behalf all applicable Premiums under this EOC have actually been paid.

The card offers a convenient way of providing important information specific to Your coverage including, but not limited to, the following:

- **Your Member identification number**. This unique identification number is preceded by a three-character alpha prefix that identifies Health Plan as Your insurer.
- Any Copayment Amounts that may apply to Your coverage.
- Important telephone numbers.

Always remember to carry Your identification card with You and present it to Your Providers or Pharmacies when receiving health care services or supplies.

Please remember that any time a change in Your family takes place it may be necessary for a new identification card to be issued to You and/or each covered dependent (refer to the **WHO GETS BENEFITS** section for instructions when changes are made). Upon receipt of the change in information, HMO will provide a new identification card.

Unauthorized, Fraudulent, Improper, or Abusive Use of Identification Cards

1. The unauthorized, fraudulent, improper, or abusive use of identification cards issued to You and Your covered dependents will include, but not be limited to, the following actions, when intentional:

a. Use of the identification card prior to Your Effective Date of Coverage;
b. Use of the identification card after Your date of termination of coverage under the EOC;
c. Obtaining prescription drugs or other benefits for persons not covered under the EOC;
d. Obtaining prescription drugs or other benefits that are not covered under the EOC;
e. Obtaining covered drugs for resale or for use by any person other than the person for whom the Prescription Order is written, even though the person is otherwise covered under the EOC;
f. Obtaining covered drugs without a Prescription Order or through the use of a forged or altered Prescription Order;
g. Obtaining quantities of prescription drugs in excess of Medically Necessary or prudent standards of use or in circumvention of the quantity limitations of the EOC;
h. Obtaining prescription drugs using Prescription Orders for the same drugs from multiple Providers;
i. Obtaining prescription drugs from multiple Pharmacies through use of the same Prescription Order.

2. The fraudulent or intentionally unauthorized, abusive, or other improper use of identification cards by any Member can result in, but is not limited to, the following sanctions being applied to all Members covered under Your coverage:
   a. Denial of benefits;
   b. Cancellation of coverage under the EOC for all Members under Your coverage;
   c. Recoupment from You or any of Your covered dependents of any benefit payments made;
   d. Pre- approval of drug purchases and medical services for all Members receiving benefits under Your coverage;
   e. Notice to proper authorities of potential violations of law or professional ethics.

Member Claims Refund

You are not expected to make payments, other than required Copayments/Coinsurance and any applicable Deductibles, for any benefits provided hereunder. However, if You make such payments, You may send HMO a claim for reimbursement, and when a refund is in order, the Provider shall make such refund to You. Your claim will be allowed only if You notify HMO within ninety (90) days from the date on which covered expenses were first incurred, unless it can be shown that it was not reasonably possible to give notice within the time limit, and that notice was given as soon as reasonably possible. However, benefits will not be allowed if notice of claim is made beyond one (1) year from the date covered expenses were incurred, except for Prescription Drug claims which must be filed within ninety (90) days of the date of purchase to qualify for reimbursement under Pharmacy Benefits. You must provide written proof of such payment to HMO within one (1) year of occurrence.

Within fifteen (15) days of receipt of written notice of a claim, HMO shall acknowledge receipt of claim and begin any necessary investigation. It may be necessary for HMO to request additional information fromYou. Claims shall be acted upon within fifteen (15) business days of receipt of a completed claim unless You are notified that additional time is needed and why. HMO will act on a completed claim no later than forty-five (45) days after the additional time notification is given to You. If HMO notifies You that HMO will pay a claim or part of a claim, HMO will pay an approved claim not later than five (5) business days after the date notice is made. Visit the website at www.christushealthplan.org or call customer service at the

toll-free number on the back of Your identification card to obtain an HMO medical claim form or a prescription reimbursement claim form.

Claim or Benefit Reconsideration

If a claim or a request for benefits is partly or completely denied by HMO, You will receive a written explanation of the reason for the denial and be entitled to a full review. If You wish to request a review or have questions regarding the explanation of benefits, call or write customer service at the phone number or address on the back of Your identification card. If You are not satisfied with the information received either on the call or in written correspondence, You may request an appeal of the decision or file a Complaint. You may obtain a review of the denial by following the process set out in **COMPLAINT AND APPEAL PROCEDURES**.

COMPLAINT AND APPEAL PROCEDURES

Customer Inquiries

You or a designated representative may direct inquiries to an HMO customer service representative by mail or by calling the toll free telephone number on the back of Your ID card. Inquiries resolved to Your satisfaction will be tracked by the HMO. If an inquiry is not resolved promptly and to Your satisfaction, within 180 days from the receipt of your EOB or Adverse Determination you may submit a Complaint or Appeal and it will be handled according to the Complaint procedure described below.

How to File a Complaint with the HMO

A "Complainant" means You or another person, including a Physician or Provider, designated to act on Your behalf, who files a Complaint.

A "Complaint" means any dissatisfaction expressed by a Complainant orally or in writing to HMO about any aspect of HMO's operation, including, but not limited to:

- information relied upon in making the benefit determination;
- HMO administration;
- procedures related to review or appeal of an Adverse Determination;
- the denial, reduction or termination of a service for reasons not related to medical necessity;
- the way a service is provided; or
- disenrollment decisions.

It does not mean a misunderstanding or problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to Your satisfaction. A Complaint also does not include a Provider's or Member's oral or written expression of dissatisfaction or disagreement with an Adverse Determination, which is defined under **How to Appeal an Adverse Determination.**

Within five (5) business days of receiving a Complaint, the HMO will send Complainant a letter acknowledging the date of receipt, along with a description of the HMO's Complaint process and timeframes. If the Complaint was oral, HMO will also enclose a one-page Complaint form clearly stating that the form must be filled out and returned to HMO for prompt resolution of the Complaint.

Within thirty (30) calendar days after HMO receives the written Complaint or Complaint form, HMO will investigate and resolve the Complaint and send Complainant a letter explaining HMO's resolution. The letter will include: 1) the specific medical and contractual reasons for the decision, including any applicable benefit exclusion, limitation or medical circumstance; 2) additional information required to adjudicate a claim, if needed; 3) the specialization of any Provider consulted; and 4) a full description of the Complaint appeal process, including deadlines for the appeal process and for the final decision on the appeal.

If You dispute the resolution of the Complaint, You may follow the HMO's Complaint appeals process described under **How to Appeal an HMO Complaint Decision**. If Your health plan is governed by the Employee Retirement Income Security Act (ERISA), You have the right to bring civil action under 502(a) of ERISA.

Complaints concerning emergencies or denial of continued hospital stays will be investigated and resolved in accordance with the medical or dental immediacy of the case, but may not exceed 24 hours from the date We receive the request. HMO will not engage in any retaliatory action against You or the Group, including termination or refusal to renew this EOC of Coverage, because You or the Group has reasonably filed a Complaint against the HMO or appealed a decision of HMO. HMO also shall not retaliate against a Physician or Provider, including termination or refusal to renew their contract, because the Physician or Provider has, on behalf of a Member, reasonably filed a Complaint against the HMO or appealed a decision of HMO.

Retrospective Utilization Review

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

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

If an extension is 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.

How to Appeal an HMO Complaint Decision

If the Complaint is not resolved to Your satisfaction, the HMO Complaint appeal process gives You the right to appear in person, by telephone or other technological methods before a Complaint appeal panel in the Service Area where You normally receive health care services, unless Complainant agrees to another site. The Complaint appeal panel can also consider a written appeal.

HMO will send Complainant an acknowledgment letter no later than five (5) business days after the date HMO receives the written request for appeal, and will complete the appeals process no later than thirty (30) calendar days after receiving the written request for appeal.

To advise HMO on resolution of the dispute, HMO will appoint persons to a Complaint appeal panel composed of an equal number of HMO staff, Physicians or other Providers, and Members of the HMO.

Complaint appeal panel representatives will not have been previously involved in the disputed decision. Physicians or other Providers must have experience in the area of care that is in dispute and must be independent of any Physician or Provider who made any prior determination. If specialty care is in dispute, the Complaint appeal panel must include a person who is a Specialist in that field. Members of the HMO on the Complaint appeal panel will not be employees of the HMO.

No later than the fifth business day before the scheduled meeting of the Complaint appeal panel, unless Complainant agrees otherwise, HMO will provide to Complainant or Complainant's designated representative:

- documentation to be presented to the Complaint appeal panel by HMO staff;
- the specialization of any Physicians or Providers consulted during the investigation;
- the name and affiliation of each HMO representative on the Complaint appeal panel; and
- the date and location of the hearing.

Complainant or a designated representative, if Member is a minor or disabled, is entitled to appear before the Complaint appeal panel in person or by conference call or other appropriate technology, and to:

- present written or oral information;
- present alternative expert testimony;
- request the presence of and question those responsible for making the prior determination that resulted in the appeal; and
- bring any person Complainant wishes, but only Complainant may directly question meeting participants.

Complainant or designee will receive a written decision of the Complaint appeal, including the specific medical determination, clinical basis and contractual criteria used to reach the final decision, and the toll-free telephone number and address of the Texas Department of Insurance (TDI).

Complaint appeals relating to an ongoing emergency or denial of continued hospitalization shall be investigated and resolved in accordance with the medical or dental immediacy of the case, but no later than one business day, but no longer than 72 hours, from HMO's receipt of the Complainant's request for an appeal. At the request of Complainant, HMO shall provide (instead of a Complaint appeal panel) a review by a Physician or Provider who has not previously reviewed the case and is of the same or similar specialty that typically manages the medical or dental condition, procedure or treatment under consideration in the appeal. The Physician or Provider reviewing the appeal may interview the patient or patient's designated representative and will decide the appeal. The Physician or Provider may deliver initial notice of the appeal decision orally if he then provides written notice no later than the third day after the date of the decision.

Upon request and free of charge, Complainant or designee may have reasonable access to, and copies of, all documents, records and other information relevant to the claim or appeal, including:

- information relied upon to make the decision;
- information submitted, considered or generated in the course of making the decision, whether or not it was relied upon to make the decision;
- descriptions of the administrative process and safeguards used to make the decision;
- records of any independent reviews conducted by HMO;

- medical judgments, including whether a particular service is Experimental, Investigational or not Medically Necessary or appropriate; and
- expert advice and consultation obtained by HMO in connection with the denied claim, whether or not the advice was relied upon to make the decision.

How to Appeal to the Texas Department of Insurance

Anyone, including persons who attempted to resolve Complaints through HMO's Complaint process and are dissatisfied with the resolution, may report an alleged violation to TDI, Consumer Protection (1111A), P. O. Box 12030, Austin, Texas 78711-2030 or fax to (512) 490-1007.

You may file a TDI Complaint:

- by mailing to the address listed above;
- by faxing to the number listed above; or
- online at www.tdi.texas.gov

For general information or information about how to resolve insurance-related Complaints call TDI Consumer Help line between 8 a.m. and 5 p.m., Central Time, Monday through Friday at (800) 252-3439. To request a TDI Complaint form call (800) 599-SHOP, or in Austin call(800) 252-3439.

The Commissioner will investigate a Complaint against HMO within sixty (60) days after TDI receives the Complaint and all information necessary to determine if a violation occurred. The Commissioner may extend the time to complete an investigation if:

- additional information is needed;
- an on-site review is necessary;
- HMO, the Physician or Provider, or Complainant does not provide all documentation necessary to complete the investigation; or
- other circumstances beyond TDI's control occur.

How to Appeal an Adverse Determination

An "Adverse Determination" means a determination by HMO or a utilization review agent that the health care services provided or proposed to be provided to You are not Medically Necessary or Experimental/Investigational. In life-threatening or urgent care circumstances or if you do not receive a timely decision, You are entitled to an immediate appeal to an Independent Review Organization ("IRO") and are not required to first comply with HMO's appeal of an Adverse Determination process. An IRO is an organization independent of the HMO which may perform a final administrative review of an Adverse Determination made by HMO.

The HMO maintains an internal appeal system that provides reasonable procedures for notification, review, and resolution of an oral or written appeal concerning dissatisfaction or disagreement with an Adverse Determination. You, a person acting on Your behalf, or Your Provider of record must initiate an appeal of an Adverse Determination (which is not part of the Complaint process).

When You, a person acting on Your behalf, or Your Provider of record expresses orally or in writing any dissatisfaction or disagreement with an Adverse Determination, HMO or a utilization review agent will treat that expression as an appeal of an Adverse Determination.

Within five (5) business days after HMO receives an appeal of Adverse Determination, HMO will send to the appealing party a letter acknowledging the date HMO received the appeal and a list of documents the appealing party must submit. If the appeal was oral, HMO will enclose a one-page appeal form clearly stating that the form must be returned to HMO for prompt resolution. HMO has thirty (30) calendar days from receipt of a written appeal of Adverse Determination or the appeal form to complete the appeal process and provide written notice of the appeal decision to the appealing party. For appeals not related to pre-service claims, this period may be extended once by the reviewing agent for a period to not exceed fifteen (15) days if the agent determines that an extension is necessity due to matters beyond their control and if they notify the provider of record and the patient beforethe expiration of the initial thirty (30) day period. If the extension is required due to failure of the Provider orMember to submit information necessary to reach a determination on the request, the notice of extension willdescribe the required information necessary to complete the request and give the Provider and Member at least forty-five (45) days from the date of receipt of the notice to provide the specified information.

The appeal will be reviewed by a health care Provider not involved in the initial decision, who is in the same or similar specialty that typically manages the medical or dental condition, procedure or treatment under review.

Notice of HMO's final decision on the appeal will include the dental, medical and contractual reasons for the resolution; clinical basis for the decision and the specialization of Provider consulted. A denial will also include notice of Your right to have an IRO review the denial and the procedures to obtain a review.

Expedited Appeal of Adverse Determination (Emergencies, Prescription Drugs or Intravenous Infusions and Continued Hospitalization Situations)

Appeals relating to continued hospital stays and prescription drugs or intravenous infusions are referred directly to an expedited appeal process for investigation and resolution. They will be concluded inaccordance with the medical or dental immediacy of the case but in no event will exceed 24 hours from the date received, to the Provider by either telephone or electronic transmission, followed by a letter within 72 hours notifying the Member and the Provider. Appeals relating to ongoing emergencies will also be referred to an expedited appeal process that will be concluded within one hour of the time all necessary information is received.

The appeal will be reviewed by a health care Provider not involved in the initial decision, who is in the same or similar specialty that typically manages the medical or dental condition, procedure or treatment under review. The Physician or Provider reviewing the appeal may interview the patient or patient's designated representative.

How to Appeal to an Independent Review Organization (IRO)

This procedure (not part of the Complaint process) pertains only to appeals of Adverse Determinations. In prescription drug and intravenous infusions, life-threatening or urgent care circumstances or if you do not

receive a timely decision, You are entitled to an immediate appeal to an IRO and are not required to comply with HMO's appeal of an Adverse Determination process.

Any party whose appeal of an Adverse Determination is denied by HMO may seek review of the decision by an IRO assigned to the appeal. At the time the appeal is denied, HMO will provide You, Your designated representative or Your Provider of record, information on how to appeal the denial, including the approved form, which You, Your designated representative, or Your Provider of record must complete and return to HMO to begin the independent review process.

- In life-threatening or urgent care situations, You, Your designated representative, or Your Provider of record may contact HMO by telephone to request the review and provide the required information.
- HMO will submit medical records, names of Providers and any documentation pertinent to the decision of the IRO.
- HMO will comply with the decision by the IRO.
- HMO will pay for the independent review.

Upon request and free of charge, Member or designee may have reasonable access to, and copies of, all documents, records and other information relevant to the claim or appeal, including:

- information relied upon to make the decision;
- information submitted, considered or generated in the course of making the decision, whether or not it was relied upon to make the decision;
- descriptions of the administrative process and safeguards used to make the decision;
- records of any independent reviews conducted by HMO;
- medical judgements, including whether a particular service is Experimental, Investigational or not Medically Necessary or appropriate; and
- expert advice and consultation obtained by HMO in connection with the denied claim, whether or not the advice was relied upon to make the decision.

The appeal process does not prohibit You from pursuing other appropriate remedies, including: injunctive relief; a declaratory judgment or other relief available under law, if the requirement to exhaust the process for appeal and review places Your health in serious jeopardy. If Your health plan is governed by the Employee Retirement Income Security Act (ERISA), You have the right to bring civil action under 502(a) of ERISA. For more information about the IRO process, call TDI on the IRO information line at (866) 554-4926, or in Austin call (512) 322-4266.

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 www.christushealthplan.org/provider-resources/prior-authorization or by calling Member Services at 1-844-856-0826.

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. CHRISTUS Health Plan (CHP) does not require a participating provider to obtain pre-authorization if in the last 6 months evaluation period, CHP has approved 90% or more of the pre-authorization requests made by the provider for health care services.

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. These guidelines are consistent with sound clinical principles and have been developed by the Plan and practicing health care Providers. If guidelines do not exist for a certain service or treatment, resource tools based on peer-reviewed, scientific medical evidence are used. The determination for non-hospitalized requests will be provided no later than the third calendar day after the date the request is received. The determination for inpatient care services will be provided within 24 hours from receipt of the request. The determination for services for post-stabilization treatment, or a life-threatening condition, will be provided within 1 hour from receipt of the request.

A Preauthorization will specify the length of time for which it is valid. A Preauthorization may also be for only a certain number of treatments or services. If the Plan receives a request to renew a Preauthorization 60 days before the expiration of an existing Preauthorization, the Plan must review the request and issue a determination indicating whether the medical or health care service is preauthorized.

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 over $500;
- Genetic Testing and counseling and treatment of Genetic Inborn Errors of Metabolism Disorders (IEM);

- Home Health Care;
- Hospice Services, Inpatient and outpatient;
- MRI, 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.

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 Preauthorization's 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 72 hours following receipt of an Appeal for **Prescription Drugs and Intravenous Infusions**

Expedited/Review of Ongoing Services

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

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

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

What If Preauthorization is Denied?

External Review by MAXIMUS Federal Services

You, an individual acting on Your behalf, or Your Provider has the right to request an immediate external review of Our Appeal decision by MAXIMUS Federal Services. . External review requests must be submitted within 180 days of the notice of decision. You do not have to exhaust Our Appeal process before asking for an external review with MAXIMUS Federal Services if the Appeal process timelines are not met or if You are suffering from a health condition that may seriously jeopardize your life,health, or ability to regain maximum function or when you are undergoing a current course of treatment using a non-formulary drug. Our notice of determination of the Appeal will include complete instructionsfor making a request for an external review by MAXIMUS Federal Services. Expedited external review may be initiated at the same time as expedited internal appeals.

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

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

In any instance where a verbal communication from a representative of CHRISTUS Health Plan differs from the terms of this Contract, the terms of this Contract shall prevail.

COVERED SERVICES AND BENEFITS

Copayments/Coinsurance

You are liable for certain Copayments/Coinsurance and any applicable Deductibles to Participating Providers, which are due at the time of service. The Copayment/Coinsurance and any Deductibles due for specific Covered Services, benefit limitations and out-of-pocket maximums can be found in the **Schedule of Benefits and Coverage**.

Deductibles

Benefits are available under this EOC after satisfaction of any applicable Deductibles indicated in the **Schedule of Benefits and Coverage.** This Deductible, unless otherwise indicated, will be applied to all categories of Covered Services, including any benefits provided in a dental plan issued in association with this EOC.

If You have several covered Dependents, all charges used to apply toward an individual Deductible amount will be applied towards the family Deductible amount shown in the **Schedule of Benefits and Coverage**. When the family Deductible amount is reached, no further individual Deductibles will have to be satisfied for the remainder of that Calendar Year.

Out-of-Pocket Maximums

HMO will determine when maximums have been reached for Covered Services based on information provided to HMO by You and Participating Providers to whom You have made payments for Covered Services. Out-of-pocket maximums will include Copayments, Coinsurance, Deductibles and any eligible dental expenses payment obligations from a dental plan associated with this EOC. Once You reach the out-of-pocket maximum You are not required to make additional payments for Covered Services for the remainder of the Calendar Year.

If You have several covered Dependents, all charges used to apply toward an individual out-of-pocket maximum will be applied towards the family out-of-pocket maximum amount shown in the **Schedule of Benefits and Coverage**. When the family out-of-pocket maximum amount is reached, You are not required to make additional payments for Covered Services for the remainder of the Calendar Year.

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.

Requirements

All Covered Services, unless otherwise specifically described:

- must be Medically Necessary;
- must be performed, prescribed, directed or authorized in advance by the PCP and/or the HMO;
- must be rendered by a Participating Provider;
- are subject to the Copayment/Coinsurance and any other amounts due shown in **Schedule of Benefit sand Coverage**;
- may have limitations, restrictions or exclusions described in **LIMITATIONS AND EXCLUSIONS;** and
- may require Preauthorization.

Professional Services

Services must be provided or arranged by the PCP and rendered by a licensed Physician. HMO may allow other health Providers to provide Covered Services that may be provided under applicable state law by such Providers. Certain services may be restricted in **LIMITATIONS AND EXCLUSIONS.**

PCP or Specialist Office Visits. Services provided in the medical office of the PCP or authorized Specialist for the diagnosis and treatment of illness or injury.

PCP or Specialist Home Visits. Medically Necessary home visits provided by Participating Physicians when, in the judgment of the PCP or authorized Specialist, the nature of the illness or injury so indicates.

Services of Participating Physicians for diagnosis, treatment and consultation are provided while You are an inpatient or outpatient in a facility for authorized Medically Necessary Covered Services or Emergency Care as defined herein. Inpatient care may be directed by a Participating Physician other than Your PCP.

A health maintenance organization (HMO) plan provides no benefits for services you receive from out-of-network physicians or providers, with specific exceptions as described in the Evidence of Coverage below. You have the right to an adequate network of in-network physicians and providers (known as network physicians and providers). If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance at: www.tdi.texas.gov/consumer.complfrm.html. If your HMO approved a referral for out-of-network services because no network physician or provider is available, or if you have received out-of-network emergency care, the HMO must, in most cases, resolve the out-of-network physician's or provider's bill so that you only have to pay any applicable in-network copayment, coinsurance, and deductible amounts. You may obtain a current directory of network physicians and providers at the following website: christushealthplan.org/find-a-provider or by calling 1-844-856-0826 for assistance in finding available network physicians and providers. If you relied on materially inaccurate directory information, you may be entitled to have a claim by an out-of-network physician or provider paid as if it were from a network physician or provider, if you present a copy of the inaccurate directory information to the HMO, dated not more than 30 days before you received the service.

Inpatient Hospital Services

Services, except Emergency Care and treatment of breast cancer, must be arranged by Your PCP and Preauthorized by HMO. Covered Services include:

1. semi-private room and board, with no limit to number of days unless otherwise indicated;
2. private rooms when Medically Necessary and authorized by the PCP;
3. special diets and meals when Medically Necessary and authorized by the PCP;
4. use of intensive care or cardiac care units and related services when Medically Necessary and authorized by the PCP;
5. use of operating and delivery rooms and related facilities;
6. anesthesia and oxygen services;
7. laboratory, x-ray and other diagnostic services;
8. drugs, medications, biologicals and their administration;
9. general nursing care;

10. special duty and private duty nursing when Medically Necessary and authorized by the PCP;
11. radiation therapy, inhalation therapy and chemotherapy;
12. whole blood, including cost and administration of whole blood, blood plasma, and blood plasma expanders, which is not replaced by or for You;
13. short-term rehabilitation therapy services in an acute hospital setting;
14. treatment of breast cancer, for a minimum of forty-eight (48) hours following a mastectomy and twenty-four (24) hours following a lymph node dissection (with no Preauthorization required); provided, however, that such minimum hours of coverage are not required if You and Your attending Physician determine that a shorter period of inpatient care is appropriate. Upon request, the length-of-stay may be extended if HMO determines that an extension is Medically Necessary; and
15. organ and tissue transplants. Preauthorization is required for any organ or tissue transplant, even if the patient is already in a Hospital under another Preauthorization. At the time of Preauthorization, HMO will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if HMO determines that an extension is Medically Necessary.

    a. Services, including donor expenses, for organ and tissue transplants are covered, but only if all the following conditions are met:

        (1) the transplant procedure is not Experimental/Investigational in nature;
        (2) donated human organs or tissue or a United States Food and Drug Administration approved artificial device are used;
        (3) the recipient is a Member;
        (4) the Member meets all of the criteria established by HMO in pertinent written medical policies; and
        (5) the Member meets all of the protocols established by the Hospital in which the transplant is performed.

        Covered Services and supplies related to an organ or tissue transplant include, but are not limited to x-rays, laboratory testing, chemotherapy, radiation therapy, prescription drugs, procurement of organs or tissues from a living or deceased donor, and complications arising from such transplant.

    b. Benefits will be determined on the same basis as any other sickness when the transplant procedure is considered Medically Necessary and meets all of the conditions cited above. Benefits will be available for:

        (1) a recipient who is a Member covered under the HMO;
        (2) a donor who is a Member covered under the HMO; or
        (3) a donor who is not a Member covered under the HMO.

    c. Covered Services and supplies include those provided for the:

        (1) donor search and acceptability testing of potential live donors;
        (2) evaluation of organs or tissues including, but not limited to, the determination of tissue matches;
        (3) removal of organs or tissues from living or deceased donors; and

(4) transportation and short-term storage of donated organs or tissues.

d. No benefits are available for a Member for the following services and supplies:

(1) living and/or travel expenses of the recipient or a live donor;
(2) expenses related to maintenance of life of a donor for purposes of organ or tissue donation;
(3) purchase of the organ or tissue other than payment for Covered Services and supplies identified above; and
(4) organ or tissue (xenograft) obtained from another species.

Outpatient Facility Services

Services provided through a Participating Hospital outpatient department, a free-standing facility, or the home setting must be prescribed by the PCP. Preauthorization may be required for the following services:

1. Infusion Therapy (including chemotherapy);
2. outpatient surgery;
3. radiation therapy; and
4. dialysis.

Outpatient Laboratory and X-Ray Services

Laboratory and radiographic procedures, services and materials, including (but not limited to) diagnostic x-rays, x-ray therapy, chemotherapy, fluoroscopy, electrocardiograms, laboratory tests and therapeutic radiology services must be ordered, authorized or arranged by the PCP and provided through a Participating facility or in the home setting. Preauthorization may be required.

Biomarker Testing

The Plan covers biomarker testing when medically necessary for the purposes of diagnosing, treating, managing, or monitoring an enrollee's disease or condition, in accordance with Texas Insurance Code §1372.003.

Biomarker testing refers to the analysis of a tissue, blood, or other biospecimen for the presence of a gene, mutation, protein, or other biomarker used to guide medical decision-making. Covered testing must be supported by medical and scientific evidence, including:

- U.S. Food and Drug Administration (FDA) approval or clearance
- Recommendations from nationally recognized clinical practice guidelines (e.g., National Comprehensive Cancer Network)
- Inclusion in the National Cancer Institute's Genetic Testing Registry; or
- Peer-reviewed medical literature that demonstrates clinical utility.

Rehabilitation Services

Rehabilitation services and physical, speech and occupational therapies that in the opinion of a Physician are Medically Necessary and meet or exceed Your treatment goals are provided when preauthorized or prescribed by Your PCP or Specialist. For a physically disabled person, treatment goals may include maintenance of functioning or prevention or slowing of further deterioration. Rehabilitation Services may be provided in the Provider's office, in a Hospital as an inpatient, in an outpatient facility, or as home health care visits. Rehabilitation services, including coverage for chiropractic services, are available from a Participating Provider when Preauthorized or prescribed by Your PCP.

Treatment of Acquired Brain Injury will be covered the same as any other physical condition. Cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation; neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing or treatment; neurofeedback therapy, remediation, post-acute transition services and community reintegration services, including outpatient day treatment services, or any other post-acute treatment services are covered, if such services are necessary as a result of and related to an Acquired Brain Injury. To ensure that appropriate post-acute care treatment is provided, HMO includes coverage for periodic reevaluation for a Member who: (1) has incurred an Acquired Brain Injury; (2) has been unresponsive to treatment; and (3) becomes responsive

to treatment at a later date. Services may be provided at a Hospital, an acute or post-acute rehabilitation hospital, an assisted living facility or any other facility at which appropriate services or therapies may be provided.

Except for treatment of Acquired Brain Injury, rehabilitation services are limited as indicated on the **Schedule of Benefits and Coverage**.

Maternity Care and Family Planning Services

Maternity Care. HMO provides coverage for inpatient care for the mother and the newborn in a Hospital for a minimum of forty-eight (48) hours following an uncomplicated vaginal delivery, or ninety-six (96) hours following an uncomplicated delivery by cesarean section. Preauthorization is not required. Upon request, the length-of-stay may be extended if HMO determines that an extension is Medically Necessary.

Covered Services, which may require Preauthorization, include:

1. prenatal visits;
2. use of Hospital delivery rooms and related facilities. If a newborn child is discharged and readmitted to a Hospital more than five (5) days after the date of birth, a separate Hospital admission Copayment/Coinsurance and any Deductible for such readmission will be required. A separate Hospital admission Copayment/Coinsurance and Deductible is required for a newborn child at time of delivery;
3. use of newborn nursery and related facilities;
4. special procedures as may be Medically Necessary and authorized by the PCP or designated Obstetrician/Gynecologist; and
5. postnatal visits. If the mother or newborn is discharged before the minimum hours of inpatient coverage have passed, the HMO provides coverage for Post-Delivery Care for the mother and newborn. Post-Delivery Care may be provided at the mother's home or a Participating Provider's office or facility. A newborn child will not be required to receive health care services only from Participating Providers if born outside the Service Area due to an emergency or born in a non-network facility to a mother who is not a Member. HMO may require the newborn to be transferred to a Participating facility, at HMO's expense, when determined to be medically appropriate by the newborn's treating Physician.

Complications of Pregnancy. Covered Services for Complications of Pregnancy will be the same as for treatment of any other physical illness and may require Preauthorization.

Family Planning. Covered Services, which may require Preauthorization, include:

- 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 screening to persons age thirty-five (35) and older while diagnostic mammograms have no age restriction;

- 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.

Fertility Preservation Services Related to Cancer Treatment

In accordance with Texas Insurance Code §§1366.101–1366.104 and HB 1649, the Plan provides coverage for standard fertility preservation services to a covered person who will undergo cancer treatment, including surgery, chemotherapy, or radiation, that may directly or indirectly cause impaired fertility, as recognized by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

Covered services include standard fertility preservation procedures, such as oocyte and sperm cryopreservation, consistent with established medical guidelines. Coverage for fertility preservation services will not be subject to limitations more restrictive than those applied to other medical services under the Plan.

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with CHRISTUS Health Plan.

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:

(a) 48 hours following an uncomplicated vaginal delivery, and

(b) 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 (a) give

birth in a hospital or other health care facility or (b) 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 48 or 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 (a) modify the terms of this coverage based on any covered person requesting less than the minimum coverage required; (b) offer the mother financial incentives or other compensation for waiver of the minimum number of hours required; (c) 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; (d) reduce payments or reimbursements below the usual and customary rate; or (f) penalize a physician for recommending inpatient care for the mother and/or the newborn child.

Mastectomy or Lymph Node Dissection

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

(a) 48 hours following a mastectomy, and

(b) 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 (a) deny any covered person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours; (b) provide money payments or rebates to encourage any covered person to accept less than the minimum inpatient hours; (c) 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 (d) provide financial or other incentives to the attending physician to encourage the physician to provide care that is less than the minimum hours.

If any person covered by this plan has questions concerning the above, please call CHRISTUS Health Plan at 1-844-856-0826 or write us at:

PO Box 169009
Irving, Texas 75016

Note: some benefits for family planning are available under **Health Maintenance and Preventive Services.**

Infertility Services. Covered Services, which may require Preauthorization, include diagnostic counseling, consultations, planning services and treatment for problems of fertility and Infertility, subject to the exclusions in **LIMITATIONS AND EXCLUSIONS**. Once the Infertility workup and testing have been completed, subsequent workups and testing will require approval of the HMO Medical Director.

Mental Health Services, Behavioral Health Treatment, Alcoholism and Substance Use 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 Use Services. This Plan will cover the diagnosis and treatment of Substance Use, which includes alcohol and drug use disorders in an Inpatient and outpatient setting. Inpatient services include Hospitalization for alcohol and drug use detoxification, Rehabilitation partial Hospitalization. Rehabilitation does not include a Residential Treatment Center or other facility 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, partial 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.

Emergency Services

PCPs provide coverage for Members 24 hours a day, 365 days a year. You must notify Your PCP within forty-eight (48) hours of receiving Emergency Care, or as soon as possible without being medically harmful or injurious to You. HMO will pay for a medical screening examination or other evaluation required by Texas or federal law and provided in the emergency department of a Hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility that is necessary to determine whether an emergency medical condition exists. CHRISTUS Health Plan will approve or deny the treatment within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient.

Emergency Care. Emergency Care services whether rendered by a Participating or non-Participating Providers will be covered, based upon the signs and symptoms presented at the time of treatment as documented by the attending health care personnel, whether the Emergency Care services were received within the Service Area or Out-of-Area. Emergency Care services are subject to the Copayment/Coinsurance and any Deductible, unless You are admitted as an inpatient directly from the emergency room, in which case You pay the inpatient Hospital Copayment and any amounts due.

If post stabilization care is required after an Emergency Care condition has been treated and stabilized, the treating Physician or Provider will contact HMO or its designee, who must approve or deny coverage of the post stabilization care requested within one hour of receiving the call.

You may receive Emergency Care services in an Urgent Care center.

Out-of-Area Services. Only Emergency Care services as described above are covered. Continuing or follow-up treatment for accidental injury or Emergency Care is limited to care required before You can return to the Service Area without medically harmful or injurious consequences.

Urgent Care Services

Urgent Care services are covered when rendered by an Urgent Care Provider for the immediate treatment of a medical condition that requires prompt medical attention but where a brief time lapse before receiving services will not endanger life or permanent health and does not require Emergency Care services.Additional charges described in **Outpatient Laboratory and X-ray Services** or **Outpatient Facility Services** may also apply.

Unless designated and recognized by HMO as an Urgent Care center, neither a hospital nor an emergency room will be considered an Urgent Care center.

Ambulance Services

Professional local ground ambulance service or air ambulance service to the nearest Hospital is covered when authorized by the PCP or for Emergency Care, as defined in this EOC.

Extended Care Services

Covered Services include the following when prescribed by the PCP and authorized by the HMO. Services may have additional limitations as indicated in the **Schedule of Benefits and Coverage**, and restrictions or exclusions described in **LIMITATIONS AND EXCLUSIONS**.

Skilled Nursing Facility Services. Services must be temporary and lead to rehabilitation and an increased ability to function. Custodial Care is not covered. If You remain in a Skilled Nursing Facility after the PCP discharges You or after You reach the maximum benefit period or period authorized by HMO, You will be liable for all subsequent costs incurred.

Hospice Care. Care that is provided by a Hospital, Skilled Nursing Facility, Hospice, home setting, or a duly licensed Hospice Care agency, is approved by HMO, and is focused on a palliative rather than curative treatment for Members who have a medical condition and a prognosis of less than 6 months to live. Services include bereavement counseling and homemaker services routinely provided by the hospice agency.

Home Health Care. Care in the home by Health Care Professionals who are Participating Providers, including but not limited to registered nurses, licensed practical nurses, physical therapists, inhalation therapists, speech or hearing therapists or home health aides. Services must be provided or arranged by the PCP.

Health Maintenance and Preventive Services

Covered Services, which may require Preauthorization and will not be subject to any Copayment/Coinsurance, Deductible or dollar maximums, include evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF") or as required by state law:

1. well child care for Members through age seventeen (17) which includes evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents;
2. periodic health assessments for Members eighteen (18) and older, based on age, sex and medical history;
3. administration of newborn screening test, including the cost of a test kit;
4. routine immunizations recommended by the American Academy of Pediatrics, U.S. Public Health Service for people in the United States and required by law and immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved. Examples of covered immunizations include diphtheria, haemophilus influenza type b, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, rotovirus, varicella and any other immunization that is required by the law for a child. (Allergy injections are not considered immunizations under this benefit provision.);
5. Colorectal cancer screening for Members starting at age 45, including colonoscopies and including a follow-up colonoscopy if the results of the initial colonoscopy, test, or procedure were abnormal and coverage for preventive services and lab tests with an "A" or "B" grade from the USPSTF;
6. bone mass measurement for the detection of low bone mass and to determine risk of osteoporosis and fractures associated with osteoporosis, for qualified individuals including postmenopausal women who are not receiving estrogen replacement therapy; individuals with vertebral abnormalities, primary hyperparathyroidism or a history of bone fractures; or individuals receiving long-term glucocorticoid therapy or being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy;
7. preventive care and screenings provided with respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the HRSA such as a well-woman gynecological exam (once every twelve months) for female Members, a medically recognized diagnostic exam for the early detection of cervical cancer for female Members age eighteen (18) and older, and coverage for any other test or screening approved by the United States Food and Drug Administration for the detection of ovarian cancer. Your PCP or any Obstetrician/Gynecologist in Your PCP's network of Participating Providers may perform the

well-woman exam. The exam may include, but is not limited to, a conventional Pap smear screening; a screening using liquid- based cytology methods alone or in combination with a test approved by the United States Food and Drug Administration for the detection of human papillomavirus. You must first obtain a Referral from Your PCP for follow-up services related to treatment of a disease or condition that is not within the scope of an Obstetrician/Gynecologist. For help in selecting an Obstetrician/Gynecologist, refer to the HMO Provider directory, contact Your PCP or call customer service;

8. a screening (non-diagnostic) low-dose mammogram to detect the presence of occult breast cancer for female Members age thirty-five (35) and over (once every twelve months), and for female Members with other risk factors. Mammograms may be obtained whether or not a well-woman exam is performed at the same time;
9. a screening test for hearing loss for Members from birth through age thirty (30) days, and necessary diagnostic follow-up care related to the screening test from birth through age twenty-four (24) months; and
10. Vision screening for all children, including a vision exam, glasses or contact lenses, medically necessary contact lenses, and low vision services;
11. 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.

To determine if a specific drug or device is available under this Preventive Services benefit contact customer service at the toll-free number on the back of Your identification card. This list may change as FDA guidelines, medical management and medical policies are modified.

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with CHRISTUS Health Plan.

Coverage of Tests for Detection of Human Papillomavirus and Cervical Cancer

Coverage is provided, for each woman enrolled in the plan who is 18 years of age or older, for expenses incurred for an annual medically recognized diagnostic examination for the early detection of cervical cancer. Coverage required under this section includes at a minimum a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

Coverage for Tests for Detection of Colorectal Cancer

Benefits are provided, for each person enrolled in the plan who is 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:

(a) an initial colonoscopy or other medical test or procedure for colorectal cancer screening, and

(b) a follow-up colonoscopy if the results of the initial colonoscopy, test, or procedure are abnormal.

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) a physical examination for the detection of prostate cancer; and

(b) a prostate-specific antigen test for each covered male who is

(1) at least 50 years of age; or

(2) at least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

If any person covered by this plan has questions concerning the above, please call CHRISTUS Health Plan at 1-844-856-0826 or write us at:

PO Box 169009

Irving, Texas 75016

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, some of these services are designated under federal law as covered Essential Health Benefits for women with reproductive capacity; these covered services may include:

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

Direct abortion is not a covered benefit.

Contraceptive drugs and devices not available under this Preventive Services benefit may be covered underother sections of this EOC, and may be subject to any applicable Copayments/Coinsurance and Deductible.

Breastfeeding Support, Counseling and Supplies. Covered Services include support and counseling services obtained from a Participating Provider during pregnancy and/or in the postpartum period. Benefits will also be provided for the rental (or, at HMO's option, the purchase) of manual, or electric breast pumps and supplies. Limited benefits will also be available for the rental (or, at HMO's option, the purchase) of hospital grade breast pumps, from a Participating Provider. You may be required to pay the full amount and submit a reimbursement claim form along with the written prescription to HMO with itemized receiptsfor the manual, electric or hospital grade breast pump and supplies. Visit the website at www.christushealthplan.org to obtain a claim form.

Examples of other covered preventive services that are not subject to Copayment/Coinsurance, Deductible or dollar maximums include smoking cessation counseling services, healthy diet counseling and obesity screening/counseling.

The covered preventive services described above may change as the USPSTF, CDC, HRSA guidelines and state laws are modified. If a recommendation or guideline for a particular preventive service does not specify the frequency, method, treatment or setting in which it must be provided, HMO may use reasonable medical management techniques to determine benefits. For more information, contact customer service at the toll-free number on Your identification card.

If a covered preventive service is provided during an office visit and is billed separately from the office visit, You may be responsible for the Copayment/Coinsurance and any applicable Deductible for the officevisit only. If an office visit and the preventive health service are not billed separately and the primary purpose of the visit was not the preventive health service, You may be responsible for the Copayment /Coinsurance and any applicable Deductible for the office visit including the preventive health service.

Additional preventive screening services, which may require Preauthorization and may be subject to Copayment/Coinsurance, Deductibles or dollar maximums, include:

1. eye and ear screenings (once every twelve months) performed or authorized by the PCP for Members through age seventeen (17) to identify vision and hearing problems. Eye screenings may be performed in the PCP office and do not include refractions;
2. eye and ear screenings (once every two years) performed or authorized by the PCP for Members eighteen (18) and older to identify vision and hearing problems. Eye screenings may be performed in the PCP office and do not include refractions;
3. early detection test for cardiovascular disease. Benefits are available for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five years when performed by a laboratory that is certified by a recognized national organization: (1) computed tomography (CT) scanning measuring coronary artery calcifications; or (2) ultrasonography measuring carotid intima-media thickness and plaque.
   Tests are available to each covered Member who is (1) a male older than 45 years of age and younger than 76 years of age, or (2) a female older than 55 years of age and younger than 76 years of age. The Member must be a diabetic or have a risk of developing coronary heart disease,

based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher.

Benefits are limited as indicated on the **Schedule of Benefits and Coverage**.

Dental Surgical Procedures

General dental services are not covered for adults over the age of 19, but limited oral surgical procedures are covered when prescribed by Your PCP and performed in a Participating Provider's office or in the inpatient or outpatient setting. The following Covered Services may require Preauthorization by HMO:

1. treatment for accidental injury to Sound Natural Adult Teeth, the jaw bones or surrounding tissues, not caused by biting or chewing, when treatment is completed within twenty-four (24) months of the initial treatment. "Sound Natural Adult Teeth" means teeth that are free of active or chronic clinical decay, have at least 50% bony support, are functional in the arch, and have not been excessively weakened by multiple dental procedures;
2. treatment or correction of a non-dental physiological condition which has resulted in severe functional impairment;
3. treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
4. diagnostic and surgical treatment of conditions affecting the temporomandibular joint (including the jaw or craniomandibular joint) as a result of an accident, a trauma, a congenital defect, a developmental defect, or a pathology; and
5. removal of complete bony impacted teeth.

Cosmetic, Reconstructive or Plastic Surgery

Coverage will be the same as for treatment of any other physical illness generally, only when prescribed or arranged by Your PCP, and may require Preauthorization by HMO. Covered Services are limited to the following:

6. surgery to correct a defect resulting from accidental injury;
7. surgery to correct a functional defect which results from a congenital and/or acquired disease or anomaly;
8. surgical reconstruction of the breast following a mastectomy, and surgical reconstruction of the other breast to achieve a symmetrical appearance; and
9. Reconstructive Surgery for Craniofacial Abnormalities for a Member.

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with CHRISTUS Health Plan.

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:

(a) all stages of the reconstruction of the breast on which mastectomy has been performed;

(b) surgery and reconstruction of the other breast to achieve a symmetrical appearance; and

(c) 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 (a) offer the covered person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above; (b) 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 (c) 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).

If any person covered by this plan has questions concerning the above, please call CHRISTUS Health Plan at 1-844-856-0826, or write us at:

PO BOX 169009
Irving, Texas 75016

Allergy Care

Covered Services for testing and treatment must be provided or arranged by the PCP.

Diabetes Care

Diabetes Self-Management Training. Covered Services, which may require Preauthorization, include instructions enabling a person with diabetes and/or his caretaker to understand the care and management of diabetes; development of an individualized management plan; nutritional counseling and proper use of diabetes equipment and supplies. Diabetes self-management training is provided upon the following occasions:

1. the initial diagnosis of diabetes;
2. a significant change in symptoms or condition that requires changes in Your self-management regime, as diagnosed by a Participating Physician or practitioner;
3. the prescription of periodic or episodic continuing education warranted by the development of new techniques and treatments for diabetes; or
4. the need for a caretaker or a change in caretakers for the person with diabetes necessitates diabetes management training for the caretaker.

Diabetes Equipment and Supplies Diabetes equipment and supplies are covered for Members diagnosed with insulin dependent or non-insulin dependent diabetes; elevated blood glucose levels induced by pregnancy; or another medical condition associated with elevated blood glucose levels.
When the following diabetes equipment and supplies are obtained, You may be required to pay the full amount of their bill and submit a reimbursement claim form to HMO with itemized receipts. Cost-sharing for insulin that is on the formulary cannot exceed $25 per prescription for a 30-day supply. Emergency refills of insulin and insulin-related equipment are covered in the same manner as a nonemergency.Visit the website at www.christushealthplan.org to obtain an HMO medical claim form. If You choose to purchasediabetes supplies utilizing pharmacy benefits, You must pay the applicable **PHARMACY BENEFITS** Copayment/Coinsurance in the **Schedule of Benefits and Coverage** and any applicable pricing differences as well as any Deductibles. No claim forms are required.
Diabetes equipment and supplies include, but are not limited to:

- blood glucose monitors
- noninvasive glucose monitors and monitors for the blind
- insulin pumps and necessary accessories
- insulin infusion devices
- biohazard disposable containers
- podiatric appliances (including up to two pairs of therapeutic footwear per Calendar Year)
- glucose meter solution
- test strips specified for use with a corresponding blood glucose monitor
- visual reading and urine test strips and tablets that test for glucose, ketones and protein
- lancets and lancet devices
- injection aids, including devices used to assist with insulin injection and needleless systems
- glucagon emergency kits
- prescription orders for insulin and insulin analog preparations

- insulin syringes
- prescriptive and nonprescriptive oral agents for controlling blood sugar levels

The diabetes equipment and supplies in the list below are only available utilizing pharmacy benefits. When You purchase these items utilizing pharmacy benefits, You must pay the applicable **PHARMACY BENEFITS** Copayment/Coinsurance in the **Schedule of Benefits and Coverage** and any applicable pricing differences as well as any Deductibles. No claim forms are required.

Prosthetic Appliances and Orthotic Devices

The following covered appliances and devices must be provided or arranged by the PCP, and may require Preauthorization by HMO.

1. Initial Prosthetic Appliances are covered subject to restrictions in the **Schedule of Benefits and Coverage** and **LIMITATIONS AND EXCLUSIONS.**
2. Repair and replacement of Prosthetic Appliances and orthotic devices are covered unless the repair or replacement is a result of misuse or loss by You.
3. Orthopedic braces, such as orthopedic appliances used to support, align, or hold bodily parts in a correct position; crutches, including rigid back, leg or neck braces; casts for treatment of any part of the legs, arms, shoulders, hips or back; special surgical and back corsets; and Physician-prescribed, directed or applied dressings, bandages, trusses and splints that are custom designed for the purpose of assisting the function of a joint.
4. Initial breast prostheses and two surgical brassieres after mastectomy.
5. Medically Necessary foot orthotics that are consistent with the Medicare Benefit Contract Manual are covered. There is no Calendar Year maximum. This is in addition to, and does not affect, the coverage for podiatric appliances shown in **Diabetes Care**.
6. 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.

Durable Medical Equipment

You must obtain services and devices through a Participating DME Provider, which must be consistent with the Medicare DME Manual, and may require Preauthorization by HMO. HMO will determine whether DME is rented or purchased, and retains the option to recover the DME upon cancellation or termination of Your coverage.

Examples of DME are: standard wheelchairs, crutches, walkers, orthopedic tractions, Hospital beds, oxygen, bedside commodes, suction machines, etc. Excluded items are listed in **LIMITATIONS AND EXCLUSIONS**.

Hearing Aids

Covered services, services and supplies, which may require Preauthorization, include one audiometric examination to determine type and extent of hearing loss once every thirty-six (36) months and the fitting and purchase of hearing aid device(s). Also covered for medically necessary hearing aids or cochlear implants include fitting and dispensing services and the provision of the ear molds as necessary to maintain optimal fit. This coverage includes the treatment for habilitation and rehabilitation, and for cochlear implant, an external speech processor and controller with necessary component and replacement every three years. Exclusions are listed in **LIMITATIONS AND EXCLUSIONS**.

Hearing Aid Coverage Clarification

The Plan provides benefits for hearing aids as described in the Schedule of Benefits. In accordance with Texas Insurance Code Chapter 1365, the Plan will not deny a claim for a hearing aid solely because the purchase price exceeds the Plan's hearing aid benefit amount.
Members may choose a hearing aid that costs more than the benefit limit and pay the difference in cost out of pocket. The Plan will still apply its standard benefit amount toward the claim.

Speech and Hearing Services

Covered Services, which may require Preauthorization, include inpatient and outpatient care and treatment for loss or impairment of speech or hearing that is not less favorable than for physical illness generally.

Autism Spectrum Disorder

Generally recognized services prescribed in relation to Autism Spectrum Disorder by Your PCP in a treatment plan recommended by that Physician are covered. No benefit maximums will apply.

Individuals providing treatment prescribed under that plan must be:

1. a health care practitioner:
   - who is licensed, certified, or registered by an appropriate agency of the state of Texas;
   - whose professional credential is recognized and accepted by an appropriate agency of the United States; or

- who is certified as a provider under the TRICARE military health system.

2. an individual acting under the supervision of a health care practitioner described in item 1.

Treatment may include services such as:

- evaluation and assessment services;
- screening and evaluation at 18 and 24 months;
- 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.

All standard contractual provisions of this EOC will apply, including but not limited to, defined terms, limitations and exclusions.

Routine Patient Costs for Participants in Certain 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:

(A) The clinical trial is approved by the United States Food and Drug Administration,

(B) 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

(C) Federally funded trials.— The study or investigation is approved or funded (which may include funding through inkind 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.

(D) 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:

i) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

ii) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

LIMITATIONS AND EXCLUSIONS

The following benefits are not covered unless specifically provided for in **COVERED SERVICES AND BENEFITS** or **PHARMACY BENEFITS**.

1. Services or supplies of non-Participating Providers, except:
   a. Emergency Care; or
   b. when authorized by HMO or Your PCP.

2. Services or supplies which are not Medically Necessary and essential to the diagnosis or direct care and treatment of a sickness, injury, condition, disease or bodily malfunction as defined herein.

3. If a service is not covered, HMO will not cover any services related to it. Related services are:
   a. services in preparation for the non-covered service;
   b. services in connection with providing the non-covered service;
   c. hospitalization required to perform the non-covered service; or
   d. services that are usually provided following the non-covered service, such as follow-up care or therapy after surgery.

4. Experimental/Investigational services and supplies. Denials based on Experimental or Investigational services are adverse determinations subject to the utilization review process including reviews by an Independent Review Organization.

5. Any charges resulting from the failure to keep a scheduled visit with a Participating Provider or for acquisition of medical records.

6. Special medical reports not directly related to treatment.

7. Examinations, testing, vaccinations or other services required by employers, insurers, schools, camps, courts, licensing authorities, other third parties or for personal travel.

8. Services or supplies provided by a person who is related to a Member by blood or marriage and self-administered services.

9. Services or supplies for injuries sustained as a result of war, declared or undeclared, or any act of war or while on active or reserve duty in the armed forces of any country or international authority.

10. Benefits for which You are covered through entitlement programs of the federal, state, or local government, including but not limited to Medicare, Medicaid or their successors.

11. Care for conditions that federal, state or local law requires to be treated in a public facility.

12. Appearances at court hearings and other legal proceedings, and any services relating to judicial or administrative proceedings or conducted as part of medical research.

13. Any services, supplies or drugs received by a Member outside of the United States, except for Emergency Care.

14. Transportation services except as described in **Ambulance Services**, or when approved by HMO.

15. Personal or comfort items, including but not limited to televisions, telephones, guest beds, admission kits, maternity kits and newborn kits provided by a Hospital or other inpatient facility.

16. Private rooms unless Medically Necessary and authorized by the HMO. If a semi-private room is not available, HMO covers a private room until a semi-private room is available.

17. Any and all transplants of organs, cells, and other tissues, except as described in **Inpatient Hospital Services**. Services or supplies related to organ and tissue transplant or other procedures when You are the donor and the recipient is not a Member are not covered.

18. The Plan does not cover any organ transplant procedure or post-transplant care if:
    a. The transplant was performed in China or any country known to have participated in forced organ harvesting; or
    b. The organ was procured through sale or donation originating in China or such country. This exclusion applies regardless of medical necessity or clinical appropriateness of the transplant. Coverage remains available for medically necessary transplants performed in countries not known for participation in forced organ harvesting.

19. Services or supplies for Custodial Care.

20. Services or supplies furnished by an institution that is primarily a place of rest, a place for the aged or any similar institution.

21. Private duty nursing, except when determined to be Medically Necessary and ordered or authorized by the PCP.

22. Services or supplies for Dietary and Nutritional Services, including home testing kits, vitamins, dietary supplements and replacements, and special food items, except:

    - an inpatient nutritional assessment program provided in and by a Hospital and approved by HMO;
    - dietary formulas necessary for the treatment of phenylketonuria or other heritable diseases;
    - as described in Diabetes Care;
    - as described in Autism Spectrum Disorder.

23. Services or supplies for Cosmetic, Reconstructive or Plastic Surgery, including breast reduction or augmentation (enlargement) surgery, even when Medically Necessary, except as described in Cosmetic, Reconstructive or Plastic Surgery.

24. Services or supplies provided primarily for:

a. Environmental Sensitivity; or

b. Clinical Ecology or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists; or

c. inpatient allergy testing or treatment.

25. Services or supplies provided for, in preparation for, or in conjunction with the following, except as described in **Maternity Care and Family Planning Services**.

a. sterilization reversal (male or female);

b. gender reassignment surgery and related treatment, including hormone therapy and medical or psychological counseling;
c. treatment of sexual dysfunction including medications, penile prostheses and other surgery, and vascular or plethysmographic studies that are used only for diagnosing impotence;
d. promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination super ovulation uterine capacitation enhancement, direct-intraperitoneal insemination, trans-uterine tubal insemination, gamete intrafallopian transfer, pronuclear oocyte stage transfer, zygote intrafallopian transfer andtubal embryo transfer;
e. any services or supplies related to in vitro fertilization or other procedures when You are the donor and the recipient is not a Member;
f. in vitro fertilization and fertility drugs.

26. Services or supplies in connection with routine foot care, including the removal of warts, corns, or calluses, or the cutting and trimming of toenails in the absence of diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency.

27. Services or supplies in connection with foot care for flat feet, fallen arches, or chronic foot strain.

28. Services or supplies for reduction of obesity or weight, including surgical procedures and prescription drugs, even if the Member has other health conditions that might be helped by a reduction of obesity or weight, except for healthy diet counseling and obesity screening/counseling as may be provided under **Preventive Services**.

29. Services or supplies for, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.

30. Services or supplies for dental care for adults over the age of 19, except as described in **Dental Surgical Procedures**.

31. Alternative treatments such as acupuncture, acupressure, hypnotism, massage therapy and aroma therapy.

32. Services or supplies for:
    a. intersegmental traction;
    b. surface EMGs;
    c. spinal manipulation under anesthesia;
    d. muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.

33. Galvanic stimulators or TENS units.

34. Disposable or consumable outpatient supplies, such as syringes, needles, blood or urine testing supplies (except as used in the treatment of diabetes); sheaths, bags, elastic garments, stockings and bandages, garter belts, ostomy bags.

35. Psychological/neuropsychological testing and psychotherapy services including, but not limited to:
    a. educational testing;
    b. employer/government mandated testing;
    c. testing to determine eligibility for disability benefits;
    d. testing for legal purposes (e.g., custody/placement evaluations, forensic evaluations, and court mandated testing);
    e. testing for vocational purposes (e.g., interest inventories, work related inventories, and career development);
    f. services directed at enhancing one's personality or lifestyle;
    g. vocational or religious counseling;
    h. activities primarily of an educational nature;
    i. music or dance therapy;
    j. bioenergetic therapy; or
    k. psychotherapeutic services accessed concurrently by more than one Mental Healthcare Provider.

36. Biofeedback (except for an Acquired Brain Injury diagnosis) or other behavior modification services.

37. Mental health services except as described in **Behavioral Health Services** or as may be provided under **Autism Spectrum Disorder.**

38. Residential Treatment Centers for Chemical Dependency that are not:
    a. accredited as such a facility by the Joint Commission on Accreditation of Hospitals;
    b. licensed as a Chemical Dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or
    c. licensed, certified or approved as a Chemical Dependency treatment program or center by any other state agency having legal authority to so license, certify or approve.

39. Trauma or wilderness programs for behavioral health or Chemical Dependency treatment.

40. Replacement for loss, damage or functional defect of hearing aids. Batteries are not covered unless needed at the time of the initial placement of the hearing aid device(s).

41. Deluxe equipment such as motor driven wheelchairs and beds (unless determined to be Medically Necessary); comfort items; bed boards; bathtub lifts; over-bed tables; air purifiers; sauna baths; exercise equipment; stethoscopes and sphygmomanometers; Experimental and/or research items; and replacement, repairs or maintenance of the DME.

42. Over-the-counter supplies or medicines and prescription drugs and medications of any kind, except:
    a. as provided while confined as an inpatient,
    b. as provided under **Autism Spectrum Disorder**;

c. as provided under **Diabetes Care**;

d. contraceptive devices and FDA-approved over-the-counter contraceptives for women with a written prescription from a Participating Provider; or

e. if covered under **PHARMACY BENEFITS**.

43. Male contraceptive devices, including over-the-counter contraceptive products such as condoms; female contraceptive devices, including over-the-counter contraceptive products such as spermicide, when not prescribed by a Participating Provider.

44. Any procedures, equipment, services, supplies, or charges for abortions for which Federal funding is prohibited. Federal funding is allowed for abortions where a pregnancy which, as certified by a Physician, places You in danger of death unless an abortion is performed.

45. Elective abortion.

PHARMACY BENEFITS

Definitions

In addition to the applicable terms provided in the **DEFINITIONS** section of this EOC, the following terms will apply specifically to this **PHARMACY BENEFITS** section.

Allowable Amount means the maximum amount determined by HMO to be eligible for consideration of payment for a particular covered drug. As applied to Participating Pharmacies the Allowable Amount is based on the provisions of the contract between HMO and the Participating Pharmacy in effect on the date of service. As applied to **Prescription Drugs Purchased Outside of the Service Area**, the Allowable Amount is based on the Participating Pharmacy contract rate.

Brand Name Drug means a drug or product manufactured by a single manufacturer as defined by a nationally recognized provider of drug product database information. There may be some cases where two manufacturers will produce the same product under one license, known as a co-licensed product, which would also be considered as a Brand Name Drug. There may also be situations where a drug's classification changes from generic to Preferred Brand Name due to a change in the market resulting in the generic being a single source, or the drug product database information changing, which would also result in a corresponding change in Copayment obligations from generic to Preferred Brand Name.

Copayment or **Copay** means the dollar amount paid by the Member for each Prescription Order filled or refilled through a Participating Pharmacy.

Coinsurance means the percentage amount paid by the Member for each Prescription Order filled or refilled through a Participating Pharmacy.

Drug List means a list of all drugs that may be covered under Your Pharmacy Benefits. The Drug List is available by accessing the website at www.christushealthplan.org. You may also contact customer service at the toll-free number on Your identification card for more information.

Generic Drug means a drug that has the same active ingredient as the Brand Name Drug and is allowed to be produced after the brand name drug's patent has expired. In determining the brand or generic classification for covered drugs and corresponding Member Copayment responsibility, HMO utilizes the generic/brand status assigned by a nationally recognized provider of drug product database information. The Drug List identifying preferred and non-preferred Generic Drugs is available by accessing the website at www.christushealthplan.org; or You may contact customer service at the toll-free number on Your identification card.

Health Care Practitioner means an advanced practice nurse, doctor of medicine, doctor of dentistry, physician assistant, doctor of osteopathy, doctor of podiatry, or other licensed person with prescription authority.

Legend Drug means a drug, biological, or compounded prescription which is required by law to have a label stating "Caution - Federal Law Prohibits Dispensing Without a Prescription," and which are approved by the FDA for a particular use or purpose.

National Drug Code (NDC) means a national classification system for the identification of drugs.

Non-Preferred Brand Name Drug means a Brand Name Drug which appears on the applicable Drug List and is subject to the Non-Preferred Brand Name Drug Copayment. The Drug List is available by accessing the website at www.christushealthplan.org.

Participating Pharmacy means an independent retail Pharmacy, chain of retail Pharmacies, mail-order program Pharmacy or a Specialty Pharmacy Provider which have entered into a written agreement with HMO to provide pharmaceutical services to Members under this EOC.

Pharmacy means a state and federally licensed establishment where the practice of pharmacy occurs, that is physically separate and apart from any Provider's office, and where Legend Drugs and devices are dispensed under Prescription Orders to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he practices.

Pharmacy Vaccine Network means the network of Participating Pharmacies which have entered into a written agreement with HMO to provide certain vaccinations to Members under this EOC.

Preferred Brand Name Drug means a Brand Name Drug which appears on the applicable Drug List and is subject to the Preferred Brand Name Drug Copayment. This list is available by accessing the website at www.christushealthplan.org.

Preferred Participating Pharmacy means a Participating Pharmacy which has a written agreement with HMO to provide pharmaceutical services to Members or an entity chosen by HMO to administer its prescriptions drug program that has been designated as a Preferred Participating Pharmacy.

Prescription Order means a written or verbal order from Your authorized Health Care Practitioner to a pharmacist for a drug or device to be dispensed.

Specialty Drugs means a high cost prescription drug that meets any of the following criteria;

(1) used in limited patient populations or indications,

(2) typically self-injected,

(3) limited availability, requires special dispensing, or delivery and/or patient support is required and therefore, they are difficult to obtain via traditional Pharmacy channels,

(4) complex reimbursement procedures are required, and/or

(5) a considerable portion of the use and costs are frequently generated through office-based medical claims.

Specialty Pharmacy Provider means a Participating Pharmacy which has entered into a written agreement with HMO to provide Specialty Drugs to Members under this EOC.

Covered Drugs

Benefits for Medically Necessary covered drugs prescribed to treat You for a chronic, disabling, or life-threatening illness covered by HMO are available if the drug is on the applicable Drug List and has been approved by the United States Food and Drug Administration (FDA) for at least one indication and is recognized by the following for treatment of the indication for which the drug is prescribed:

- a prescription drug reference compendium approved by the Texas Department of Insurance, or
- substantially accepted peer-reviewed medical literature.

As new drugs are approved by the Food and Drug Administration (FDA), such drugs, unless the intended use is specifically excluded by HMO, may be eligible for benefits if included on the applicable Drug List. Some equivalent drugs are manufactured under multiple brand names. In such cases, HMO may limit benefits to only one of the brand equivalents available.

Drugs listed on the Plan's formulary will continue to be offered at the contracted benefit level until the Plan's renewal date.

You are responsible for any Copayments/Coinsurance for covered drugs shown in the **Schedule ofBenefits and Coverage** and pricing differences that may apply to the covered drug dispensed. If You receivea partial supply of a prescription drug from Your pharmacy, the cost-sharing amount will be prorated basedon the number of days' supply of the drug actually dispensed.

Injectable Drugs. Injectable drugs approved by the FDA for self-administration are covered. Injectable drugs include, but are not limited to, insulin and Imitrex.

The day supply of disposable syringes and needles You will need for self-administered injections will be limited on each occasion dispensed to amounts appropriate to the dosage amounts of covered injectable drugs actually prescribed and dispensed, but cannot exceed 100 syringes and needles per Prescription Order in a 30-day period.

Diabetes Supplies for Diabetes Care. Insulin, insulin analogs, insulin pens, insulin syringes, needles, injection devices, glucagon emergency kits, lancets, lancet devices, glucose meter solution, test strips specified for use with a corresponding blood glucose monitor, visual reading strips and urine and blood testing strips, and tablets which test for glucose, ketones, and protein, and prescriptive and nonprescriptive oral agents for controlling blood sugar levels are covered.

A separate Copayment/Coinsurance will apply to each fill of a prescription purchased on the same day for insulin and insulin syringes.

Preventive Care. Over-the-counter drugs which, have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF") or as required by state law will be covered and will not be subject to any Copayment, Coinsurance, Deductible or dollar maximums.

Vaccinations obtained through certain Participating Pharmacies. Benefits for vaccinations are shown in the **Schedule of Benefits and Coverage**. These vaccinations are available through certain Participating Pharmacies that have contracted with HMO to provide this service. To locate one of these Participating Pharmacies in the Pharmacy Vaccine Network in Your area and to determine which vaccinations are covered

under this benefit, access the website at www.christushealthplan.org or contact customer service at the toll-free number on Your identification card.

Each Participating Pharmacy included in the Pharmacy Vaccine Network that has contracted with HMO to provide this service may have age, scheduling, or other requirements that will apply, so you are encouraged to contact them in advance.

Formulas for the Treatment of Phenylketonuria or Other Heritable Diseases. Dietary formulas necessary for the treatment of phenylketonuria or other heritable diseases are covered.

Amino Acid-Based Elemental Formulas. Formulas, regardless of the formula delivery method, used for the diagnosis and treatment of:

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

A Prescription Order from your Health Care Practitioner is required. The Plan provides coverage for Amino Acid-Based Elemental Formulas on a basis no less favorable tan the basis on which prescription drugs and other medications and related services are covered by the Plan, and to the same exact extent that the plan provides coverage for drugs that are available only on the orders of a physician.

Orally Administered Anticancer Medication. Benefits are available for Medically Necessary orally administered anticancer medication that is used to kill or slow the growth of cancerous cells. Copayments/Coinsurance will not apply to certain orally administered anticancer medications. To determine if a specific drug is included in this benefit contact customer service at the toll-free number on Your identification card.

Specialty Drugs. Benefits are available for Specialty Drugs as described in **Specialty Pharmacy Program**.

Off-label Drugs: 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 andmust be medically necessary. Off-label drugs will not be denied solely on the basis that the drug is not included in the Formulary.

Selecting a Pharmacy

When You need a Prescription Order filled, You should use a Participating Pharmacy. Each prescription or refill is subject to the Copayment/Coinsurance shown in the **Schedule of Benefits and Coverage** and any applicable pricing differences. You may be required to pay for limited or non-Covered Services. No claim forms are required.

Although You can go to any Participating Pharmacy, Your benefits for drugs and other items covered under this provision will be greater when You obtain them from a Preferred Participating Pharmacy. Your Copayments will be less when using a Preferred Participating Pharmacy.

If You are unsure whether a Pharmacy is a Participating Pharmacy, You may access the website at www.christushealthplan.org (Provider Finder). Preferred Participating Pharmacies will also be identified in Provider Finder. You can also call customer service at the toll-free telephone number on the back of Your identification card for information regarding Participating Pharmacies and Preferred Participating Pharmacies.

Mail-Order Program. If You elect to use the mail-order service, You must mail Your Prescription Order to the address provided on the mail-order prescription form and send in Your payment for each prescription filled or refilled. Each prescription or refill is subject to the Copayment/Coinsurance shown in the **Schedule of Benefits and Coverage** and any applicable pricing differences, payable by Member directly to the mail order Pharmacy.

Some drugs may not be available through the mail-order program. If You have any questions about this mail-order program, need assistance in determining the amount of Your payment, or need to obtain the mail-order prescription claim form, access the website at www.christushealthplan.org or contact customer service at the toll-free number on Your identification card. Mail the completed form, Your Prescription Order(s) and payment to the address indicated on the form.

Specialty Pharmacy Program. The Specialty Drug delivery service integrates Specialty Drug benefits with the Member's overall medical and prescription drug benefits. This program provides delivery of medications directly from the Specialty Pharmacy Provider to Your Health Care Practitioner, administration location or to the Member that is undergoing treatment for a complex Medical Condition.

The HMO Specialty Pharmacy Program delivery service offers:

- Coordination of coverage between You, Your Health Care Practitioner and HMO,
- Educational materials about the patient's particular condition and information about managing potential medication side effects,
- Syringes, sharps containers, alcohol swabs and other supplies with every shipment for FDA approved self-injectable medications, and
- Access to a pharmacist for urgent medication issues 24 hours a day, 7 days a week, 365 days each year.

The Drug List which includes these Specialty Drugs is available by accessing the website at www.christushealthplan.org or by contacting customer service at the toll-free number on Your identification card. Your cost will be the applicable Copayment/Coinsurance shown in the **Schedule of Benefits and Coverage** as well as any applicable pricing differences.

Clinician-Administered Drugs – Member Protections
In accordance with Texas Insurance Code Chapter 1369 and HB 1647, the Plan prohibits the following practices for clinician-administered drugs used to treat an enrollee with a chronic, complex, rare, or life-threatening medical condition:

- The Plan does not require dispensing of clinician-administered drugs by a specific pharmacy or network pharmacy
- The Plan does not limit providers to bill for or be reimbursed under the pharmacy benefit instead of the medical benefit, unless:
    - The enrollee provides informed consent, and
    - The provider submits an attestation stating that billing under the pharmacy benefit does not increase risk of adverse outcomes or care delays;

The Plan does not impose any additional fees or higher cost-sharing solely because a clinician-administered drug was dispensed by a non-network pharmacy or based on the enrollee's choice of pharmacy.

Prescription Drugs Purchased Outside of the Service Area. HMO will reimburse You for the Allowable Amount of the prescription drugs less the Out-of-Area Drug Copayment/Coinsurance shown in the **Schedule of Benefit sand Coverage,** for covered prescription drugs which You purchase outside of the Service Area. You must submit a completed claim form to HMO, including Your name, the prescribing authorized Health Care Practitioner's name, the date of purchase, NDC of the drug, and itemized receipts indicating the total cost of the prescription within ninety (90) days of the date of purchase to qualify for reimbursement under the **PHARMACY BENEFITS.** You may access the website at www.christushealthplan.org to obtain a prescription drug claim form.

Prorated Cost-Share Amount for Partial Supplies. The Plan will prorate any cost-sharing amount charged for a partial supply of a prescription drug if the pharmacy or the Member's prescribing physician notifies the Plan that the quantity dispensed is to synchronize the dates that the pharmacy dispenses the Member's prescription drugs, and the synchronization of the dates in in the best interest of the Member, if the Member agrees to the synchronization. The prorated amount must be based on the number of days' supply of the drug is actually dispensed. This applies only to medication that:

- Is covered by the Plan;
- Meets the Prior Authorization criteria specifically applicable to the medication under the Plan on the date the request for synchronization is made;
- Is used for treatment and management of a chronic illness;
- May be prescribed with refills;
- Is a formulation that can be effectively dispensed in accordance with the medication synchronization plan described above; and
- Is not, according to the schedules established by the commissioner of the Department of State Health Services under Chapter 481, Health and Safety Code, a Schedule II substance or a Schedule III controlled substance containing hydrocodone.

Your Cost

How Copayment/Coinsurance Amounts Apply. If the Allowable Amount of the Drug is less than the Copayment/Coinsurance, You pay the lower cost. You will pay no more than the applicable Preferred Brand Name Drug or Non-Preferred Brand Name Drug Copayment/Coinsurance if the prescription has no generic equivalent. If You receive a Brand Name Drug when a generic equivalent is available, the Copayment/Coinsurance will be the total of the Generic Drug Copayment/Coinsurance plus the difference between the cost of the Generic Drug equivalent and the cost of the Brand Name Drug. Exceptions to this may be allowed for certain preventive medications (including prescription contraceptive medications) if

Your Health Care Practitioner submits a request to HMO indicating that the Generic Drug would be medically inappropriate, along with supporting documentation. If HMO grants the exception request, any difference between the Allowable Amount for the Brand Name Drug and the Generic Drug equivalent will be waived.

Supply Limits for Prescription Contraceptive Drugs

In accordance with Texas Insurance Code §1369.1013, the Plan allows enrollees to obtain:

- A three-month supply of a covered prescription contraceptive drug at one time when the drug is first dispensed; and
- A 12-month supply of the same covered prescription contraceptive drug at one time for each subsequent refill.

The Plan will cover only one 12-month supply per 12-month period unless medically indicated. This provision applies only to drugs covered under the Plan's outpatient prescription drug benefit and dispensed at a participating pharmacy.

About Your Benefits

Covered Drug List. A list of all covered drugs is shown on the Drug List. HMO will periodically review the Drug List and adjust it to modify the preferred/non-preferred Brand Name Drug status of new and existing drugs. Changes to the Drug List will be implemented on the next renewal date of the Group Agreement and are subject to the requirements of Texas Insurance Code, 1369.0541. The Drug List and any modifications thereto will be made available to Members. You, the member, are entitled to a 60 day notice for modification of drug coverage. This list is available by accessing the website at www.christushealthplan.org or by contacting customer service at the toll-free number on Your identification card.

Adverse Determinations about Prescription Drugs

A utilization review agent will provide notice of an adverse determination for a concurrent review of the provision of prescription drugs or intravenous infusions for which the Member is receiving health benefits under the health insurance Contract no later than the 30th day before the date on which the provision of prescription drugs or intravenous infusions will be discontinued.

Exception Requests. You, or Your prescribing Health Care Practitioner, can ask for a Drug List exception if Your drug is not on the Drug List (also known as a formulary). To request this exception, You, or Your prescriber, can call the number on the back of Your identification card to ask for a review. If You have a health condition that may jeopardize Your life, health or keep You from regaining function, or Your current drug therapy uses a non-covered drug, You, or Your prescriber, may be able to ask for an expedited review process. HMO will let You, and Your prescriber, know the coverage decision within 72 hours after they receive Your request, and 24 hours for an expedited review. If the coverage request is denied, HMO will let You and Your prescriber know why it was denied and offer You a covered alternative drug (if applicable). If Your exception is denied, You may appeal the decision according to the Pharmacy appeals process You will receive with the denial determination. Call the number on the back of Your identification card if You have any questions.

Prescription Drug Coverage Inquiries: In accordance with Texas Insurance Code §1369.094 and SB 622, CHRISTUS Health Plan will, upon request from a Member or their prescribing provider, provide the following information:

- Whether a specific prescription drug is included in the Plan's formulary.
- Applicable utilization management requirements, such as prior authorization, step therapy, or quantity limits.
- Covered alternative drugs, if the requested drug is not on the formulary.
- Cost-sharing requirements or tier placement for covered drugs.

This information will be provided in a timely manner and made available electronically or through other accessible means. The Plan will not withhold this information based

Day Supply. Benefits for covered drugs obtained from a Participating Pharmacy are provided up to the maximum day supply limit as shown in the **Schedule of Benefits and Coverage**. HMO has the right to determine the day supply. Payment for benefits covered by HMO may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum day supply limitation.

If You are leaving the country or need an extended supply of medications, call customer service at least two weeks before You intend to leave. Extended supplies or vacation override are not available through the mail-order program, but may be approved through the retail Pharmacy only. In some cases, You may be asked to provide proof of continued membership eligibility under the EOC.

Dispensing/Quantity Versus Time Limits. The maximum quantity of a given prescription drug indicates the number of units to be dispensed and is determined based on pertinent medical information and clinical efficacy and safety. Quantities of some drugs are restricted regardless of the quantity ordered by the Health Care Practitioner. To determine if a specific drug is subject to this limitation, You may access the website at www.christushealthplan.org or contact customer service at the toll-free number on Your identification card.

If a Prescription Order is written for a certain quantity of medication to be taken in a time period directed by a Health Care Practitioner, the Prescription Order will only be covered for a clinically appropriate predetermined quantity of medication for the specified amount of time. Dispensing limits are based upon FDA dosing recommendations and nationally recognized clinical guidelines.

If You require a Prescription Order in excess of the dispensing limit established by HMO, ask Your Health Care Practitioner to submit a request for clinical review on Your behalf. The Health Care Practitioner can obtain an override request form by accessing our website at www.christushealthplan.org. Any pertinent medical information along with the completed form should be faxed to Clinical Pharmacy Programs at the fax number indicated on the form. The request will be approved or denied after evaluation of the submitted clinical information. HMO has the right to determine dispensing limits at its sole discretion. Payment for benefits covered by HMO may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum quantity limitation.

Controlled Substance Limits. In the event HMO determines that a Member may be receiving quantities of a Controlled Substance not supported by FDA approved dosages or recognized treatment guidelines, any additional drugs may be subject to a review for medical necessity, appropriateness and other coverage restrictions such as limiting coverage to services by a certain Provider and/or Participating Pharmacy for the prescribing and dispensing of the Controlled Substance.

Step Therapy. Coverage for certain prescription drugs or drug classes is subject to a step therapy program. Step therapy programs favor the use of clinically acceptable alternative medications that may be less costly for you prior to those medications on the step therapy list of drugs being covered under HMO. These programs do not apply to prescription drugs associated with the treatment of stage-four advanced, metastatic cancer or associated conditions.

When You submit a Prescription Order to a Participating Pharmacy for one of these designated medications, the pharmacist will be alerted if the online review of Your prescription claims history indicates an acceptable alternative medication has not been previously tried. If so, a toll-free phone number will be provided to You for Your Health Care Practitioner to call and obtain additional program and criteria information. A list of step therapy medications is available to You and Your Health Care Practitioner on our website at www.christushealthplan.org or contact customer service at the toll-free number on Your identification card.

If it is Medically Necessary, coverage can be obtained for the prescription drugs or drug classes subject to the step therapy program without trying an alternative medication first. In this case, Your Health Care Practitioner must contact HMO to obtain prior authorization for coverage of such drug. If authorization is granted, the Health Care Practitioner will be notified and the medication will then be covered at the applicable Copayment/Coinsurance.

Although You may currently be on step therapy, Your Claim may need to be reviewed to see if the criteria for coverage of further treatment has been met. A documented treatment with a generic or brand therapeutic alternative medication may be required for continued coverage of the Brand Name Drug.

Step Therapy – Serious Mental Illness

In accordance with Texas Insurance Code §§1369.0546–1369.0547, the Plan's step therapy protocols for prescription drugs used to treat a serious mental illness (as defined under Texas law) will comply with the following:

- For enrollees 18 years of age or older, the Plan may not require a failure to respond to more than one different prescription drug before covering the prescribed drug. This limitation does not apply

to generic or pharmaceutical equivalents.

- The Plan may implement step therapy protocols for generic or pharmaceutical equivalents no more than once per plan year, or when a drug is newly added to the formulary.
- Enrollees and providers may request a step therapy exception, and such requests will be reviewed in accordance with applicable law and plan procedures.

Prior Authorization. Coverage for certain designated prescription drugs is subject to prior authorization criteria. This means that in order to ensure that a drug is safe, effective, and part of a specific treatment plan, certain medications may require prior authorization and the evaluation of additional clinical information before dispensing. You and Your Health Care Practitioner may access a list of the medications which require prior authorization on our website at www.christushealthplan.org or contact customer service at the toll-free number on Your identification card.

When You submit a Prescription Order to a Participating Pharmacy for one of these designated medications, the pharmacist will be alerted online if Your Prescription Order is on the list of medications which require prior authorization before it can be filled. If this occurs, Your Health Care Practitioner will be required to submit an authorization form. This form may also be submitted by Your Health Care Practitioner in advance of the request to the Pharmacy. The Health Care Practitioner can obtain the authorization form by accessing our website at www.christushealthplan.org. The requested medication may be approved or denied for coverage by HMO based upon its accordance with established clinical criteria.

Annual Prior Authorization Limitation for Certain Chronic Conditions
In accordance with Texas Insurance Code §§1369.651–1369.654, the Plan may not require more than one prior authorization per year for a prescription drug used to treat an enrollee for:

- An autoimmune disease
- Hemophilia
- Von Willebrand disease

This applies when the prescription drug is used for the same diagnosis and continued treatment.
The Plan may require a new prior authorization only if:

- The enrollee's prescription drug benefit formulary changes
- The prescribing provider changes the dosage or frequency
- Clinical evidence supports that a new prior authorization is needed for medical safety; or
- There is suspected fraud, waste, or abuse.

Right of Appeal. You have the right to appeal as explained in the **COMPLAINT AND APPEAL PROCEDURES** section of this EOC.

PHARMACY BENEFITS LIMITATIONS AND EXCLUSIONS

Pharmacy benefits are not available for*:*

1. Drugs that are not shown on the Drug List.

2. Drugs which by law do not require a Prescription Order, except as indicated under Preventive Care in **PHARMACY BENEFITS,** from an authorized Health Care Practitioner and Legend Drugs or covered devices for which no valid Prescription Order is obtained. (Insulin, insulin analogs, insulin pens, prescriptive and nonprescriptive oral agents for controlling blood sugar levels, and vaccinations administered through certain Participating Pharmacies shown in the **Schedule of Benefits and Coverage** are covered.)

3. Prescription drugs if there is an over-the-counter product available with the same active ingredient(s) in the same strength, unless otherwise determined by HMO.

4. Drugs required by law to be labeled: "Caution - Limited by Federal Law to Investigational Use," or Experimental drugs, even though a charge is made for the drugs.

5. Drugs, that the use or intended use of would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.

6. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the identification card.

7. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction that is not covered under HMO, or for which benefits have been exhausted.

8. Drugs injected, ingested, or applied in a Physician's office or during confinement while a patient in a Hospital, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.

9. Drugs for which the Pharmacy's usual retail price to the general public is less than or equal to the Copayment.

10. Drugs purchased from a non-Participating Pharmacy in the Service Area.

11. Devices or Durable Medical Equipment (DME) such as but not limited to therapeutic devices, including support garments and other non-medicinal substances, even though such devices may require a Prescription Order. (Disposable hypodermic needles, syringes for self-administered injections and contraceptive devices are covered). However, You do have certain DME benefits available under the **Durable Medical Equipment** section in **COVERED SERVICES AND BENEFITS.** Coverage for female contraceptive devices and the rental (or, at HMO's option the purchase) of manual or electric breast pumps is provided as indicated under the **Health Maintenance and Preventives Services** section in **COVERED SERVICES AND BENEFITS.**

12. Male contraceptive devices, including over-the-counter contraceptive products such as condoms; female contraceptive devices, including over-the-counter contraceptive products such as spermicide, when not prescribed by a Participating Provider.

13. Any special services provided by a Pharmacy, including but not limited to counseling and delivery. Vaccinations shown in the **Schedule of Benefits and Coverage** administered through certain Participating Pharmacies are an exception to this exclusion.

14. Drugs dispensed in quantities in excess of the day supply amounts indicated in the **Schedule of Benefits and Coverage**, or refills of any prescriptions in excess of the number of refills specified by theauthorized Health Care Practitioner or by law, or any drugs or medicines dispensed more than one (1) year after the Prescription Order date.

15. Administration or injection of any drugs.

16. Injectable drugs except Specialty Drugs or those approved by the FDA for self-administration.

17. Athletic performance enhancement drugs.

18. Rogaine, minoxidil or any other drugs, medications, solutions or preparations used or intended for use in the treatment of hair loss, hair thinning or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.

19. Any prescription antiseptic or fluoride mouthwashes, mouth rinses or topical oral solutions or preparations.

20. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.

21. Retin A or pharmacologically similar topical drugs.

22. Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss or dietary control.

23. Drugs to treat sexual dysfunction including but not limited to sildenafil citrate, phentolamine, apomorphine, and alprostadil in oral and topical form.

24. Drugs for the treatment of Infertility (oral and injectable).

25. Prescription Orders which do not meet the required step therapy criteria.

26. Prescription Orders which do not meet the required prior authorization criteria.

27. Some equivalent drugs manufactured under multiple brand names. HMO may limit benefits to only one of the brand equivalents available. If You do not accept the brand that is covered under this EOC, the Brand Name Drug purchases will not be covered under any benefit level.

28. Replacement of drugs or other items that have been lost, stolen, destroyed or misplaced.

29. Shipping, handling or delivery charges.

30. Brand Name Drugs in a drug class where there is an over-the-counter alternative available.

31. Prescription Orders written by a member of Your immediate family, or a self-prescribed Prescription Order.

37. Drugs which are repackaged by anyone other than the original manufacturer.

32. Drugs determined by HMO to have inferior efficacy or significant safety issues.

COORDINATION OF THIS CONTRACT'S BENEFITS WITH OTHER BENEFITS

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

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

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

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

Definitions

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

(1) Health plan includes:

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

(2) Health plan does not include:

- disability income protection coverage;
- the Texas Health Insurance Pool;
- workers' compensation insurance coverage;
- hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage;
- supplemental benefit coverage;
- accident only coverage;
- specified accident coverage;
- school accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis;
- benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
- Medicare supplement policies;
- a state plan under Medicaid;
- a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan; or
- an individual accident and health insurance contract that is designed to fully integrate with other policies through a 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 thoseof 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 deductibles, and 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 deductible or 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 decide the order in which secondary plans' benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or

plans and the benefits of any other health plan that, under the rules in this section, has its benefits determined before those of that secondary plan.

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

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

2. Dependent Child Covered Under More Than One Health Plan. Unless there is a court order stating otherwise, health plans covering a dependent child must determine the order of benefits using the following rules that apply:
   A. For a dependent child whose parents are married or are living together, whether or not they have ever been married: (A) The health plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or (B) If both parents have the same birthday, the health plan that has covered the parent the longest is the primary plan.

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

      i. if a court order states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the health plan of that parent has actual knowledge of those terms, that health plan is primary for plan years commencing after the health plan is given notice of the court decree;
      ii. if a court order states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of (h)(2)(A) determine the order of benefits;
      iii. if a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of (h)(2)(A) determine the order of benefits;

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

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

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

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

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

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

5. Longer or Shorter Length of Coverage. The health plan that has covered the person as an employee, member, contractholder, 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.

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

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

Facility of Payment

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

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

Right of Recovery

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

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 insurance 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 theTexas 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 "allowableexpense" 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 toward our own plan deductible.

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.

Questions About COB?
Contact the Texas Department of Insurance
1-800-252-3439
In Austin Call 512-463-6515

GENERAL PROVISIONS

Termination of Coverage

Group is liable for Premium payments from the time You cease to be eligible for coverage until the end of the Contract Month in which Group notifies HMO that You are no longer covered by the Group and are not eligible for coverage. Group is required to provide coverage for You until the end of the Contract Month in which the termination notice is received by HMO.

Subject to the preceding paragraph, coverage of any Member who ceases to be eligible as determined in **WHO GETS BENEFITS; Eligibility** will terminate on the last day of the Contract Month in which Group notifies HMO that the Member is no longer eligible for coverage and eligibility ceases unless otherwise specified and agreed upon by the Group and HMO. This paragraph also applies to a Dependent of Subscriber who has lost eligibility, for whatever reason, including the death of Subscriber.

If this EOC is terminated for nonpayment of Premium, Your coverage shall be terminated effective after the last day of the Grace Period. Only Members for whom the stipulated payment is actually received by HMO shall be entitled to health services covered hereunder and then only for the Contract Month for which such payment is received. If any required payment is not received by the Premium due date, then You shall be terminated at the end of the Grace Period. You shall be responsible for the cost of services rendered to You during the Grace Period in the event Premium payments are not made by Group.

Your coverage is terminated upon the termination of the Group Agreement. The fact that Group does not notify You of the termination of Your coverage due to the termination of the Group Agreement shall not deem continuation of Your coverage beyond the date coverage terminates.

If Your coverage is terminated, Premium payments received on Your account applicable to periods after the effective date of termination shall be refunded to Group within thirty (30) days, and neither HMO nor Participating Providers shall have any further liability under this EOC. Any claims for refunds by Group must be made within sixty (60) days from the effective day of termination of Your coverage or otherwise such claims shall be deemed waived.

Except as expressly provided below and elsewhere in this EOC and subject to the provisions of **COBRA Continuation Coverage, State Continuation Coverage or Transfer of Residence**, HMO may terminate coverage for Group upon sixty (60) days prior written notice.

Group Termination. HMO may terminate this EOC for Group in the case of:

Cause	Effective Date of Termination
(1) Nonpayment of Premium	At the end of the Grace Period
(2) Fraud or intentional misrepresentation of a material fact on the part of Group	After thirty (30) days written notice
(3) Non-compliance by Group with a material HMO provision relating to any employer contribution or Group participation rules	In accordance with applicable state law

(4)	No Member residing or working in the Service Area	After thirty (30) days written notice
(5)	Termination of membership of Group in an association, but only if coverage is terminated uniformly without regard to a health status related factor of a covered individual	After thirty (30) days written notice

Renewal of Group Coverage. HMO will renew this EOC with Group unless Group was terminated under **Termination of Coverage; Group Termination.**

Non-Renewal of All Group Coverage

- HMO may not renew this EOC if HMO elects to not renew all HMO contracts issued to other large or small employers, as applicable, in the Service Area. HMO must notify Group of such non-renewal at least one hundred eighty (180) days before the date on which coverageterminates for Group.

- HMO may elect to discontinue a particular type of coverage for all large or small employers only if notice is provided to each large or small employer, as applicable at least ninety (90) days before the date on which coverage terminates for Group. HMO must offer each employer the option to purchase other coverage offered at the time of discontinuation.

Member Termination. HMO may terminate this EOC for a Member in the case of:

Cause	Effective Date of Termination
(1) Fraud or intentional misrepresentation of a material fact, except as described in **Incontestability** of this EOC	After thirty (30) days written notice
(2) Fraud in the use of services or facilities	After thirty (30) days written notice
(3) Failure to meet eligibility requirements	Immediately, subject to **COBRA Continuation Coverage, State Continuation Coverage** or **Transfer**

Renewal of Member Coverage. HMO will renew Your EOC unless You were terminated under **Termination of Coverage; Member Termination.**

COBRA Continuation Coverage

COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985 as modified by the Tax Reform Act of 1986. This Act permits You or covered Dependents to elect to continue Your Group coverage as follows:

Employees and their covered Dependents will not be eligible for the continuation of coverage provided by this section if the Group is exempt from the provisions of COBRA; however, they may be eligible for continuation of coverage as provided by **State Continuation Coverage** of this EOC.

Minimum Size of Group. The Group must have normally employed more than twenty (20) employees on a typical business day during the preceding Calendar Year. This refers to the number of employees employed; not the number of employees covered by a Health Benefit Plan, and includes full-time and part-time employees.

Loss of Coverage. For loss of coverage due to termination (other than for gross misconduct) or reduction of hours of employment, You may elect to continue coverage for eighteen (18) months after eligibility for coverage under this EOC would otherwise cease.

You may elect to continue coverage for thirty-six (36) months after eligibility for coverage under this EOC would otherwise cease if coverage terminates as the result of:

- divorce;
- Subscriber's death;
- Subscriber's entitlement to Medicare benefits; or
- cessation of covered Dependent child status under **WHO GETS BENEFITS; Eligibility** of this EOC.

COBRA continuation coverage under this EOC ends at the earliest of the following events:

- the last day of the continued coverage whether eighteenth (18) month or thirty-sixth (36) month period;
- the first day on which timely payment of Premium is not made subject to the Premium section of the Group Agreement;
- the first day on which the Group Agreement between Group and HMO is not in full force and effect;
- the first day on which You are actually covered by any other group Health Benefit Plan. In the event You have a preexisting condition and would be denied coverage under the new Health Benefit Plan for a preexisting condition, continuation coverage will not be terminated until the last day of the continuation period, or the date upon which the preexisting condition becomes covered under the new Health Benefit Plan, whichever occurs first; or
- the date You are entitled to Medicare.

Extensions of Coverage Periods. The eighteen (18) month coverage period may be extended if an event which would otherwise qualify You for the thirty-six (36) month coverage period occurs during the eighteen

(18) month period, but in no event may coverage be longer than thirty-six (36) months from the event which qualified You for continuation coverage initially.

In the event You are determined, within the meaning of the Social Security Act, to be disabled and You notify the Group before the end of the initial eighteen (18) month period, continuation coverage may be extended up to an additional eleven (11) months for a total of twenty-nine (29) months. This provision is limited to Members who are disabled at any time during the first sixty (60) days of continuation coverage under **COBRA Continuation Coverage** of this EOC and only when the qualifying event is Member's reduction in hours or termination. You may be charged a higher rate for the extended period.

Responsibility to Provide Member With Notice of Continuation Rights. The Group is responsible for providing the necessary notification to Members, within sixty (60) days from the date of the COBRA qualifying event, as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986.

Responsibility to Pay Premiums to HMO. Coverage for the sixty (60) day period as described above to initially enroll will be extended only where Subscriber or You pay the applicable Premium charges due within forty-five (45) days of submitting the application to the Group and Group in turn remitting same to HMO.

Premiums due HMO for the continuation of coverage under this section shall be due in accordance with the procedures of the Premium section of the Group Agreement and shall be calculated in accordance with applicable federal law and regulations.

For additional information regarding Your COBRA coverage, refer to the Continuation Coverage Rights described more fully in the federally mandated COBRA Notice that follows this EOC.

State Continuation Coverage

Continuation Privilege for Certain Dependents. A covered Dependent who has been a Member of HMO for at least one year or who is an infant under one year of age may be eligible to continue coverage under this EOC if coverage would otherwise terminate because of:

- the death of Subscriber;
- the retirement of Subscriber; or
- divorce.

You must give written notice to Group within fifteen (15) days of the occurrence of any of the above to activate this continuation of coverage option. Upon receiving this written notice, Group will send You the forms that should be used to enroll for this continuation of coverage. If You do not submit this completed enrollment form to Group within sixty (60) days of the occurrence of any of the above, You will lose the right to this continuation of coverage under this section. Coverage remains in effect during this sixty (60) day period, provided any applicable Premiums and administrative charges are paid.

Continuation of coverage under this section will terminate on the earliest to occur of:

- the end of the three (3) year period after the date of Subscriber's death or retirement;
- the end of the three (3) year period after the date of the divorce or legal separation;
- the date You become eligible for similar coverage under any substantially similar coverage under another health insurance contract, Hospital or medical service Subscriber contract, medical practice or other prepayment Health Benefit Plan, or by any other program; or
- the end of the period for which You have paid any applicable Premiums.

Continuation of Group Coverage Privilege. In the event Your coverage has been terminated for any reason except (i) involuntary termination for cause, or (ii) discontinuance of the Group Agreement, either in its entirety or with respect to an insured class, You shall be entitled to continuation of Group coverage if You have been continuously insured under the EOC or under any group contract providing similar benefits which it replaces for at least three (3) consecutive months immediately prior to the termination.

You must request continuation of Group coverage, in writing, to the Group or HMO within sixty (60) days following the later of the date the Group coverage would otherwise terminate or the date You are given notice by the Group. Your first monthly Premium required to establish continuation coverage must be given to the Group within forty-five (45) days of the initial election of continuation coverage. All subsequent payments must be made no later than thirty (30) days after the payment due date.

Continuation of coverage under this section will terminate on the earliest to occur of:

- the date on which You exhaust the maximum continuation period which is:
  a. if You are not eligible for COBRA continuation coverage, nine months after the date of state continuation coverage;
  b. if You are covered under COBRA continuation coverage, six additional months following any period of COBRA continuation coverage;
- the date on which failure to make timely payments would terminate coverage;
- the date on which the Group coverage terminates in its entirety; or
- the date on which You are covered for similar benefits by another Hospital, surgical, medical, or major medical expense insurance contract or Hospital or medical service Subscriber contract or medical practice or other prepayment Health Benefit Plan or any other program.

Transfer of Residence

Within the HMO Service Area: If Subscriber changes primary residence, notification must be made to HMO within thirty (30) days of such change.

Outside the HMO Service Area: If Subscriber no longer resides or works in the Service Area, such change will result in loss of eligibility and Subscriber must notify HMO within thirty (30) days of such change.

Reimbursement - Acts of Third Parties

HMO will provide services to You due to the act or omissions of another person. However, if You are entitled to a recovery from any third party with respect to those services, You shall agree in writing, subject to the provisions of Section 140.005 of the Civil Practice and Remedies Code:

1. To reimburse HMO to the extent of the Allowable Amount that would have been charged to You for health care services if You were not covered under this EOC. Such reimbursement must be made immediately upon collection of damages for Hospital or medical expenses by You whether by action at law, settlement or otherwise.

2. To assign to HMO a right of recovery from a third party for Hospital and medical expenses paid by HMO on Your behalf and to provide HMO with any reasonable help necessary for HMO to pursue a recovery. In addition, HMO will be entitled to recover attorneys' fees and court costs related to its subrogation efforts only if the HMO aids in the collection of damages from a third party.

Assignment

This EOC is not assignable by Group without the written consent of HMO. The coverage and any benefits under this EOC are not assignable by any Member without the written consent of HMO.

Cancellation

Except as otherwise provided herein, HMO shall not have the right to cancel or terminate any EOC issued to any Subscriber while the Group Agreement remains in force and effect, and while said Subscriber remains in the eligible class of employees of Group, and Premiums are paid in accordance with the terms of this EOC.

Clerical Error

Clerical error, of Group or HMO in keeping any records pertaining to the coverage hereunder will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

Entire EOC

This EOC, any attachments, amendments, the Group Agreement, and the individual applications, if any, of Subscribers constitute the entire contract between the parties and as of the effective date hereof, supersede all other contracts between the parties.

Force Majeure

In the event that due to circumstances not within the commercially reasonable control of HMO, the rendering of professional or Hospital Services provided under this EOC is delayed or rendered impractical, HMO shall make a good faith effort to arrange for an alternative method of providing

coverage. These circumstances may include, but are not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of the Participating Providers' personnel or similar causes. In such event, Participating Providers shall render the Hospital and Professional Services provided for under the EOC in so far as practical, and according to their best judgment; but HMO and Participating Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Form or Content of EOC

No agent or employee of HMO is authorized to change the form or content of this EOC except to make necessary and proper insertions in blank spaces. Changes can be made only through endorsement authorized and signed by an officer of HMO. No agent or other person, except an authorized officer of HMO, has authority to waive any conditions or restrictions of this EOC, to extend the time for making a payment, or to bind HMO by making any promise or representation or by giving or receiving any information.

Gender

The use of any gender herein shall be deemed to include the other gender and, whenever appropriate, the use of the singular herein shall be deemed to include the plural (and vice versa).

Incontestability

All statements made by You are considered representations and not warranties. A statement may not be used to void, cancel or non-renew Your coverage or reduce benefits unless it is in a written enrollment application signed by Subscriber and a signed copy of the enrollment application has been furnished to Subscriber or to the Subscriber's personal representative. Coverage may only be contested because of fraud or intentional misrepresentation of material fact on the enrollment application other than a misrepresentation related to health status.

Interpretation of EOC

The laws of the state of Texas shall be applied to interpretations of this EOC. Where applicable, the interpretation of this EOC shall be guided by the direct-service nature of HMO's operations as opposed to a health insurance program. If the EOC contains any provision not in conformity with the Texas Health Maintenance Organization Act or other applicable laws, the EOC shall not be rendered invalid, but shall be construed and applied as if it were in full compliance with the Texas Health Maintenance Organization Act and other applicable laws.

Limitation of Liability

Liability for any errors or omissions by HMO (or its officers, directors, employees, agents, or independent contractors) in the administration of this EOC, or in the performance of any duty of responsibility contemplated by this EOC, shall be limited to the maximum benefits, which should have been paid under the EOC had the errors or omissions not occurred, unless any such errors or omissions are adjudged to be the result of willful misconduct or gross negligence of HMO.

Modifications

This EOC shall be subject to amendment, modification, and termination in accordance with any provision hereof or by mutual agreement between HMO and Group without the consent or concurrence of Members. By electing medical and Hospital coverage under HMO or accepting HMO benefits, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, and provisions hereof.

Notice

Any notice under this EOC may be given by United States mail, first class, postage prepaid, addressed as follows:

- If to HMO, to the address on the face page of this EOC.
- If to You, at the last address known to HMO.
- Or electronically if by an agreement between HMO and the Member.

Patient/Provider Relationship

Participating Providers maintain a Provider-patient relationship with Members and are solely responsible to You for all health services. If a Participating Provider cannot establish a satisfactory Provider-patient relationship, the Participating Provider may send a written request to HMO to terminate the Provider-patient relationship, and this request may be applicable to other Providers in the same group practice, if applicable.

Relationship of Parties

The relationship between HMO and Participating Providers is that of an independent contractor relationship. Participating Providers are not agents or employees of HMO; HMO or any employee of HMO is not an employee or agent of Participating Providers. HMO shall not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by You while receiving care from any Participating Provider. HMO makes no express or implied warranties or representations concerning the qualifications, continued participation, or quality of services of any Physician, Hospital or other Participating Provider.

Reports and Records

HMO is entitled to receive from any Provider of services to Members, information reasonably necessary to administer this EOC subject to all applicable confidentiality requirements described below. By accepting coverage under this EOC, the Subscriber, for himself or herself, and for all Dependents covered hereunder, authorizes each and every Provider who renders services to You hereunder to:

- disclose all facts pertaining to Your care, treatment and physical condition to HMO, or a medical, dental, or mental health professional that HMO may engage to assist it in reviewing a treatment or claim;
- render reports pertaining to Your care, treatment and physical condition to HMO, or a medical, dental, or mental health professional that HMO may engage to assist it in reviewing a treatment or claim; and
- permit copying of Your records by HMO.

Information contained in Your medical records and information received from Physicians, surgeons, Hospitals or other Health Care Professionals incident to the Physician-patient relationship or Hospital-patient relationship shall be kept confidential in accordance with applicable law.

Subtitles

The subtitles included within this EOC are provided for the purpose of identification and convenience and are not part of the complete EOC as described in **Entire EOC.**

Actuarial Value

The use of a metallic name, such as Platinum, Gold, Silver or Bronze, or other statements with respect to a health benefit plan's actuarial value, is not an indicator of the actual amount of expenses that a particular person will be responsible to pay out of his/her own pocket. A person's out of pocket expenses will vary depending on many factors, such as the particular health care services, health care providers and particular benefit plan chosen. Please note that metallic names reflect only an approximation of the actuarial value of a particular benefit plan.

CHRISTUS® Health Plan

SERVICE AREA MAP

Network Analysis

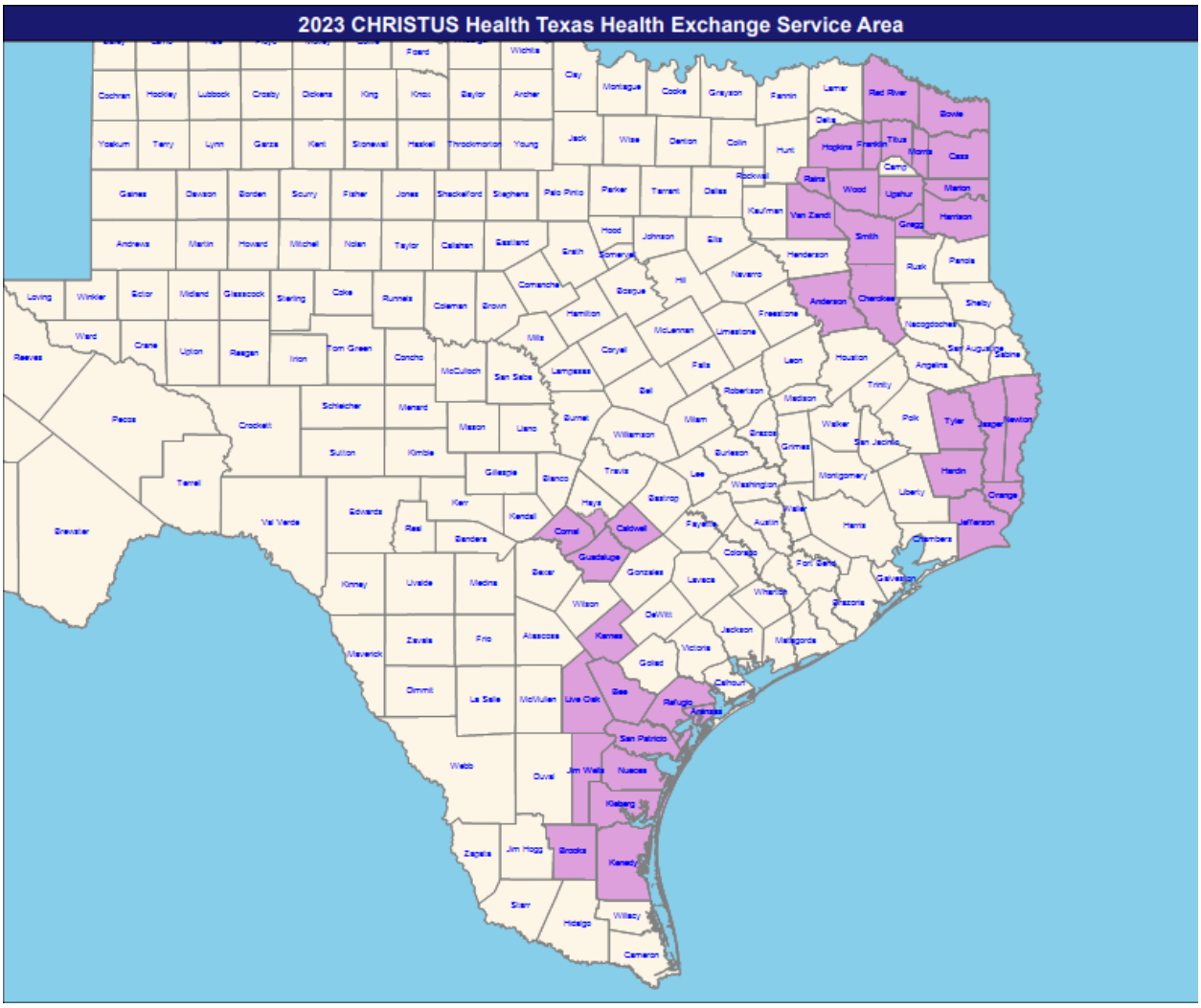
Map

June 22, 2023

Service Areas

TDI_EOC 2023

87.54 miles



CHRISTUS® Health Plan

844.282.3025, TTY 711

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

CHRISTUShealthplan.org

25-1126550