FirstCare HEALTH PLANS

Contents

Individual Schedule of Benefits

Health Maintenance Organization
FirstCare Select Plus HMO
IND Bronze HSA HMO 6750 - Native American Zero
26539TX0140006-02
BHI20M21

You have the option to choose this Consumer Choice of Benefits Health Maintenance Organization that, 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 policies in Texas. If you choose this standard health benefit plan, consult with your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage. The following is a summary of the copay amounts you and any dependents must pay when receiving the services listed below. Refer to your Evidence of Coverage for a detailed explanation of covered and non-covered services. If you have any questions, or would like more information about FirstCare's benefits and medical services go to www.firstcare.com/marketplace or contact our Customer Service Team, Monday through Friday, 8 a.m. – 6 p.m. CT, at 1.855.572.7238, TTY Line 711.

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

PLAN YEAR	Calendar Year
MEDICAL DEDUCTIBLE	$0 per Member $0 per Family
PRESCRIPTION DRUG DEDUCTIBLE	$0
OUT-OF-POCKET MAXIMUM *Includes Medical and Rx Deductible, Copays and Coinsurance.*	$0 per Member $0 per Family
ANNUAL MAXIMUM	Unlimited

COVERED MEDICAL SERVICES	
GENERAL SERVICES	*Copay Charges*
• **Adult PCP Office Visit** *Note: Office visit charge applies when seen by a physician and/or a licensed clinician under the supervision of the physician.*	No charge
• **Pediatric PCP Office Visit** (For a covered dependent through the age of 18). *Note: Office visit charge applies when seen by a physician and/or a licensed clinician under the supervision of the physician.*	No charge
• **Specialist Office Visit** *Note: Office visit charge applies when seen by a physician and/or a licensed clinician under the supervision of the physician.*	No charge

COVERED MEDICAL SERVICES

GENERAL SERVICES	*Copay Charges*
• **Preventive Care Services** Prenatal visits; Prostate and Colorectal Cancer Screening; Routine Immunizations; Routine Physical Exams; Tubal Ligation; Well-Woman Exams; any 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.	No charge
• **Diagnostic Test** Routine Lab (Blood Work) and X-rays.	No charge
• **Imaging and Radiology** (both Facility and Physician charges) Angiogram; CT Scan; MRI; Myelography; PET Scan; Stress Test; Ultrasound.	No charge
• **Outpatient Services** Facility Charges; Medical Injectables; Medical Supplies; Observation Unit; Outpatient Surgical Procedures; Pain Management; Physician Services.	No charge
• **Emergency Room** Copayment waived if episode results in hospitalization for the same condition within 24 hours.	No charge
• **Ambulance Services** Air/Ground.	No charge
• **Urgent Care**	No charge
• **Inpatient Services** Blood and Blood Products; Chemical Abuse Services; Coronary Care Units; Drugs including specialty pharmacy drugs; Facility Charges; Intensive Care Unit (ICU); Laboratory Tests/X-rays; Maternity Labor and Delivery; Medical Injectables; Medical Supplies; Mental Health Services; Neonatal Intensive Care Unit (NICU); Operating/Recovery Room; Pain Management; Physician Services; Pre-Admission Testing; Rehabilitation Facility; Serious Mental Illness; Skilled Nursing Facility¥; Surgical Procedures.	No charge
• **Outpatient Mental Health/ Chemical Abuse Services** Alcohol and Drug Dependency; Outpatient Mental Health Care; Serious Mental Illness.	No charge
• **Maternity Services/ Family Planning/ Infertility** Postnatal Care; Family Planning Services (as medically necessary); Diagnosis of Infertility.	No charge
• **Rehabilitation Services¥** Physical Therapy; Occupational Therapy; Speech Therapy; Chiropractic Care.	No charge
• **Habilitation Services¥** Physical Therapy; Occupational Therapy; Speech Therapy; Chiropractic Care.	No charge
• **Home Health Care¥** Private duty nursing in a limited set of circumstances (Refer to plan document).	No charge
• **Durable Medical Equipment (DME)** Orthotics; Prosthetics.	No charge
• **Diabetes Management** Diabetes Self-Management Training, Education, Care Management.	No charge
• **Diabetic Equipment & Supplies**	Same as DME or Rx, as appropriate
• **Nutritional Counseling**	No charge

COVERED MEDICAL SERVICES	
GENERAL SERVICES	*Copay Charges*
• **Telemedicine and Telehealth Services**	The amount of the copayment may not exceed the amount of the copayment required for a comparable medical service provided through a face-to-face consultation.
• **Other Services** Including, but not limited to: Allergy Testing/Serum/Injections; Amino Acid-Based Elemental Formulas; Autism Spectrum Disorders; Brain Injury; Cardiovascular Disease Screening Test¥; Chemotherapy; Craniofacial; Dialysis Services; EKG; Genetic Testing; Hearing Aids¥ and Cochlear Implants; Home Infusion Medications; Hospice Care; Inherited Metabolic Disorders-PKU; Internal Implantable Devices; Limited Accidental Dental Care; Non-Preventive Colonoscopy (Facility/Physician); Organ Transplant Services; Surgical Procedures in Physician Office; Temporomandibular; Vasectomy.	No charge
• **All Other Covered Services** *(not specified herein)*	No charge

OTHER PEDIATRIC CARE SERVICES *Reserved only for covered dependents through the age of 18.*	*Copay Charges*
• **Annual Routine Eye Exam**	No charge
• **Annual Eye Glasses** Limited to one pair of eyeglasses per plan year.	No charge
• **Dental Services**	Not covered

PRESCRIPTION DRUG SERVICES	*Copay Charges*	
	30-day Standard	*90-day Maintenance**
• **ACA Preventive Drugs**	$0 copay	$0 copay
• **Tier 1** Generic Drugs	No charge	No charge
• **Tier 2** Preferred Brand Name Drugs	No charge	No charge
• **Tier 3** Non-Preferred Brand Name Drugs	No charge	No charge
• **Tier 4** Specialty Drugs and Oral Chemotherapy Drugs	No charge	Not covered
• **Preferred Diabetic test strips for blood glucose monitors**	No charge	No charge
• **Non-Preferred Diabetic test strips for blood glucose monitors**	Non-formulary	Non-formulary

*Maintenance-eligible drugs allowed up to a 90-day supply if obtained through a Baylor Scott & White Pharmacy or participating 90-day retail or mail order pharmacy provider.
Mail Order: Available for a 1- to 90-day supply. Non-maintenance drugs obtained through mail order are limited to a 30- to 34-day supply maximum.
Some Specialty drugs may require prior authorization. 30-day supply only.

Covered Service Limitations¥:

- **Cardiovascular Disease Screening Test**
  Limited to once every 5 years
- **Habilitation Services**
  (Physical Therapy, Occupational Therapy, Speech Therapy and Chiropractic Care)
  Limited to 35 combined visits per plan year
  Limits may not apply for Therapies for Children with Developmental Delays and Autism Spectrum Disorder.
- **Hearing Aids**
  Limited to one device per ear every 3 years
- **Home Health Care**
  Limited to 60 visits per plan year
- **Rehabilitation Services**
  (Physical Therapy, Occupational Therapy, Speech Therapy and Chiropractic Care)
  Limited to 35 combined visits per plan year
  Limits may not apply for Therapies for Children with Developmental Delays and Autism Spectrum Disorder.
- **Skilled Nursing Facility**
  Limited to 25 days per plan year

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

THIS EVIDENCE OF COVERAGE IS NOT A MEDICARE SUPPLEMENT POLICY

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE 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 EVIDENCE OF COVERAGE IS GOVERNED BY THE LAWS OF THE STATE OF TEXAS AND APPLICABLE FEDERAL LAW. THIS EVIDENCE OF COVERAGE MAY BE PURCHASED THROUGH THE FEDERAL HEALTH INSURANCE MARKETPLACE (REFERRED TO AS “THE EXCHANGE”) OR IT MAY BE PURCHASED DIRECTLY FROM FIRSTCARE HEALTH PLANS.

Welcome To FirstCare

Dear Subscriber:

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

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

A representative from Our Customer Service Department will be calling to assist You in understanding Your FirstCare coverage. However, if you have questions or need information about how to use Your FirstCare Plan before you receive this call, please contact Our Customer Service Department at 1-855-572-7238, visit www.FirstCare.com and the myFirstCare Self Service secure Member web portal.

Thank You for selecting FirstCare.

SHA,L.L.C. dba FirstCare
[12940 N Highway 183
Austin, Texas 78750]
[(512) 257-6000]
[1-855-572-7238]
www.FirstCare.com

FirstCare
HEALTH PLANS

INDIVIDUAL CONTRACT

EVIDENCE OF COVERAGE

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

You have 10 days to examine this Evidence of Coverage after You received it. If after examining it You are not satisfied for any reason, You may return it within the 10-day period and the premium you have paid will be returned to You. However, if You receive any services prior to returning this Evidence of Coverage, You will be responsible for the cost of those services.

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

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

IMPORTANT NOTICE

To obtain information or make a Complaint: You may call FirstCare's toll free telephone number for information or to make a Complaint at:

1-855-572-7238

You may also write to Us at:

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

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

1-800 252-3439

You may write the Texas Department of Insurance:

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

PREMIUM OR CLAIM DISPUTES:

Should You have a dispute concerning Your premium or about a claim, You should contact FirstCare first. If the dispute is not resolved, You may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:

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

AVISO IMPORTANTE

Para obtener información o para presentar una queja:

Usted puede comunicarse con FirstCare llamando al número de teléfono gratuito de FirstCare's para información o para presentar una queja al:

1-855-572-7238

Usted también puede escribirnos a:

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

Usted puede escribir al Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, derechos o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas:

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

DISPUTAS POR PRIMAS O RECLAMACIONES:

Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con FirstCare primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU POLIZA:

Este aviso es solamente para propósitos informativos y no se convierte en parte o condición del documento adjunto.

TABLE OF CONTENTS

This document, known as the "Evidence of Coverage," describes the benefits available to you under your FirstCare Health Plan. At the time you enroll in FirstCare, and at other times after that, We may also provide supplements (known as "Riders or Amendments") that describe any additional benefits or any changes in your benefits or the terms of your coverage.

Throughout this document, "You" and "Your" refer to a FirstCare Member, including any eligible Dependents of the FirstCare Member (such as spouses and children) who are also enrolled in the Plan. "We," "Our," and "Us" refer to FirstCare. "Your Plan" and "the Plan" refer to the FirstCare Health Plan which is described in this document, together with your Schedule of Copayments.

Here is what you will find in this document:

SECTION 1: Requirements For All Health Care Services. This section describes the general requirements that apply to all health care services covered under Your Plan. For instance, it tells you which health care professionals you may go to for covered services. It also describes referrals to specialists and prior approvals for hospitalizations and other services.

SECTION 2: Eligibility and Enrollment. This section explains eligibility requirements for membership in FirstCare and effective dates for newly eligible Dependents.

SECTION 3: What Is Covered. This section tells you which health care services are covered under Your Plan, along with any limits on coverage for specific services. Section 3 also tells you the amount (if any) you have to pay at the time you receive services. This amount is called your "Copayment".

SECTION 4: Emergency and Out-of-Area Urgent Care Services. This section describes what services We will cover in a medical emergency, both inside and outside of FirstCare's Service Area. It explains your coverage for urgent care services when you are *outside* the FirstCare Service Area. This section also tells you how to get covered care if you urgently need services while you are *inside* the Service Area.

SECTION 5: What Is Not Covered. This section describes health care services that are not covered under Your Plan.

SECTION 6: Utilization Review (U.R.) Program. This section describes the pre-approval process required for some benefits.

SECTION 7: Premiums and Termination of Coverage or Benefits. This section tells you about your premiums, when they are due and what happens if your payments are late or if you fail to make premium payments. This section also provides specific reasons why your coverage or benefits may be terminated or canceled.

SECTION 8: Coordination of Benefits and Subrogation. This section describes the order of benefit determination rules when a Member has coverage under more than one plan**.**

SECTION 9: Member Complaint & Appeal Procedure. This section describes the process FirstCare has developed for you to follow should you have a Complaint or dissatisfaction about any aspect of Our operation. The section also tells you how to use Our Appeal process if you disagree with Our resolution to your Complaint.

SECTION 10: Miscellaneous Provisions. This section describes certain provisions including reimbursement of claims that you have paid, authority to examine your health records and incontestability provisions.

SECTION 11: Definitions. This section provides definitions of some of the terms used throughout this document. This document also uses specific medical terms for certain illnesses and treatments, which may not be defined in Section 10. If you have questions about any of these terms, please visit www.FirstCare.com and the myFirstCare Self Service secure Member web portal.

SECTION 12: Required Disclosures

SECTION 1 – REQUIREMENTS FOR ALL HEALTH CARE SERVICES

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

Medical Necessity

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

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

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

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

Primary Care Physician

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

Your Right to Choose an Obstetrician or Gynecologist

You are permitted to designate and visit an obstetrician or gynecologist to obtain direct access to the health care services provided by Your designated obstetrician or gynecologist, without a referral from Your PCP or prior authorization from Us. You are not required to choose an obstetrician or gynecologist, but may decide to have Your PCP provide these services.

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

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

If You need help choosing a FirstCare obstetrician/gynecologist or to change Your Physician, please visit www.FirstCare.com and the myFirstCare Self Service secure Member web portal.

Participating Providers

The service must be provided:

- by a Physician or other health care professional who participates in the FirstCare network; and
- at a Hospital, laboratory or other Facility that also participates in the FirstCare network.

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

For more information on Participating Providers, check the FirstCare Provider Directory. Remember that the provider directory is subject to change, so please visit www.FirstCare.vitalschoice.com for current information.

There are special circumstances under which You may obtain Covered Health Services from providers who are not part of the FirstCare network, also known as Non-Participating Providers. A more detailed definition of Non-Participating Provider appears in Section 11, *Definitions*:

- You may have to use Non-Participating Providers for emergency or out-of-area urgent care services described in Section 4*, Emergency and Out-of-Area Urgent Care Services*;
- If We determine Medically Necessary care cannot be provided by any health care provider participating in the FirstCare network, Your PCP may refer You to an Non-Participating Provider. We will process necessary referrals to Non-Participating Providers within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation;
- If Medically Necessary covered services, other than emergency care, are not available through Your Participating Provider on the request of the Participating Provider, We will provide for a review by a Non-Participating Provider with expertise in the same specialty as or a specialty similar to the type of health care provider to whom a referral is requested before We may deny the referral.
- Non-Participating Providers may be used in cases of court-ordered coverage for Dependent children who live inside or outside of FirstCare's Service Area. However, We must approve services, equipment or supplies that normally require an authorization (e.g. inpatient and outpatient procedures, rehabilitation, speech, occupational, or physical therapies, durable medical equipment or supplies) in advance or it will not be covered. Please refer to the specific benefit coverage detailed in Section 3*, What Is Covered*;
- When We agree to continue coverage for the services of a provider who stops participating in the FirstCare network, You may only use a Non-Participating Provider in accordance with the Continuity of Coverage provision in this section, when these arrangements have been pre-approved by Us; and
- In all cases, Medically Necessary Emergency Care received from a non-participating Physician or non-Participating Provider will be reimbursed according to the terms of the Evidence of Coverage at the usual and customary or agreed upon rate, except for Copayments, and charges for non-covered services. You will be held harmless for any amounts beyond the Copayment or other Out-of-Pocket amounts that You would have paid had the network included network Physicians or providers from whom You could obtain the services.

Ancillary Providers

An Ancillary Provider is a provider with whom a PCP may be required to consult and/or coordinate care for certain Covered Health Services on Your behalf. We do not require You to have a referral to see an ancillary provider. Your PCP may be required to consult with an Ancillary Provider on Your behalf to provide certain services, such as mental health services. If You need to obtain information about the health care services that require consultation with an Ancillary Provider, the identity of the Ancillary Providers who coordinate referrals for such health care services in Your area, or a current list of providers of those health care specialty services in Your area, please visit www.FirstCare.com and the myFirstCare Self Service secure Member web portal.

Continuity of Coverage

If You or Your Covered Dependents are receiving health care services from a Participating Provider whose relationship with the Plan as a Participating Provider is terminated by the provider, the Plan will assist that provider to give You no less than 30 days' advance notice of the termination. However, if a provider is terminated for reasons related to imminent harm, the Plan will notify You immediately

Except for medical incompetence or unprofessional behavior, the termination does not release the Plan from reimbursing the Participating Provider for providing treatment to You or Your Covered Dependent in certain special circumstances. Special circumstance means a condition which Your physician or provider, or Your Covered Dependent's physician or provider reasonable believes could cause harm to You or Your Covered Dependent if the physician or provider discontinues treatment of the Member, and include a disability, acute condition, life threatening illness, or being past the twenty-fourth week of pregnancy. However, the Participating Provider must first identify the special circumstance and submit a request to Plan's Medical Director that You or Your Covered Dependent be permitted to continue treatment under the Participating Provider's care. The Participating Provider must agree not to seek payment from You or Your Covered Dependent of any amounts for which You would not be responsible if the Health Professional or Participating Physician were still under contract with the Plan. If the request is granted, the Plan's obligation to pay for the services of the Participating Provider shall not exceed 90 days from the date of termination or nine (9) months in the case of a terminal illness with which You or Your Covered Dependent was diagnosed at the time of the termination and shall not exceed the contract rate. If You or a Covered Dependent is past the twenty-fourth (24th) week of pregnancy at the time of termination, Health Plan's obligation to reimburse a terminated Participating Provider for services extends through delivery of the child, immediate postpartum care and the follow-up checkup within the first six weeks of delivery.

Other Restrictions

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

Copayments

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

Deductible

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

Out-of-Pocket Maximum

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

FirstCare Review

In making any decision about coverage of Your health care services under The Plan, We may consult with any health care professional or organization that We believe will be helpful, if permitted by law. We also have the right to have health care professionals of Our choice examine Your medical records and physical condition, if permitted by law. We may use this information to assist in the coordination of Your covered services (such as planning for Your care after You are discharged from the Hospital), to help Us in making decisions about pre-approval of services, and other decisions concerning Your coverage under The Plan.

SECTION 2 – ELIGIBILITY AND ENROLLMENT

For persons enrolling through the Exchange, eligibility for this coverage will be determined by the Exchange in accordance with applicable law. For questions regarding eligibility, refer to healthcare.gov.

Subscriber Coverage

To be eligible to enroll as a FirstCare Subscriber, You must reside, live, or work in the FirstCare Service Area.

Dependent Coverage

To be eligible to enroll as a Dependent, a person must be an eligible Dependent of a Subscriber, and;

- Be Your spouse as defined by Texas law;
- Be a child (including a step-child, a legally adopted child or a child who has become the subject of a suit for adoption) of You or Your spouse who is under age 26;
- Be a child for whom You or Your spouse is a court appointed legal guardian. You must provide proof of such guardianship with Your Dependent's enrollment form;
- Be a child who is and continues to be both:
    - **a.** Unable to maintain self-sufficient employment because of a mental or physical handicap; and
    - **b.** Mainly dependent upon You for economic support and maintenance. You must provide proof of Your child's incapacity and dependency (e.g. a Physician's statement) to Us within 31 days of Your child's reaching the limiting age of 26. Afterward, You may be required to show proof of Your child's dependency, but not more often than once per year;
- Be a newborn child of You or Your spouse. To make sure Your child has continued coverage, You must notify Us, either verbally or in writing, of the addition of Your newborn as a Dependent within 31 days following Your child's birth, and pay any additional premium charges. (Note: If you have enrolled through the Exchange, You must notify the Exchange within 30 days of your intent to add Your newborn child).
- If Your newborn child is born outside the FirstCare Service Area due to an emergency, or is born in an Non-Participating Facility to a mother who does not have coverage under this Evidence of Coverage, We may require transfer to a Plan Facility and, if applicable, to a Participating Provider. Such transfer must be medically appropriate and approved by the newborn's treating Physician; We will cover expenses associated with transferring a newborn to a Plan Facility. Congenital defects are treated the same as any other illness or injury for which coverage is provided;
- Be an unmarried child of a Dependent (i.e., the Subscriber's grandchild) who is dependent upon You (i.e., grandparent) for support as defined by the United States Internal Revenue Code and applicable federal regulations, and who otherwise meets the requirements for an unmarried child specified above. Coverage may not be terminated solely because the covered child is no longer Your or Your spouse's Dependent for federal income tax purposes; or
- Be a child who resides inside or outside the FirstCare Service Area and whose coverage under The Plan is required by You or Your spouse through a medical support order or dental support order issued under Section 14.061, Texas Family Code. We shall provide coverage that is comparable health or dental coverage to that provided to other Dependents under The Plan. (Note: If You have enrolled through the Exchange, You must notify the Exchange within 30 days of your intent to add a child subject to a medical support or dental support court order).

Enrollment and Effective Date of Coverage

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

1. Initial Enrollment

If Your coverage was purchased through the Exchange or directly from FirstCare, Annual Open Enrollment Periods apply to You.

2. Annual Open Enrollment Periods/Effective Date of Coverage

You may apply for or change coverage in a Qualified Health Plan (QHP) (*See Definitions in* Section 11) through the Exchange for Yourself and/or Your eligible Dependents during the annual Open Enrollment Period designated by the Exchange.

When You enroll during the annual Open Enrollment Period, Your and/or Your eligible Dependents' effective date will be the following January 1, unless otherwise designated by the Exchange and FirstCare, as appropriate.

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

This section describing Annual Open Enrollment Periods is subject to change by the Exchange, FirstCare, and/or applicable law, as appropriate.

3. Late Enrollees/Special Enrollment/Effective Dates of Coverage

Health care reform requires health Plans to offer late and special enrollment periods. Eligible individuals and Dependents are allowed to enroll in a QHP (on the Exchange) or directly in a FirstCare health Plan, or change from one to another, as a result of the triggering events listed below. The special enrollment period generally is sixty (60) calendar days from the date of the triggering event. Coverage is effective as of the first day of the following month for elections made by the 15th of the preceding month and on the first day of the second following month for elections made between the 16th and the last day of a month, unless specified otherwise below.

You, and when specified below, Your Dependent, are allowed to enroll in a Plan or change from one to another as a result of the following triggering events:

- You or Your Dependent
    - Loses Minimum Essential Coverage; New coverage for You and/or eligible Dependents will be effective no later than the first day of the month following the loss. A loss of Minimum Essential Coverage does not include failure to pay Premiums on a timely basis, including COBRA Premiums prior to the expiration of COBRA coverage, or situations allowing for a Rescission. Rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect. Loss of Minimum Essential Coverage does include loss of coverage because You no longer reside, live or work in a health Plan's service area. It also includes expiration of COBRA continuation coverage.
    - Is enrolled in any non-calendar year group health plan or individual health insurance coverage, even if You or Your Dependent has the option to renew such coverage. The date of the loss of coverage is the last day of the plan or policy year;
    - Loses pregnancy-related coverage or loses access to health care services through coverage provided to a pregnant woman's unborn child. The date of the loss of coverage is the last day the qualified individual would have pregnancy-related coverage or access to health care services through the unborn child coverage; or
    - Loses medically needy coverage only once per calendar year. The date of the loss of coverage is the last day the consumer would have medically needy coverage.
- You gain a Dependent or become a Dependent through marriage, birth, adoption, suit for adoption, placement for adoption, or placement in foster care, or through a child support order or other court order. In the case of marriage, at least one spouse must demonstrate having Minimum Essential Coverage for 1 or more days during the 60 days preceding the date of

marriage. At the option of the Exchange, You lose a Dependent or are no longer considered a Dependent through divorce or legal separation, or if You or Your Dependent die. New coverage for You and/or Your eligible Dependents will be effective on the date of the birth, adoption, foster care placement, placement for adoption or the date the Subscriber becomes a party to a suit in which the Subscriber seeks to adopt a child. However, for Members enrolled through the Exchange, advance payments of any Premium Tax Credit and Cost-Sharing Reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month. The effective date for court-ordered eligible child coverage will be determined by FirstCare in accordance with the provisions of the court order.

- You or Your Dependent, become newly eligible for enrollment in a QHP through the Exchange.
- Your or Your Dependent's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct, or inaction of an officer, employee or agent of the Exchange or HHS;
- You or Your Dependent adequately demonstrates to the Exchange that the QHP in which You are enrolled substantially violated a material provision of their contract in relation to You;
- You become newly eligible or newly ineligible for advance payments of the Premium Tax Credit or have a change in eligibility for Cost-Sharing Reductions, regardless of whether You are already enrolled in a QHP.
- You or Your Dependent gains access to a new QHP as a result of a permanent move and Minimum Essential Coverage for one or more days during the 60 days preceding the date of the permanent move;
- You gain or maintain status as a Native American or become the Dependent of a Native American and may enroll in a QHP or change from one QHP to another one time per month.
- You or Your Dependent demonstrate to the Exchange that You meet other exceptional circumstances (as defined by the Exchange).
- You are a victim of domestic abuse or spousal abandonment or a Dependent or unmarried victim within a household, are enrolled in Minimum Essential Coverage, and seeking to enroll in coverage separate from the perpetrator of the abuse or abandonment. You are a Dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim, may enroll in coverage at the same time as the victim.
- Due to a qualifying event, You are assessed by the Exchange as potentially eligible for Medicaid or the Children's Health Insurance Program (CHIP), and are determined ineligible for Medicaid or CHIP by the State Medicaid or CHIP agency either after Open Enrollment has ended or more than 60 days after the qualifying event. You also may have applied for coverage at the State Medicaid or CHIP agency during the annual Open Enrollment period, and are determined ineligible for Medicaid or CHIP after Open Enrollment has ended.
- You or Your Dependent adequately demonstrates to the Exchange that a material error related to plan benefits, service area, or premium influenced Your decision to purchase a QHP through the Exchange.
- At the option of the Exchange, You or Your Dependent provide satisfactory documentary evidence to verify Your eligibility for an insurance affordability program or enrollment in a QHP through the Exchange following termination of Exchange enrollment due to a failure to verify such status within the time period specified in §155.315 or is under 100 percent of the Federal poverty level and did not enroll in coverage while waiting for HHS to verify Your citizenship, status as a national, or lawful presence.

Limitation

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

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

Notice of Ineligibility

It is your responsibility to notify FirstCare and the Exchange (if applicable) of any changes that will affect You or Your Dependents eligibility for services or benefits under this Plan within 30 days of the event.

Child Only Coverage

Eligible children who have not attained age 21 may enroll as the sole Subscriber under this Evidence of Coverage (health care plan). In such event, this Evidence of Coverage is considered child-only coverage and the following restrictions apply:

- Each child is enrolled individually as the sole Subscriber; the parent or legal guardian is not covered and is not eligible for benefits under this health care plan.
- No additional Dependents may be added to the enrolled child's coverage. Each child must be enrolled in his/her own health care plan. Note: If a child covered under this Evidence of Coverage acquires a new eligible child of his/her own, the new eligible child may be enrolled in his/her own health care plan coverage if application for coverage is made within 60 days.
- If a child is under the age of 18, his/her parent, legal guardian, or other responsible party must submit the application for child-only insurance form, along with any exhibits, appendices, addenda and/or other required information to FirstCare and the Exchange, as appropriate. For any child under 18 covered under this Evidence of Coverage, any obligations set forth in this Evidence of Coverage, any exhibits, appendices, addenda and/or other required information will be the obligations of the parent, legal guardian, or other responsible party applying for coverage on the child’s behalf. Application for a child-only coverage will not be accepted for an adult child that has attained age 21 as of the beginning of The Plan year. Adult children (at least 18 years of age but no older than 20 years of age) who are applying as the sole Subscriber under this Evidence of Coverage must apply for their own individual health care plan and must sign or authorize the applications(s).

SECTION 3 – WHAT IS COVERED

Some services outlined in the section below may require pre-approval in order for the service to be covered. Refer to the prior authorization list posted at [www.FirstCare.com] [and the myFirstCare Self Service secure Member web portal] to determine if a specific service requires pre-approval.

This section describes:

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

OUTPATIENT SERVICES

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

The outpatient services covered by Your Plan are:

1. Physician Office Visits

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

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

2. Services At Home

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

3. Laboratory Services

We cover laboratory services from a participating laboratory provider when the PCP, a Participating Provider, or other authorized Non-Participating Provider prescribes them.

4. Radiology Services

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

5. Surgical Procedures In Your Physician's Office

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

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

6. Materials Provided In Your Physician's Office

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

- General medical supplies (e.g. gauze, bandages, etc.)
- Dressings, casts, and splints.

Note: Some items may be subject to a prior authorization requirement. Refer to Section 6, *Utilization Review Program, Pre-Authorization Requirements.*

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

We cover medical injectable drugs, defined Hybrid Injectable, radiation therapy, specified transplant anti-rejection therapy, home infusion medications (excluding "self-injectable" drugs), specified Cancer Chemotherapy and defined associated agents and prescribed orally administered anticancer medications. Refer to the Schedule of Copayments for details.

Injectable Medications recognized by the Federal Drug Agency (FDA) as appropriate for self-administration (referred to as "self-injectable" drugs), regardless of the enrollee's ability to self-administer, are covered when they are on the FirstCare Formulary. Please see Section 3, *What is Covered, Prescription Drug Services* for details.

Note: Some items may be subject to a prior authorization requirement. Refer to Section 6, *Utilization Review Program, Pre-Authorization Requirements.*

8. Pre-Natal and Post-Natal Obstetrical Care

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

9. Rehabilitation Services

We cover outpatient rehabilitation including chiropractic care, physical, occupational and speech services that meet these conditions:

- Your PCP or in plan specialist, orders such rehabilitation or therapy services; and
- The services can be expected to meet or exceed the treatment goals established for You by Your Physician; and
- The services are given by a doctor, a licensed therapist, or chiropractor; and
- You are progressing toward the treatment goals in response to participating in the therapy.

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

10. Habilitation Services

We cover outpatient habilitation including chiropractic care, physical, occupational and speech therapy services that meet these conditions:

- Your PCP or participating specialist, orders such rehabilitation or therapy services; and
- The services can be expected to meet or exceed the treatment goals established for You by Your Physician; and
- The services are given by a doctor of osteopathy, a licensed therapist or chiropractor; and
- You are progressing toward the treatment goals in response to participating in the therapy.

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

11. Therapies for Children with Developmental Delays

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

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

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

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

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

12. Acquired Brain Injury

We provide coverage for certain benefits related to Acquired Brain Injury. Coverage includes the following services:

- Cognitive Rehabilitation Therapy;
- Cognitive Communication Therapy;
- Neurocognitive Therapy and Rehabilitation;
- Neurobehavioral, Neurophysiological, Neuropsychological, and Psychophysiological Testing and Treatment;
- Neurofeedback Therapy;
- Remediation required for and related to treatment of an Acquired Brain Injury
- Post-Acute Transition Services;
- Post-Acute-Care Treatment Services; or

- Community Reintegration Services, including outpatient day treatment services, or other post-acute care treatment services necessary as a result of and related to an Acquired Brain Injury.

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

- Has incurred an Acquired Brain Injury;
- Has been unresponsive to treatment; and
- Becomes responsive to treatment at a later date.

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

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

As required by the Texas Insurance Code Chapter 1352, We will not refuse required covered services for and related to treatment of an Acquired Brain Injury solely because they are provided by an assisted living Facility.

13. Outpatient Surgery

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

14. Pain Management Services

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

- Your PCP or participating plan specialist orders such pain management services;
- Services can be expected to meet or exceed treatment goals established for You by Your Physician;
- Services are scientifically proven and evidence-based to improve Your medical condition.

Note: Some items may be subject to a prior authorization requirement. Refer to Section 6, *Utilization Review Program, Pre-Authorization Requirements.*

15. Allergy Testing and Injections

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

Note: Some items may be subject to a prior authorization requirement. Refer to Section 6, *Utilization Review Program, Pre-Authorization Requirements.*

16. Anti-Smoking Programs

We cover anti-smoking programs including but not limited to, tobacco abuse and smoking cessation programs.

17. Short-Term Mental Health Services

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

- The mental illness or disorder being treated is listed in the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM), at the time services are provided;
- The initial evaluation, diagnosis, medical management and ongoing medication management of attention deficit disorder (ADD) and attention deficit hyperactivity disorder (ADHD) are also covered. Visits for medication management are not included in the maximum allowed visits.

Benefits for mental health conditions are covered under the same terms and conditions applicable to the plan's medical and surgical benefits and coverage..

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

18. Serious Mental Illness Services

Treatment of serious mental illness is covered if the mental illness or disorder being treated is one of the following psychiatric illnesses as defined by the most current DSM:

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

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

19. Autism Spectrum Disorder

We provide the following Autism coverage:

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

2. An individual acting under the supervision of a health care practitioner

Generally recognized services may include services such as:

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

20. Chemical Dependency Treatment

Outpatient treatment for chemical dependency (abuse of, psychological or physical dependence on, or addiction to alcohol or a controlled substance) and detoxification are covered. Coverage is provided on the same terms and conditions as medical and surgical benefits for any other physical illness.

PREVENTIVE HEALTH CARE SERVICES

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

The preventive health care services covered by Your Plan are:

1. Routine Physical Examinations

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

2. Well-Baby And Well-Child Care

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

3. Routine Immunizations

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

4. Well-Woman Examinations

For women who are Plan Members, We cover one annual well-woman gynecological examination for the early detection of ovarian cancer and cervical cancer. You may choose to have Your PCP or Your designated obstetrician/gynecologist perform the well-woman examination.

The examination includes a CA 125 blood test, and a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for

the detection of the human papillomavirus. A screening test required under this section must be performed in accordance with the guidelines adopted by the American College of Obstetricians and Gynecologists or another similar national organization of medical professionals recognized by the State of Texas.

5. Screening Mammogram

Diagnostic and screening mammograms are provided by all forms of Low Dose Mammography, including Digital Mammography and Breast Tomosynthesis, to detect breast cancer. Annual screening mammograms are provided for women 35 years of age or older. Mammograms may be obtained by referral from Your PCP or Plan obstetrician/gynecologist or other Specialist, whether or not a well-woman examination is performed at the same time.

6. Bone Mass Measurement

We cover bone mass measurement services for the detection of low bone mass and to determine the risk of osteoporosis and fractures associated with osteoporosis.

7. Examination for Detection of Prostate Cancer

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

8. Screening for Detection of Colorectal Cancer

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

9. Cardiovascular Disease Testing

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

10. Routine Sight, Speech and, Hearing Screening

We cover routine screenings of vision, speech, and hearing for Dependent Members through age 19. We also cover one hearing screening every Plan Year for all Members. A screening test for hearing loss is covered for a newborn child through the date the child is 30 days old. We also cover the necessary diagnostic follow-up care related to the screening test through the date the child is 24 months old.

11. Pediatric Vision Care Services

We cover the following pediatric vision services for Dependent Members through the age of 18:

- One routine eye exam per Plan Year
- One set of frames from the T-2 Collection series per Plan Year

- One set of Standard, Single, Bi focal and Trifocal or Lenticular lenses per plan year. (Lenses include fashion and gradient tinting ultraviolet protective coating, oversized and glass grey #3 prescription, polycarbonate prescription lenses with scratch resistance coating and low vision items)
- Contact lenses covered once per plan year, in lieu of the Collection series eyeglasses.
- Contact lenses for Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders and Irregular Astigmatism.

Services must be provided by a licensed ophthalmologist or optometrist operating within the scope of his or her license, or a dispensing optician.

How the Vision Benefits Work

You may visit any Participating Provider and receive benefits for a vision examination and covered Vision Materials. For the most current list of Participating Providers visit Our website https://firstcare.vitalschoice.com. You may visit www.FirstCare.com or the myFirstCare Self Service secure Member web portal.

You may receive Your eye examination and eyeglasses on different dates or through different Participating Provider locations. However, compete eyeglasses must be obtained at one time, from one Participating Provider.

Fees charged for services other than a covered vision examination or covered vision materials, and amounts in excess of those payable under this Pediatric Vision benefit, must be paid in full by You to the Provider. This pediatric vision benefit may not be combined with any discount, promotional offering, or other group benefit plans. Allowances are on-time use benefits; no remaining balances are carried over to be used later.

12. All Other Preventive Services

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

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

The preventive care services described above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, please visit www.FirstCare.com and the myFirstCare Self Service secure Member web portal.
Examples of covered services included are routine annual physicals, immunizations, well−child care, cancer screening mammograms, bone density testing, screening for prostate cancer and colorectal cancer, smoking cessation counseling services and healthy diet counseling and obesity screening and counseling.

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

FAMILY PLANNING SERVICES

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

1. Family Planning

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

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

Coverage is provided for the following contraceptive materials and services:

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

Coverage for all other prescription contraceptives, including but not limited to oral medications, and patches are described in Section 3, *What is Covered, Prescription Drug Services*.

2. Infertility Services

We will cover only diagnostic testing to determine the cause of infertility. Refer also to Section 5, *What is Not Covered.*

INPATIENT SERVICES

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

To be covered, all admissions must be to a participating Hospital, Skilled Nursing Facility, or other inpatient Facility. The only exceptions to this requirement are admissions covered under Section 4*, Emergency and Out-of-Area Urgent Care Services,* or pre-approved non-participating facilities when the services, equipment, or supply is determined to be Medically Necessary**.** If We determine that Medically Necessary services cannot be performed at one of Our participating inpatient facilities, We will approve admission to non-participating facilities.

1. Obstetrical Services

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

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

Note: *If your Newborn requires confinement in Neonatal Intensive Care Unit (NICU), then any applicable Deductible/Copayment will be applied separately to Your newborn, for any covered charges associated with that confinement. This is in addition to any applicable Mother Deductible / Copayment.*

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

2. Mastectomy or Related Procedures

We will approve inpatient admissions for mastectomy or related procedures in accordance with the standards described below.

We cover inpatient care following a mastectomy or related procedures for the treatment of breast cancer for a minimum of 48 hours following a mastectomy and 24 hours following a lymph node dissection, unless You and Your attending Physician determine that a shorter period of inpatient care is appropriate.

We cover all stages of reconstruction of the breast to mastectomy, including surgical reconstruction to restore or achieve breast symmetry or balance of a breast on which mastectomy surgery has not been performed and prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

See also Section 5, *What is Not Covered.*

3. Room, Meals, and General Nursing Care

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

We cover special diets during inpatient care, if they are prescribed by a Physician. We cover private duty nursing. Your Physician must recommend it.

4. Medical, Surgical and Obstetrical Services

We cover these medical, surgical, and obstetrical services:

- Physician services;
- Operating room and related facilities;
- Anesthesia and oxygen services;
- Intensive care and other special care units and services;
- Radiology, laboratory, and other diagnostic tests;
- Prescription medications and biologicals for use while You are an inpatient;
- Radiation and inhalation therapies; and
- Whole blood, blood derivatives, or blood components and their administration.

5. Observation Unit Admission

We cover stays in the observation unit of a Hospital, or admissions to another approved Facility if the admission for observation is ordered by Your PCP or participating specialist.

6. Rehabilitation Services

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

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

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

7. Habilitation Services

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

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

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

8. Skilled Nursing Facility

We cover inpatient care in a Skilled Nursing Facility if it meets all of these conditions:

- Services are delivered under the supervision of a Physician and are delivered by and require the judgment of a qualified and appropriately licensed provider, such as a registered or licensed vocational nurse, physical therapist, occupational therapist, respiratory therapist, or speech-language pathologist.
- Services are reasonable to treat a specific health condition, Illness, or Injury.
- Services are expected to result in a significant and measurable improvement in Your medical condition or functional capabilities.
- The skilled services needed cannot be provided in a less-intense setting, such as through intermittent home health skilled nursing visits and custodial support.
- Services are supported by evidence-based medical guidelines or literature as being specific, effective and reasonable treatment for your diagnosis and physical condition.

Please refer to Section 5, *What is Not Covered* for exclusions.

9. Short-Term Mental Health Services

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

Benefits for mental health conditions are covered under the same terms and conditions applicable to the plan's medical and surgical benefits and coverage.

10. Serious Mental Illness Services

Treatment for serious mental illness is covered if the mental illness or disorder being treated is one of the following psychiatric illnesses as defined by the most current DSM:

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

11. Chemical Dependency Treatment

Inpatient treatment for chemical dependency (abuse of, psychological or physical dependence on, or addiction to alcohol or a controlled substance) and detoxification are covered. Coverage is provided on the same terms and conditions as medical and surgical benefits for any other physical illness.

12. Blood and Blood Products

We provide coverage for:

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

TELEMEDICINE AND TELEHEALTH SERVICES

Your Plan includes coverage for Telemedicine and Telehealth services. Services may be rendered by a Participating Provider. The amount of the Deductible or Copayment may not exceed the amount of the Deductible or Copayment required for a comparable medical service provided through a face-to-face consultation.

OTHER HEALTH CARE SERVICES

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

1. Home Health Care

Health Services include:

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

Home Health Agency means a business that:

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

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

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

Home health services are provided unless the attending Physician certifies that hospitalization or confinement in a skilled Facility would be required if a treatment plan for home health care were not provided.

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

1. A licensed home health agency; or

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

- Skilled care that exceeds the capacity of periodic home care from a licensed home health agency AND
- Your care can be safely managed in the home setting AND
- Your PCP is willing and able to follow You during private duty nursing service AND
- The care is not being used for the purpose of providing Custodial Care or for the reason of Member/family convenience.

2. Home Infusion Therapy

We cover the administration of medication (including chemotherapy), fluids or nutrition by intravenous infusion in Your home. Home infusion therapy medications are covered under "Medical Injectable Drugs". These benefits include Home Infusion Therapy:

- Equipment and supplies needed to administer the therapy;
- Delivery services;
- Related nursing services; and
- Patient and Family education.

Injectable Medications recognized by the FDA as appropriate for self-administration (referred to as "self-injectable" drugs), regardless of the enrollee's ability to self-administer, are covered when on the FirstCare Formulary. Please see Section 3*, What is Covered, Prescription Drug Services*, of this Evidence of Coverage for details.

3. Non-Emergency Ambulance Transport Service

We cover non-emergency ambulance transport (for example, You are discharged from an inpatient Facility and need to be moved to a Skilled Nursing Facility).

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

4. Reconstructive Surgery Services

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

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

5. Prosthetics and Orthotics

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

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

Orthopedic/corrective shoes, shoe inserts, arch supports, Orthotic inserts and other supportive devices for the feet are covered, when pre-approved and Medically Necessary. We cover ankle braces required for recovery after surgery.

6. Internal Implantable Devices

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

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

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

7. Durable Medical Equipment

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

Durable Medical Equipment (DME) is medical equipment that in the absence of illness or injury is of no medical or other value to You, which is able to withstand repeated use by more than one person and is not disposable. Examples of such equipment include but are not limited to: crutches, Hospital

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

Coverage is provided for the DME meeting the following conditions:

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

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

8. Medical Supplies

The following medical supplies are covered.

- Standard ostomy supplies, sterile dressing kits, such as tracheostomy and central line dressing kits, as well as those medical supplies requiring a Physician's order to purchase, when purchased through a Participating Provider. Supplies that can be purchased over-the-counter without a Physician order are not covered. See Section 5*, What is Not Covered*.
- Disposable Home Infusion Therapy supplies
- Allergy syringes.

9. Diabetes Services

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

Diabetes Equipment and Supplies

See Durable Medical Equipment and Supplies in this section. Insulin Pump Supplies can be obtained in 30-day amounts through this Durable Medical Supply benefit or in a 90-day amount through a Participating Mail Service Pharmacy. Please visit www.FirstCare.com and the myFirstCare Self Service secure Member web portal for more information.

Diabetes Medications

The following medications for the treatment of diabetes are covered:

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

Medications are limited to a 30-day supply when purchased through a retail Plan pharmacy or a 90-day supply when purchased through a Participating Mail Service Pharmacy. For information on participating pharmacies, please visit www.FirstCare.com and the myFirstCare Self Service secure Member web portal.

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

Diabetes Self-Management Education

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

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

10. Hearing Aids and Cochlear Implants

We provide coverage for a hearing aid or cochlear implant and related services and supplies for a covered individual. Refer to the Schedule of Copayments for details.

Coverage includes:

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

Limitations:

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

- one cochlear implant in each ear with internal replacement as medically or audiologically necessary.

Coverage required under this section is subject to any provision that applies generally to coverage provided for durable medical equipment benefits under The Plan, including a provision relating to Deductibles, Copayments, or prior authorization.

11. Limited Accidental Dental-Related Services

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

- Treatment of, including removal of broken teeth as necessary to reduce a fractured jaw.
- Reconstruction of a dental ridge resulting from removal of a malignant tumor.
- Extraction of teeth prior to radiation therapy of the head and neck.
- Dentures as a result of radiation therapy of the head and neck or replacement dentures due to changes in the mouth as a result of radiation therapy of the head and neck.

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

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

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

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

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

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

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

12. Temporomandibular Joint Syndrome (TMJ) Services

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

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

13. Dialysis Services

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

14. Organ and Stem Cell Transplants

Preauthorization is required for any organ, tissue, or United States Food and Drug Administration (FDA) approved artificial device transplant, even if the Member is already in a treatment Facility under another preauthorization.
The covered transplants or device must meet all of the following conditions or they will not be covered:

- The recipient is a Member.
- The Member meets all of the criteria used by FirstCare to determine Medical Necessity for the transplant.
- The Member meets all of the protocols established by the Facility in which the transplant is performed.
- A contracted medical Facility designated and approved by FirstCare as being in Our transplant network is authorized to evaluate the Member's case, has determined that the proposed transplant is appropriate for treatment of the Member's condition and has agreed to perform the transplant;
- The proposed transplant is not Experimental or Investigational for treatment of the Member's condition, and is not to be performed in connection with a drug, device, or medical treatment or procedure that is Experimental or Investigational.
- Donated human organs or tissues or an FDA approved artificial device are used.

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

Note: *Denials for Medically Necessary or Experimental/Investigational treatments or procedures are eligible for review by an Independent Review Organization (IRO). See Section 9 for information on Member Complaint and Appeal Procedures.*

Limitations & Non-covered Services

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

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

15. Chemotherapy

We cover chemotherapy services.

16. Radiation Therapy

We cover radiation therapy services.

17. Amino Acid-Based Elemental Formulas

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

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

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

18. Clinical Trials – Routine Patient Care

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

Routine patient care costs DO NOT include:

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

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

19. Hospice Services

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

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

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

20. Nutritional Counseling

Your Plan includes coverage for nutritional counseling services from a Participating Provider. Refer to the Schedule of Copayments for benefit details.

PRESCRIPTION DRUG SERVICES

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

You and Your Covered Dependents shall be eligible to receive prescription drugs on the following basis:

Covered Drugs, Pharmaceuticals and Other Medications

The only covered drugs, pharmaceuticals or other medications (herein collectively referred to as "drug" or "drugs") covered hereunder are those which, under Federal or State law, may be dispensed only pursuant to an order from a licensed Health Professional with appropriate law enforcement agency registrations; which are prescribed by:

a. a Network Health Professional, or
b. in connection with emergency Treatment, a Health Professional in attendance on You or Your Covered Dependent at an emergency facility, or
c. by a Referral Health Professional to whom You or Your Covered Dependent has been referred by a Network Health Professional; which are used for the Treatment of an illness or injury covered under this Agreement;
d. filled through a Health Plan Network Pharmacy in accordance with this Agreement.

As medically appropriate, the Medical Director may require the substitution of any drug for another drug or form of Treatment which, based upon the recommendations of the Pharmacy and Therapeutics Committee or the Pharmacy and Therapeutics subcommittee, and the Medical Director's professional judgment provides equal or better results at a lower cost. Special dietary formulas for individuals with phenylketonuria or other heritable diseases are also covered under this prescription drug benefit. . Coverage is provided to the same extent that the plan provides coverage for drugs that are available only on the orders of a physician Heritable diseases are inherited diseases that may result in mental or physical retardation or death. Phenylketonuria is an inherited condition that may cause severe mental retardation if not treated.

Coverage for Off-Label Use of Drugs

Drugs prescribed to treat You, or Your Covered Dependent's, covered chronic, disabling or life-threatening illness are potentially coverable, under this prescription drug benefit if the drug has been approved by the Food and Drug Administration for at least one indication and is recognized for treatment of the indication for which the drug is prescribed in either a prescription drug reference compendium or substantially accepted peer reviewed medical literature. If the indication for which the drug is prescribed is not a FDA approved indication of the drug being prescribed, the health plan reserves the right to exempt the drug from coverage for that off label use within the prescription benefit plan. Coverage of the drug includes coverage of medically necessary services associated with the administration of the drug, but does not include coverage for experimental drugs not otherwise approved for any indication by the Food and Drug Administration or coverage for a drug that the Food and Drug Administration has not approved, or prescription drug reference compendia or peer reviewed medical literature has not deemed as a medically-accepted use for the proposed indication.

Evidence Based Formulary Development

Health Plan provides coverage for prescription drugs in accordance with an evidence based formulary developed by physicians and pharmacists comprising the Pharmacy and Therapeutics Committee. A formulary is a list of drugs for which Health Plan provides coverage. The Pharmacy and Therapeutics Committee meets at least quarterly to review the scientific evidence, economic data, and a wide range of other information about drugs for potential formulary placement and coverage. Based upon that review, the committee selects the drugs it believes to be the safest and most efficacious of those drugs which meet the desired goals of providing appropriate therapy at the most reasonable cost. Once such determination is made, the Health Plan may obtain or access contracts with the manufacturer of the drugs for rebates. The committee will not select a drug for the formulary until enough clinical evidence is available to allow the committee to determine the drug's comparable safety and efficacy. The committee defines this timeframe as 180 days of availability. The committee determines which drugs to add or delete, supply and dosage limitations, sequence of use, and all other aspects about the Health Plan formulary. Health plan will provide written notice of the modification to the drug formulary to the commissioner and each affected individual health benefit plan holder, not later than the 60th day before the date the modification is effective.

Request for Formulary Information

You or Your Covered Dependent may contact the Health Plan to find out if a specific drug is on the formulary. The Health Plan must respond to Your request about the drug formulary no later than the third business day after the date of the request to disclose whether a specific drug is on the formulary. However, the presence of a drug on a drug formulary does not guarantee that Your Health Professional will prescribe the drug for a particular medical condition or mental illness.

Formulary Lists

Copayments vary based upon the tier level a particular drug has been placed on by the Health Plan. Drugs on the Health Plan formulary, which are preferred generic drugs, require the lowest Copayment. Drugs on the Health Plan formulary, which are preferred name brand drugs require an increased Copayment. Drugs, which are not on the preferred generic or preferred brand tiers on the Health Plan formulary, which are alternate choice drugs or other drugs for some medical conditions not treated by drugs on the preferred tiers, may not be covered by the Health Plan or may require the largest Copayment, depending on the plan of benefits selected. If a particular drug appeared on the Health Plan formulary at the beginning of Your Plan Year, Health Plan shall make such drug available at the contracted benefit level until the end of the Plan Year, regardless of whether the prescribed drug has been removed from the Health Plan's formulary.

Prescription drugs designated on the drug formulary as Specialty Pharmacy drugs that are dispensed at a participating pharmacy and self-administered or administered in the office of a Participating Provider may be covered under this Evidence of Coverage, subject to the Specialty Pharmacy Copayments, Coinsurance, and Deductibles indicated in the Schedule of Benefits.

You or Your Covered Dependent may contact Health Plan to obtain a copy of the Specialty Pharmacy Drugs appearing on the drug formulary.

Drugs on the health plan formulary and Specialty Pharmacy Drugs may require preauthorization by a Medical Director or be subject to medical coverage requirements.

Drugs not listed on formulary may be covered if:

1. The drug is not excluded from coverage;
2. The drug is medically necessary;
3. The formulary alternatives have been tried but were insufficient to treat your condition, or there are clinically significant reasons why the formulary alternatives would not be appropriate.

The prescribing Health Professional must submit a written request for prior authorization or request for an appeal to the Health Plan for consideration of coverage. If the request is denied, You and the Health Professional may appeal the denial (see UTILIZATION REVIEW PROGRAM in this Evidence of Coverage).

Inpatient Prescription Drugs

Prescription Drugs, including Specialty Pharmacy Drugs, administered while admitted to a Participating Inpatient facility will be covered as part of Your Inpatient benefit.

Specialty Pharmacy Drugs

Certain classes of Specialty Pharmacy Drugs must be dispensed from one of the participating Specialty Pharmacy providers. Such classes of Specialty Pharmacy Drugs dispensed by a participating Specialty Pharmacy provider will be subject to the formulary Copayment for Specialty Pharmacy Drugs specified in the Schedule of Benefits. Failure to obtain these specific classes of Specialty Pharmacy Drugs from the participating Specialty Pharmacy provider may result in denial of coverage for such Specialty Pharmacy Drug. You or Your Covered Dependent may contact the Health Plan to obtain a copy of the classes of Specialty Pharmacy Drugs which must be obtained from the Participating Scott and White Specialty Pharmacy Providers.

Office or Clinic Administered Non-Specialty Pharmacy Drugs

Prescription Drugs which do not meet the definition of Specialty Pharmacy Drugs and which are dispensed and administered to You or Your Covered Dependent in the office of a Participating Provider or in another Outpatient setting, will be covered as a part of Your Medical Services benefit, and no additional Copayments are required for outpatient prescription drugs so dispensed and administered. These drugs may require preauthorization by a Medical Director in order to be covered as a part of Your Medical Services benefit.

Specialty Pharmacy Drugs will be covered pursuant to the Preferred Specialty Pharmacy Drugs benefit, regardless of whether or not the Specialty Pharmacy Drug is administered in the office of a Participating Provider or other Outpatient setting.

Authorization Requirements

For certain medications, the Health Plan limits the quantity You or Your Covered Dependent can receive over a certain period to be sure that You are taking a safe amount of a drug. Coverage of certain drugs may also require a previous failure of another medication. Other drugs may be subject to other clinical restrictions. Preauthorization for some drugs may be required.

One-time prescriptions or refillable prescriptions that exceed the authorization requirement amounts in the Schedule of Benefits will require preauthorization by the Medical Director.

If coverage for a particular drug or quantity of drug is denied, You and Your Health Professional may appeal the denial (see MEMBER COMPLAINT & APPEAL PROCEDURE of this Evidence of Coverage).

Your Provider may submit a request for an exception to step therapy protocol. If an exception request is not denied within 72 hours of the request, the request will be considered granted. If the prescribing provider feels that a denial would result in death or serious harm, the request will be considered granted if not denied within 24 hours of the request.

Step therapy protocol does not apply to drugs used to treat Stage 4 Advanced Metastatic Cancer or associate conditions.

Refill Limitations

Refill prescription will not be covered until You or Your Covered Dependent's existing supply is less than 25% of the prescription amount.

These limitations will be calculated based upon the prescription being taken at the prescribed dosage and appropriate intervals.

Refills of prescription eye drops to treat chronic eye disease are allowed if:

- the original prescription states that additional quantities of the eye drops are needed;
- the refill does not exceed the total quantity of dosage units authorized by the prescribing provider on the original prescription, including refills; and
- the refill is dispensed on or before the last day of the prescribed dosage period; and
    - not earlier than the 21st day after the date a prescription for a 30-day supply of eye drops is dispensed;
    - not earlier than the 42nd day after the date a prescription for a 60-day supply of eye drops is dispensed;
    - not earlier than the 63rd day after the date a prescription for a 90-day supply of eye drops is dispensed

Maintenance Drugs

In order for a drug to be considered a Maintenance Drug, the drug must appear on the Health Plan's maintenance drug list.

Prescriptions to treat chronic illnesses will be considered for medical synchronization as follows:

- Meet prior authorization criteria
- 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
- Is not a Schedule II or III controlled substance containing hydrocodone
- May qualify for synchronizing refills and pro-rated cost sharing amounts for partial supplies of certain medications.

Copayments, Deductible

You must pay the Copayment per quantity and days' supply dispensed per prescription as stated in the Schedule of Benefits. Any Deductible, and/or Copayments for prescription drugs shall be considered Out-of-Pocket Expenses for purposes of meeting Your Out-of-Pocket Maximum. The amount You pay for a prescription medication will not be more than the Copayment, as stated in the Schedule of Benefits, the allowed amount for the prescription medication, or the actual price of the medication.

Oral Anticancer Medications

Oral anticancer medications are covered under the Preferred Specialty Drug benefit, and are subject to the cost-sharing amounts applied to Specialty Drugs in the Schedule of Benefits.

Prescriptions for drugs included in the Oral Oncology Dispensing Program will be restricted to a 15-day supply for the first two months of therapy. Note that for members with a flat fee co-payment, drugs included in the Oral Oncology Dispensing Program will be subject to 50% of the applicable copayment amount as listed in the Schedule of Benefits. Following the first four fills of a drug in the Oral Oncology Dispensing Program, members continuing on therapy may fill their prescription for a maximum day supply allowed per the schedule of benefits.

The *Exception Prior Authorization Process* is Available to Members as described below:

FirstCare offers a Prescription Drug Exception Process for Members to request coverage of clinically appropriate drugs not covered on FirstCare's Formulary.

1. Exigent Requests

- A Member, a Member's designee, or the Member's prescribing Physician (or other prescriber) may submit a request to FirstCare for an expedited review of a non-covered drug based on exigent circumstances.
- Exigent circumstances exist when a Member is suffering from a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when a Member is undergoing a current course of treatment using a Non-Formulary drug.
- FirstCare shall make its coverage determination on an expedited review request based on exigent circumstances and notify the Member or the Member's designee and the prescribing Physician (or other prescriber, as appropriate) of its coverage determination no later than 24 hours after it receives the request.
- If FirstCare grants an exception based on exigent circumstances, it shall provide coverage of the Non-Formulary drug for the duration of the exigency. Cost-sharing (Deductibles/Co-payments) for drugs approved through the exigent exception process will count toward the annual limits on per Member cost-sharing (annual Deductibles and Out-of-Pocket Maximums).

2. Standard Requests

- A Member, a Member's designee, or the Member's prescribing Physician (or other prescriber) may request a standard review of a decision that a drug is not covered by the Plan.
- FirstCare shall make its determination on a standard exception and notify the Member or the Member's designee and the prescribing Physician (or other prescriber, as appropriate) of its coverage determination no later than 72 hours following receipt of the request.
- If FirstCare grants a standard exception request it shall provide coverage of the Non-Formulary drug for the duration of the prescription, including refills. Cost-sharing (Deductibles/Copayments) for drugs approved through the standard exception process will count toward the annual limits on per Member cost-sharing (annual Deductibles and Out-of-Pocket Maximums).

3. External Reviews

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

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

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

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

Emergency Care

1. What is Emergency Care

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

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

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

Emergency care includes the following services:

- An initial medical screening examination by the Facility providing the emergency care or other evaluation required by state or federal law that is necessary to determine whether an emergency medical condition exists;
- Services for the treatment and stabilization of an emergency condition; and
- Post-stabilization care originating in a Hospital emergency room, Freestanding Emergency Medical Care Facility, or comparable emergency Facility, if approved by Us, provided that We must approve or deny coverage within the time appropriate to the circumstances relating to the delivery of services and the condition of the patient not to exceed one hour of a request for approval by the treating Physician or the Hospital emergency room.

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

2. Requirements for All Emergency Care

Emergency care must meet all of these conditions:

- If You are emergently admitted to a non-participating Facility, You must contact The Plan within 24 hours, unless it is impossible to do so; and
- You (or someone acting for You) must agree to be transferred to the care of Participating Providers as soon as this can be done without harming Your condition. We do not cover services provided by Non-Participating Providers after the point at which You can be safely transferred to the care of a Participating Provider.

FirstCare has the right to review the services and circumstances in which You received them. We will cover the initial medical screening evaluation necessary to determine whether an emergency medical condition exists and services to treat and stabilize. After an emergency condition has been stabilized, Your Physician must pre-authorize continued treatment or it may not be covered. FirstCare will approve or deny continued treatment after stabilization of Your emergency condition within one hour of your Physician's request.

Out-of-Area Urgent Care

1. *What is Out-of-Area Urgent Care*

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

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

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

2. Requirements for Urgent Care

If Your condition is not serious enough to be a medical emergency, You should first seek care through Your PCP, as You would for Your regular covered care.

If You urgently need services while inside the FirstCare Service Area, care from Participating Providers is covered. Please remember that We will not cover urgent care inside the Service Area from a Non-Participating Provider.

Urgent care must meet all of these conditions:

- Before receiving treatment for urgent care, You should try to contact Your PCP and explain Your medical circumstances to him or her;
- You must obtain the services immediately after the urgent condition occurs, or as soon as possible afterward.
- If You were unable to contact Your PCP before seeking treatment, You (or someone acting for You) must contact Your PCP for advice and instructions as soon as possible after the urgent condition occurs.

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

Services and Copayments

We will cover the following services:

- Hospital emergency room services, including an initial medical screening examination;
- Services in an outpatient emergency, Freestanding Emergency Medical Care Facility, or urgent care center. We will also cover Emergency Services in a comparable Facility;
- Ground, Sea, or Air Ambulance services and ambulance transportation for emergency conditions. Air Ambulance for emergency transport is covered to the nearest hospital equipped to treat Your condition only when transport by ground ambulance or other means would endanger Your life or cause permanent damage to Your health. Please refer to Section 5, *What is Not Covered* for exclusions.
- Any other covered health care services detailed in Section 3*, What Is Covered*. However, the services must meet all of the conditions described above under this section. Your specific Copayments for these services are outlined in the *Schedule of Copayments.*

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

Payment Procedures

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

In all cases, Medically Necessary Emergency Care received from a non-participating Physician or non-Participating Provider will be reimbursed according to the terms of the Evidence of Coverage at the usual and customary or agreed upon rate, except for Copayments, and charges for non-covered services.. You will be held harmless for any amounts beyond the Copayment or other Out-of-Pocket amounts that You would have paid had the network included network Physicians or providers from whom You could obtain the services.

You should contact Our Customer Service Department at 1-855-572-7238, visit www.FirstCare.com and the myFirstCare Self Service secure Member web portal if the Non-Participating Provider bills You for amounts beyond the amount paid by Us.

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

You are only responsible for Your Copayment for emergency care received from in-network/Participating Providers. You should contact us if You receive a bill for amounts beyond Your Copayment.

SECTION 5 – WHAT IS NOT COVERED

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

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

We will not pay for the following services:

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

2. The following types of **Alternative Services,** therapy, counseling and related services or supplies:

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

3. **Ambulance** services/transportation are not covered:
    - When another mode of transportation is clinically appropriate;
    - For stable, non-emergency conditions, unless pre-authorized;
    - When provided for the convenience of the Member, family, companion, ambulance provider, Hospital, or attending Physician;
    - Where no transportation of a Member occurs.

    Additionally, **Air or Sea Ambulance** services are not covered:
    - When ground ambulance is clinically appropriate;
    - To locations other than an acute care Hospital.

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

5. **Biofeedback** services, except for the treatment of Acquired Brain Injury and for rehabilitation of Acquired Brain Injury.

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

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

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

9. **Cosmetic**, plastic, medical or surgical procedures, and cosmetic therapy and related services or supplies, including, but not limited to Hospital confinements, Prescription Drugs, diagnostic laboratory tests and x-rays or surgery and other reconstructive procedures (including any related prostheses,

except breast prosthesis following mastectomy), unless specifically provided in Section 3*, What Is Covered*. Among the procedures We do not cover are:

- Excision or reformation of any skin on any part of the body, hair transplantation, removal of port wine stains, chemical peels or abrasions of the skin, removal of superficial veins, tattoos or tattoo removal, the enlargement, reduction, implantation or change in the appearance in a portion of the body unless determined to be Medically Necessary;
- Removing or altering sagging skin;
- Changing the appearance of any part of Your body (such as enlargement, reduction or implantation, except for breast reconstruction following a mastectomy);
- Hair transplants or removal;
- Peeling or abrasion of the skin;
- Any procedure that does not repair a functional disorder; and
- Rhinoplasty and associated surgery except when Medically Necessary to correct deviated septum.

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

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

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

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

12. All expenses associated with routine **dental care** or oral surgery (except for corrective treatment of an accidental Injury to natural teeth) or any treatment relating to the teeth, jaws, or adjacent structures (for example, periodontium), including but not limited to:

- Cleaning the teeth;
- Any services related to crowns, bridges, filings, or periodontics;
- Rapid palatal expanders;
- X-rays or exams;
- Dentures or dental implants;
- Dental prostheses, or shortening or lengthening of the mandible or maxillae for Members over age 19, correction of malocclusion, and any non-surgical dental care involved in the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome, such as oral appliances and devices;
- Treatment of dental abscess or granuloma;
- Treatment of gingival tissues (other than for tumors);
- Surgery or treatment for overbite or under bite and any malocclusion associated thereto, including those deemed congenital or developmental anomalies; and
- Orthodontics, such as splints, positioners, extracting teeth, or repairing damaged teeth.

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

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

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

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

- Corrective shoes, shoe inserts, arch supports, and Orthotic inserts, except as provided for under Section 3*, What is Covered* and for the treatment of diabetes;
- Equipment and appliances considered disposable or convenient for use in the home, such as over-the counter bandages and dressings;
- Comfort or convenience items, such as bathtub chairs, whirlpool tubs, safety grab bars, stair gliders or elevators, over-the-bed tables, bed boards, saunas, and exercise equipment;
- Environmental control equipment, such as air conditioners, purifiers, humidifiers, dehumidifiers, electrostatic machines, and heat lamps;
- Consumable medical supplies, such as over-the-counter bandages, dressings, and other disposable supplies, skin preparations, surgical leggings, elastic stockings, TED stockings, stump socks and compression garments.
- Foam cervical collars;
- Stethoscopes, sphygmomanometers, and recording or hand-held pulse oximeters;
- Hygienic or self-help items or equipment; and
- Electric, deluxe, and custom wheelchairs or auto tilt chairs.
- Sequential lymphedema compression devices, except for treatment after a mastectomy.

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

- Medications for use outside of the Hospital or other inpatient Facility, including take-home and over-the-counter drugs, except those used in the treatment of diabetes or if otherwise covered as described in Section 3*, What is Covered, Prescription Drug Services*, of this Evidence of Coverage; or
- Experimental drugs and agents; or
- Drugs used to treat cosmetic conditions; or
- Drug Efficacy Study Implementation (DESI) Drugs

16. Educational testing and therapy, motor or language skills, or services that are educational in nature or are for vocational testing or training.

17. Electron Beam Tomography (EBT).

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

19. Weekend admission charges for **non-Emergency Care** services, unless Medically Necessary

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

21. Equine or Hippo therapy.

22. **Experimental or Investigational** drugs, devices, treatments, or procedures. This includes any drug, device, treatment, or procedure that would not be used in the absence of the Experimental or Investigational drug, device, treatment, or procedure. We consider a drug, device, treatment, or procedure to be Experimental or Investigational if:

    - It cannot be lawfully marketed without the approval of the U. S. Food and Drug Administration, and approval for marketing has not been given at the time it is provided;
    - It was reviewed and approved by the treating Facility's Institutional Review Board or similar committee, or if federal law requires it to be reviewed and approved by that committee. This exclusion also applies if the informed consent form used with the drug, device, treatment or procedure was (or was requested by federal law to be) reviewed and approved by that committee;
    - Reliable evidence shows that the drug, device, treatment, or procedure is the subject of ongoing Phase I or Phase II clinical trials; is the research, Experimental study, or Investigational arm of ongoing Phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness, or its effectiveness compared to a standard method of treatment or diagnosis;
    - The safety and/or efficacy has not been established by reliable, accepted medical evidence; or
    - Reliable evidence shows that the prevailing opinion among experts is that further studies or clinical trials of the drug, device, treatment, or procedure are needed to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness, or its effectiveness compared to a standard method of treatment or diagnosis.

    "Reliable evidence" includes only published reports and articles in authoritative medical and scientific literature, and written protocols and informed consent forms used by the treating Facility or by another Facility studying substantially the same drug, device, treatment, or procedure.

    Denials for Medically Necessary or Experimental & Investigational drugs, devices, treatments or procedures are eligible for review by an Independent Review Organization (IRO). See Section 9 for information on Member Complaint and Appeal Procedures.

23. **Routine foot care**, including treatment of weak, strained or flat feet, corns, calluses, or medications such as Lamisil or Sporanox for the treatment of uncomplicated nail fungus. We also do not cover corrective orthopedic shoes, arch supports, splints or other foot care items, except as noted under Section 3*, What is Covered*. This will not apply to the removal of nail roots. We do not cover ankle braces, with the exception of those listed under Section 3*, What is Covered.*

24. **Genetic counseling and testing**, with the exception of those required under applicable state or federal law and Medically Necessary perinatal genetic counseling. Genetic testing related to pre-implantation of embryos for in-vitro fertilization is not covered. Genetic testing results or the refusal to submit to genetic testing will not be used to reject, deny, limit, cancel, refuse to renew, increase premiums for, or otherwise adversely affect eligibility for or coverage under this plan.

25. **Hearing Devices:** Hearing aid batteries or cords, temporary or disposable hearing aids, repair or replacement of hearing aids due to normal wear, loss, or damage, a hearing aid that does not meet the specifications prescribed for correction of hearing loss.

26. All charges for inpatient **Hospital** days that exceed the medically recommended length of stay for the diagnosis, unless Medically Necessary.

27. **Illegal acts**: Charges for services received as a result of Injury or Sickness caused by or contributed to by the covered person engaging in an illegal act or occupation or by committing or attempting to commit a crime, criminal act, assault or other felonious behavior. For purposes of this exclusion, an act is "illegal" if it is contrary to or in violation of law, and includes, but is not limited to, operating a motor vehicle, recreational vehicle or watercraft while intoxicated. Intoxication includes situations in

which the covered person has a blood alcohol content or concentration (BAC) which exceeds the applicable legal limit. This exclusion does not apply if the Injury resulted from an act of domestic violence or medical condition (including both physical and mental health), or in case of emergency, the initial medical screening examination, treatment and stabilization of an emergency condition.

28. **Infertility** drugs, treatment, reversal of voluntary sterilization; gamete intra-fallopian transfer (GIFT); zygote intra-fallopian transfer (ZIFT); in vitro fertilization (IVF); any costs related to surrogate parenting; sperm banking for future use; or any assisted reproductive technology or related treatment that is not specified in Section 3*, What is Covered*

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

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

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

32. **Mastectomy** for relief of pain, prophylactic mastectomy to reduce the risk of breast cancer occurrence (except when You have been previously diagnosed with breast cancer), or due to any disease or illness other than for the treatment of breast cancer.

33. Inpatient and outpatient treatment, surgery, service, procedures or supplies that are not **Medically Necessary**; even if they are prescribed or recommended by a Health Care provider, dentist or ordered by a court of law.

Denials for Medically Necessary or Experimental & Investigational drugs, devices, treatments or procedures are eligible for review by an Independent Review Organization (IRO). See Section 9 for information on Member Complaint and Appeal Procedures.

34. The following **Medications**:

- Medications not listed on the FirstCare Formulary unless otherwise stated.
- Drugs that by law do not require a prescription unless listed in the Formulary.
- Prescriptions written in connection with any treatment or service that is not a covered benefit unless listed in the Formulary.
- With the exception of contraceptive devices, devices of any kind, even those requiring a prescription, including but not limited to therapeutic devices, health appliances, hypodermic needles or similar items.
- Any medication that is not Medically Necessary. Denials for medications that are not medically necessary are subject to the Member Complaint and Appeal Procedures outlined in Section 9 of Your Evidence of Coverage.
- Any over-the-counter medications that are not required by the Patient Protection & Affordable Care Act (PPACA).
- Vitamins, minerals, and/or nutritional supplements that are not required by the PPACA (regardless of whether or not these are Legend or over-the-counter).
- Medications prescribed for non-FDA approved indications, referred to as off-label drug use, are not covered. This includes Experimental and Investigational drugs used to treat any disease or condition that is excluded from coverage under this Plan or that the FDA has determined to be contraindicated for treatment of the current indication. Off-label drug use will be covered if the drug is approved by the FDA for at least one indication, and is recognized by reproducible studies for treatment of the indication for which the drug is

prescribed in substantially accepted peer-reviewed national medical professional journals and a nationally recognized medical technology evaluation service

- Appetite suppressants; anti-smoking aids in excess of what is required by Section 2713 of the Patient Protection & Affordable Care Act; medications used for any cosmetic improvement, including wrinkles, uncomplicated nail fungus regardless of ambulation or pain; hair loss, growth or removal; idiopathic non-growth hormone deficiency short stature; and, DESI Drugs.
- Prescriptions or refills that replace lost, stolen, spoiled, expired, spilled or are otherwise misplaced or mishandled by You.
- Prescriptions written for the treatment of infertility.
- Compound Medications
- anything which is not specified as covered or not defined as a drug, such as therapeutic devices, appliances, machines including syringes, except disposable syringes for insulin dependent Members, glucometers, and asthma spacers;
- drugs used for Treatments or medical conditions not covered by this Evidence of Coverage;
- any initial or refill prescription dispensed more than one (1) year after the date of the Health Professional's order;
- except for medical emergencies, drugs not obtained at a Network Pharmacy;
- drugs given or administered to You or a Covered Dependent while at a hospital, skilled nursing facility, or other facility;
- blood, blood plasma, and other blood products; except as covered by Medical benefits under the Evidence of Coverage;
- a prescription that has an over the counter alternative;
- initial or refill prescriptions the supply of which would extend past the termination of this Evidence of Coverage, even if the Health Professional's order was issued prior to termination
-

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

35. **Mental health** services for the treatment of the following conditions: mental retardation; senile deterioration, such as progressive dementia of Alzheimer's and Alzheimer's like diseases; sleep disorders and factitious disorders. Marriage counseling is not a Covered Health Service.

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

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

38. If a service is **not covered** under The Plan, We will not cover any services that are related to it. Related services are:

- Services provided in preparation for the non-covered service;
- Services provided in connection with providing the non-covered service; or
- Services that are usually provided following the non-covered service, such as follow-up care or therapy after surgery.
- Complications from non-covered service
- All care related to services that are not covered, including direct complications and pre or post care.

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

39. **Obesity:** Services intended primarily to treat obesity, such as gastric bypasses and balloons, vertical sleeve gastrectomy, bileo-pancreatic diversion (duodenal switch), stomach stapling, jaw wiring, vertical banding, gastric plication, vagal blocking therapy, Aspire Assist, intragastric balloon, weight reduction programs, gym memberships, gym equipment, Prescription Drugs, or other treatments for obesity (except preventive services related to obesity including screening for obesity in adults, counseling and behavioral interventions to promote sustained weight loss, diet and behavioral counseling in primary care to promote healthy maintenance of hyperlipidemia and cardiovascular risk factors along with other diet-related chronic disease factors) even if prescribed by a Physician or if You have medical conditions that might be helped by weight loss, regardless of Medical Necessity. Any complications/services related to the treatment of obesity will not be covered under this Plan.

40. Prophylactic **oophorectomy:** removal of one or both ovaries in the absence of malignant disease to reduce the risk of ovarian cancer occurrence.
41. **Orthotripsy** and related procedures.

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

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

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

45. **Physical therapy services**, unless rendered by a physical therapist.

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

47. **Long-term rehabilitative services**: Long term is defined as more than two months. Limitations do not apply to Acquired Brain Injury, Therapies for Children with Developmental Delays or Autism Spectrum Disorder as specified in Section 3, *What is Covered* of the Evidence of Coverage.

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

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

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

    Denials for Medical Necessity or Experimental/Investigational drugs, devices, treatments or procedures are eligible for review by an Independent Review Organization (IRO). See Section 9 for information on Member Complaints and Appeal Procedures.

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

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

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

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

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

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

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

58. **Skilled Nursing Facility** inpatient care exclusions:

- When the criteria in Section 3, *What is Covered, Inpatient Services, Skilled Nursing Facility* is not met;
- When services do not require the skills of a qualified provider and/or required procedures may be carried out safely and effectively by an appropriately trained patient, family or caregiver;
- When services are for maintenance programs or care;
- When the services are for Custodial Care only;
- When Medically Necessary care/services can be safely and appropriately provided at a less intense level of care.

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

60. **Sports rehabilitation** refers to continued treatment for sports related injuries in an effort to improve above and beyond normal ability to perform activities of daily living (ADLs). **Sports-related rehabilitation** or other similar avocational activities is not covered because it is not considered treatment of disease. This includes, but is not limited to: baseball, pitching/throwing, cheerleading, golfing, martial arts of all types, organized football, baseball, basketball, soccer, lacrosse, swimming, track and field, etc. at a college, high school, or other school or community setting, professional and amateur tennis, professional and amateur/hobby/academic dance, and competitive weightlifting and similar activities.

61. Disposable or consumable outpatient **supplies**, such as needles, blood or urine testing supplies (except supplies used in the treatment of diabetes and allergy syringes) and sheaths, bags, elastic garments and bandages, home testing kits, vitamins, dietary supplements and replacements, special food items and formulas.

62. Oral appliances and devices for **temporomandibular joint (TMJ)** syndrome.

63. Elective, non-therapeutic **termination of pregnancy** (abortions) including any abortion-inducing medications, except where the life of the mother would be endangered if the fetus were to be carried to term or a medical emergency places the woman in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed.

64. **Transportation**, except for ambulance or air ambulance (in accordance with Section 4, *Emergency and Urgent Care, Services and Copayments*) used for transport in a medical emergency or when We have pre-approved services for medical transport purposes only (e.g. from a Hospital to a Skilled Nursing Facility).

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

66. **Urgent Care** inside the Service Area from a Non-Participating Provider.

67. **Adult Vision Care Services (for Members over the age of 19):** .Eye examinations to determine the need for corrective lenses, or the presence of vision problems: eyeglasses (including eyeglasses and contact lenses prescribed following vision surgery); contact lenses , except for treatment of Keratoconus, and any other items or services for the correction of Your eyesight, including but not limited to: eye exercises, orthoptics, vision training, vision therapy, radial keratotomy (RK), automated lamellar keratoplasty (ALK or LK), astigmatic keratotomy (AK), laser vision corrective surgery and photo refractive keratectomy (PRK-laser) unless specifically provided in Section 3*, What Is Covered.*

68. **Pediatric Vision Care Services:**
    - Routine eye exam does not include professional services for contact lenses
    - Laser eye surgery (LASIK)
    - Any vision service, treatment or materials not specifically listed as a covered service;
    - Services and materials not meeting accepted standards of optometric practice;
    - Telephone consultations;
    - Any services that are strictly cosmetic in nature including, but not limited to, charges or personalization or characterization of Prosthetic appliances;
    - Special lens designs of coatings other than those described in this benefit;
    - Replacement of lost/stolen eyewear;
    - Non-prescription (Plano) lenses;
    - Two pairs of eyeglasses in lieu of bifocals;
    - Insurance of contact lenses

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

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

Limitations Due To Certain Conditions

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

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

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

Definitions

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

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

Effect on Benefits

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

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

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

If a retrospective utilization review is conducted, the Utilization Review Agent shall provide notice of an Adverse Benefit Determination in writing to You and Your Health Care Provider not later than 30 days after the date on which the claim is received.

The period may be extended once by the Utilization Review Agent for a period not to exceed 15 days, if the Utilization Review Agent:

- determines that an extension is necessary due to matters beyond the Utilization Review Agent's control; and
- notifies You and Your Health Care Provider before the expiration of the initial 30-day period of the circumstances requiring the extension and the date by which the Utilization Review Agent expects to make a determination.

If the extension is required because of the failure You or Your Health Care Provider to submit information necessary to reach a determination on the request, the notice of extension must:

- specifically describe the required information necessary to complete the request; and
- give You and Your Health Care Provider at least 45 days from the date of receipt of the notice of extension to provide the specified information.

If the period for making the determination is extended because of You or Your Health Care Provider’s failure to submit the information necessary to make the determination, the period for making the determination is tolled

from the date on which the Utilization Review Agent sends the notification of the extension to You or Your Health Care Provider until the earlier of:

- the date on which You or Your Health Care Provider responds to the request for additional information; or
- the date by which the specified information was to have been submitted.

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

Utilization Review Program Requirements

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

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

Pre-Authorization Requirements

We require that certain medical services, care, or treatments be pre-authorized before We will pay for all related Covered Health Services. Preauthorization means that We review and confirm that proposed services, care, or treatments are Medically Necessary. You are responsible for ensuring that Your Physician obtains preauthorization for any proposed services at least five (5) days before You receive them. For a listing of the services requiring preauthorization, please visit [www.FirstCare.com] [and the myFirstCare Self Service secure Member web portal.] A paper copy is available upon request. This listing is subject to change.

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

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

We will respond to a request for preauthorization within the following time periods:

- For non-hospitalized requests, a determination will be issued and transmitted not later than the third calendar day after the date the request is received by Us.
- If the proposed medical or health care services are for concurrent hospitalization care, We will issue and transmit a determination indicating whether proposed services are pre-authorized within 24 hours of receipt of the request.
- If the proposed medical care or health care services involve post-stabilization treatment, or a Life-Threatening condition We will issue and transmit a determination indicating whether proposed services are pre-authorized within the time appropriate to the circumstances relating to the delivery of the services and Your condition, but in no case to exceed one hour from receipt of the request.

Your Physician may submit a request to renew an existing authorization at least 60 days before the authorization expires. We shall, if practicable, review the request for medical necessity and issue a determination before the existing authorization expires.

Case Management Program

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

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

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

Referrals for Case Management can be made by visiting www.FirstCare.com and the myFirstCare Self Service secure Member web portal, or can be made by email sent to casemgmt@firstcare.com.

Disease Management Program

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

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

Participation in disease management is completely voluntary and Members may opt in or out at any time without affecting their benefits. Members who agree to participate receive phone calls from specially trained nurses and other staff, as well as helpful information in the mail. You can sign up or get more information by visiting www.FirstCare.com and the myFirstCare Self Service secure Member web portal.

SECTION 7 – PREMIUMS AND TERMINATION OF COVERAGE

Premiums

Premium rates are set out in the Premium Rate Schedule. The Subscriber agrees to remit the entire Premium payment on or before the due date. Due date is the first day of the month for which the payment is due. We accept premium payments directly from You. If you purchased your coverage on the Exchange, the Exchange may offer You a choice of multiple payment options, which may include an electronic payment option. If You receive advance payment of Premium Tax Credits, We will receive payments from two different sources (i.e., the Treasury Department and either You or the Exchange) on Your behalf.

Only if FirstCare 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 for You and/or Your Dependents or there is a bank draft failure, then You will be terminated at the end of the Grace Period. You will be responsible for the cost of services rendered to You or Your Dependents during the Grace Period of the Contract Month in the event that Premium payments are not made by You.

A Grace Period of 31 days will be granted for the payment of each premium falling due after the first Premium, during which Grace Period, the Evidence of Coverage shall continue in force. After a Grace Period of 31 days, coverage under this Evidence of Coverage will automatically terminate on the last day of the coverage period for which Premiums have been paid, unless coverage is extended as described in the next paragraph.

If you are receiving a Premium Tax Credit under the Affordable Care Act, you have a three-month grace period for paying premiums. If full payment of the premium is not made within the three month grace period, then coverage will retroactively terminate on the last day of the first month of the three-month grace period.

Medical Claim Overview during Grace Period

- FirstCare will pay provider's medical claims on members who are within the three month grace period.
- If the member fails to pay their premium, FirstCare will cancel the member's coverage retroactive to the last day of the first month of the grace period and seek recovery of payment for services received in the second and third months of the grace period from the provider.

Pharmacy Claim Overview during Grace Period

- FirstCare will pay pharmacy claims on members who are within the first month grace period.
- FirstCare will not pay pharmacy claims on members who are in the second or third month grace period. Members will be responsible for 100% of pharmacy costs during the second and third month of the grace period.
- Once members pay back overdue premiums, at the Member's request, FirstCare will reimburse the Member for the covered expense according to the enrolled plan benefits.

1. Premium Rate Changes

- We reserve the right to adjust the premium on each anniversary date of this Evidence of Coverage upon 60 days' notice to You.
- If You change Your place of residence and such change results in a change in Premium, the Premium applicable to this Plan shall automatically change to the rate applicable to the new place of residence effective on the first day of The Plan month following the date of such change in residence. If such change is to a lower Premium rate and You fail to notify Us in writing of such change prior to the date of change, Your right to refund of overpayment shall be limited to the overpayment for the 6 months immediately preceding the date of notification to Us.

- If You and/or Your covered spouse and/or other Dependent(s) attain an age resulting in an increased Premium rate, the Premium applicable to this Plan shall automatically change to the rate applicable to the new age effective on the anniversary date of Your Plan.

2. Failure to Render Premium Payments

Failure to make Premium payments within the Grace Period will result in termination of coverage retroactive to the last date through which premiums were paid. The Subscriber shall be responsible for any services received during the Grace Period.

3. Returned Checks

FirstCare reserves the right to charge a service fee to any Subscriber whose check is returned by the bank.

4. Third Party Premium Payments

Payment of premiums for individual plans are a personal expense to be paid for directly by individual and family plan subscribers using personal funds. Personal funds do not include payment from a business account for a sole proprietorship or Limited Liability Corporation (LLC). In compliance with federal guidance, FirstCare will accept third party payment for premium from the following entities:

1. the Ryan White HIV/AIDS Program under title XXVI of the Public Health Services Act;
2. Indian tribes, tribal organizations, or urban Indian organizations; and
3. State and federal Government programs

Except as provided above, third-party entities shall not pay FirstCare directly for any or all of a member's premium. Premium payments from any other party will not be credited to Your account which may result in termination or cancellation of coverage in accordance with the Termination provisions of this Evidence of Coverage.

Termination of Coverage

You may terminate coverage voluntarily by giving appropriate notice to FirstCare and to the Exchange (if applicable). The effective date of coverage termination will be fourteen (14) calendar days after Your request, unless You request a later date, or an earlier date that We are able to carry out.

For coverage purchased on the Exchange, the Exchange *may* terminate Your coverage but *must allow* Us to terminate coverage – when:

- You are no longer eligible for coverage through the Exchange. The last day of coverage is the last day of the month following the month in which the notice is sent by the Exchange unless You request an earlier termination effective date;
- You change from one QHP to another during the annual Open Enrollment Period. The last day of coverage in your prior QHP is the day before the effective date of coverage in your new QHP;
- The plan terminates.

Whether You have purchased coverage on the Exchange <u>*or*</u> directly from FirstCare, We may terminate Your coverage under the following circumstances:

- Your coverage is rescinded (see Section below); or
- Your premiums are unpaid and any applicable Grace Period has been exhausted.
- Termination due to our discontinuance of a particular type of individual coverage in the Service Area. Coverage may be canceled after 90 days written notice, in which case We must offer to each Member

on a guaranteed issue basis any other individual basic health care coverage offered by FirstCare in that Service Area. If FirstCare completely withdraws from the individual market in the Service Area, coverage under this Plan may be canceled after 180 days written notice to the state insurance commissioner and the Members, in which case FirstCare may not re-enter the individual market in that Service Area for five years beginning on the date of discontinuance of the last coverage not renewed.

- Failure of the Subscriber to reside, live or work in the Service Area, coverage may be canceled after 30 days' written notice. Coverage for a child who is the subject of a medical support order cannot be canceled solely because the child does not reside, live or work in the Service Area.

Refunds

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

Rescissions

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

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

Continuation of Coverage Due to Change in Marital Status

If a Dependent's coverage terminates due to a change in marital status, Your former spouse may be issued coverage that most nearly approximates the coverage of the Evidence of Coverage that was in effect prior to the change in marital status and without furnishing evidence of insurability. In order to enroll in such coverage, Your former spouse must continue to reside, live or work in the Service Area, submit a completed application within thirty-one (31) days after the date of the change in marital status and submit Premium payments required under such Evidence of Coverage. The effective date of such coverage shall be the effective date of coverage under the prior Evidence of Coverage.

Reinstatement Upon Acceptance of Late Premium

In any case where termination resulted from failure to make timely payment of Premium, the subsequent acceptance of such Premium payments by FirstCare or our duly authorized agents shall reinstate the coverage. For purposes of this provision, mere receipt and/or negotiation of a late Premium payment does not constitute acceptance. The reinstated Evidence of Coverage shall cover only loss resulting from injury as may be sustained after the date of reinstatement and loss due to sickness as may begin more than ten days after such date. In all other respects, the Subscriber and FirstCare shall have the same rights hereunder as they had under the Evidence of Coverage immediately before the due date of the defaulted Premiums, including the right of the Subscriber to apply the period of time this Evidence of Coverage was in effect immediately before the due date of the defaulted Premiums toward satisfaction of any waiting periods for benefits, if any, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any Premium payments accepted in connection with a reinstatement shall be applied to a period for which Premiums have not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

No Automatic Reinstatement

A Subscriber and/or a Subscriber's Dependents shall not be reinstated automatically if coverage is terminated. To be reinstated, a Subscriber and/or a Subscriber's Dependent(s) must reapply at the next Open Enrollment Period.

SECTION 8 - COORDINATION OF BENEFITS AND SUBROGATION

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

Coordination of Benefits (COB)

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

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

   Plan includes: group, blanket, or franchise accident and health insurance 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.

   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 policy that is designed to fully integrate with other policies through a variable Deductible.

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

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

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

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

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

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

Rules of Coordination

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

1. Non-Dependent/Dependent

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

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

2. Dependent Child Covered Under More Than One Plan

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

a. For a Dependent child whose parents are married or living together, whether or not they have ever been married:

- The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
- If both parents have the same birthday, the benefits of the plan that covered one parent longer are determined before those of the plan that covered the other parent for a shorter period of time.

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

- If a court order states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the Dependent child's health care expenses, and that parent's spouse does, then the spouse's plan is the primary plan. This clause must not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court order provision.
- If a court order states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of (B)(2)(a) must determine the order of benefits.
- If a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of (B)(2)(a) must determine the order of benefits.
- If there is no court order allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

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

- For a Dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of (B)(2)(a) or (B)(2)(b) must determine the order of benefits as if those individuals were the parents of the child.
- For a Dependent child who has coverage under either or both parents plans and has his or her own coverage as a Dependent under a spouse's plan (B)(5) applies.
- In the event the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the order of benefits must be determined by applying the birthday rule in (B)(2)(a) to the Dependent child's parent(s) and the Dependent's spouse
- In the event none of the provisions listed above determines the order of benefits, the allowable expenses must be shared equally between plans.

3. Active/Retired or Laid-off Employee

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

4. COBRA or State Continuation Coverage

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

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

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

5. Longer/Shorter Length of Coverage

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

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

The start of a new plan does not include:

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

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

6. Employer Providers

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

7. Military Providers

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

8. Release of Information

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

9. Recovery of Payments

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

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

10. On-The-Job Injury/Illness

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

Subrogation, Reimbursement and/or Third Party Responsibility

1. Subrogation

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

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

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

2. Right of Reimbursement

a. If We pay benefits and You recover or are entitled to recover benefits from other coverage or from any legally responsible party, We have the right to recover from You the amount We have paid.
b. You must notify Us, in writing, within 31 days of any benefit payment, settlement, compromise or judgment. If You waive or impair our right to reimbursement, We will suspend payment of past or future services until all outstanding lien(s) are resolved
c. If You recover payment from and release any legally responsible party for future medical expenses relating to an illness or bodily injury, We shall have a continuing right to seek reimbursement from You. This right, however, shall apply only to the extent allowed by law.
d. This reimbursement obligation exists in full regardless of whether the settlement, compromise, or judgment designates the recovery as including or excluding medical expenses.

3. Our Right of Subrogation

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

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

4. Excess Insurance

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

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

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

5. Wrongful Death

In the event that the Member(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

6. Obligations

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

- To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
- To provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
- To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
- To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
- To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
- To not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Beneficiary may have against any responsible party or Coverage.

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

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

7. Minor Status

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

8. Severability

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

SECTION 9 – MEMBER COMPLAINT AND APPEAL PROCEDURE

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

Complaint Procedure

If You notify Us orally or in writing of a Complaint, We will not later than the fifth business day after the date of the receipt of the Complaint, send to You a letter acknowledging the date We received Your Complaint. We will enclose a one-page Complaint form that we encourage you to complete and return to Us for prompt resolution.

Complaints should be directed to the Customer Service Department at 1-855-572-7238 or in writing to:

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

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

Your Complaint concerning an emergency or denial of continued stay for hospitalization will be resolved within 24 hours from the time of receipt of Your Complaint. The investigation and resolution shall be concluded in accordance with the medical immediacy of the case.

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

Complaint Appeal Procedure

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

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

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

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

- Any documentation to be presented to the panel by Our staff;
- The specialization of any Physicians or providers consulted during the investigation; and

- The name and affiliation of each of Our representatives on the panel.

You or a designated representative is entitled to:

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

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

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

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

Adverse Benefit Determination Appeal Procedure

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

- The principal reasons for the Adverse Benefit Determination.
- The clinical basis for the Adverse Benefit Determination.
- A description or source of the screening criteria that were utilized as guidelines in making the determination.
- The specialty of the Physician making the denial.
- Notification of the right to appeal an Adverse Benefit Determination internally to FirstCare and externally to an Independent Review Organization.
- Notification of the procedures for appealing an Adverse Benefit Determination internally and/or to an Independent Review Organization.
- Notification to the Member who has a Life-Threatening condition of the Member's right to an immediate review by an Independent Review Organization and the procedure to obtain that review.
- A procedure for an expedited internal appeal of a denial of prescription drugs or intravenous infusions for which You are receiving benefits under the Plan will be resolved within one business day. The procedure includes a review by a health care provider who:
    1) has not previously reviewed the case; and
    2) is of the same or a similar specialty as the health care provider who would typically manage the medical condition, procedure, or treatment under review in the appeal.
- Immediate appeal to an Independent Review Organization for denial of Prescription Drugs or intravenous infusions. Notwithstanding any other law, in a circumstance involving the provision of Prescription Drugs or intravenous infusions for which the patient is receiving benefits under the Evidence of Coverage, the enrollee is:

1. Entitled to an immediate appeal to an Independent Review Organization; and
2. Not required to comply with procedures for an internal review of the Utilization Review Agent's Adverse Benefit Determination

- Information about the availability of, and contact information for, the Consumer Assistance desk at the Texas Department of Insurance.
- Statement that You are entitled to receive reasonable access to/copies of documents, records and other information relevant to the Adverse Benefit Determination.

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

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

Investigation and resolution of appeals relating to ongoing emergencies or denials of continued stays for hospitalization shall be conducted in accordance with the medical immediacy of the case but in no event to exceed 24 hours after Your request for appeal.

Due to the ongoing emergency or continued Hospital stay, and upon Your Appeal, We shall provide a review by a Physician or provider who has not previously reviewed the case and is of the same or similar specialty as typically manages the medical condition, procedure, or treatment under discussion for review of the appeal.

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

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

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

Filing Complaints with the Texas Department of Insurance

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

Consumer Protection, MC 111-1A
Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104

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

- Additional information is needed;
- An on-site review is necessary;

- We, the Physician or provider, or You do not provide all documentation necessary to complete the investigation; or
- Other circumstances beyond the control of the Texas Department of Insurance occur.

Appeals to an Independent Review Organization (IRO)

Medical Appeals

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

Denials for Medically Necessary or Experimental/Investigational treatments or procedures are eligible for review by an Independent Review Organization (IRO).

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

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

With respect to a standard external review, a final decision written notice will be provided to the health plan and the claimant by the Independent Review Organization within 45 days after the IRO receives the request. With respect to an expedited external review, a final decision written notice will be provided as prompt as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request.

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

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

Pharmacy Appeals

Where a medication is not covered on the Formulary or awaiting Formulary review, an exception prior authorization allows clinical review for Medical Necessity and coverage.

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

If We deny a request for a standard exception or for an expedited exception, the Member, the Member's designee, or the Member's prescribing Physician (or other prescriber) may submit a request that the original

exception request and subsequent denial of such request be reviewed by an Independent Review Organization.

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

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

SECTION 10 – MISCELLANEOUS PROVISIONS

Entire Evidence of Coverage

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

Change in Premium Upon Notice

We accept premium payments directly from You. The Exchange may offer You a choice of multiple payment options, which may include an electronic payment option. If You receive advance payment of premium tax credits, We will receive payments from two different sources (i.e., the Treasury Department and either You or the Exchange) on Your behalf.

We reserve the right to adjust the premium on each anniversary date of this Evidence of Coverage upon 60 days' notice to You. See Section 7*, Premiums and Termination of Coverage* for more details.

Cancellation

Except as otherwise provided herein, FirstCare (and the Exchange, if applicable to You) will not have the right to cancel Your coverage if the following requirements are met:

- You and Your Dependents, if any, remain eligible for coverage in accordance with this Evidence of Coverage; and
- All applicable premiums have been paid in accordance with this Contract.

Authority

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

If You purchased this Plan through the Exchange, in no event shall FirstCare be considered the agent of the Exchange or be responsible for the Exchange. All information You provide to the Exchange and received by FirstCare from the Exchange will be relied upon as accurate and complete. You will promptly notify the Exchange and FirstCare of any changes to such information.

Authorization to Examine Health Records

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

Notice of Claim

It is not expected that You will make payment for Covered Health Services, other than required Copayments. However, if You pay for Covered Health Services in addition to the required Copayment(s), You must file a claim with Us within 180 days from the date You incurred Covered Health Services, unless You can document as soon as reasonably possible after the 180-day period, to Our satisfaction, good cause why such claim could not be filed within such 180-day period. Provided, however, reimbursement shall not be

allowed if a claim is made beyond one year from the date such Covered Health Services were first incurred. We will provide forms for the submission of written proof of payment. You may contact Our Customer Service Department at 1-855-572-7238.

Payment of Claims

Payment of claims to You will be handled as follows:

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

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

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

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

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

Legal Action

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

Notice

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

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

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

Interpretation of this Evidence of Coverage

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

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

Assignment

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

Gender

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

Modifications

This Contract/Evidence of Coverage shall be subject to amendment, modification, or termination without the consent of any Member when required by law or regulatory order. In all other cases, We will provide 60 days advance written notice to You before the effective date of any material modification to this Contract, including changes in preventive care. You must provide Us 30 days' prior written notice of Your cancellation of this Contract resulting from a material change to the Contract.

Clerical Error

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

Headings and Captions

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

Incontestability

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

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

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

Premium Rebates and Premium Abatements

1. Rebate

In the event federal or state law requires FirstCare to rebate a portion of annual Premiums paid, FirstCare will directly provide any rebate owed Subscribers or former Subscribers to such persons in amounts as required by law.

If any rebate is owed a Subscriber or former Subscriber, FirstCare will provide the rebate to the Subscriber or former Subscriber no later than August 1 following the end of the medical loss ratio ("MLR") reporting year.

FirstCare will provide any rebate owed to a Subscriber in the form of a Premium credit, lump-sum check or, if a Subscriber paid the premium using a credit card or direct debit, by lump-sum reimbursement to the account used to pay the Premium. However, FirstCare will provide any rebate owed to a former Subscriber in the form of lump-sum check or lump-sum reimbursement using the same method used for payment, such as credit card or direct debit.

If a rebate is provided in the form of a Premium credit, FirstCare will provide any rebate by applying the full amount due to the first Premium payment due on or after August 1 following the end of the MLR reporting year. If the rebate owed is greater than the Premium due, FirstCare will apply any overage to succeeding Premium payments until the full amount of the rebate has been credited.

At the time any rebate is provided, FirstCare will provide to each FirstCare Subscriber or former Subscriber who receives a rebate a notice containing at least the following information:

- A general description of the concept of a MLR;
- The purpose of setting a MLR standard;
- The applicable MLR standard;
- FirstCare's MLR;
- FirstCare's aggregate premium revenue as reported under federal MLR regulations (minus any federal and state taxes and licensing and regulatory fees that may be excluded from premium revenue under those regulations); and
- The rebate percentage and amount owed based upon the difference between the FirstCare's MLR and the applicable MLR standard.

2. Abatement

FirstCare may from time to time determine to abate (in whole or in part) the Premium due under this Evidence of Coverage for particular period(s).

Any abatement of premium by FirstCare represents a determination by FirstCare not to collect Premium for the applicable period(s) and does not effect a reduction in the rates under this contract. An abatement for one period shall not constitute a precedent or create an expectation or right as to any abatement in any future period(s).

FirstCare makes no representation or warranty that any rebate or abatement owed or provided is exempt from any federal, state, or local taxes (including any related notice, withholding or reporting requirements). It will be the obligation of each Subscriber or former Subscriber (if applicable) owed or provided a rebate or an abatement to determine the applicability of and comply with any applicable federal, state or local laws or regulations.

Actuarial Value

The use of a metallic name, such as Platinum, Gold, Silver or Bronze, or other statements with respect to a 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.

SECTION 11 – DEFINITIONS

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

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

Adverse Benefit Determination: Denials that involve medical judgment (including, but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational) and rescissions of coverage (whether or not the rescission has any effect on any particular benefit at that time).

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

Annual Maximum: The Annual Maximum amount for Non-Essential Health Benefits that We will pay for any Member under all health plans issued by Us providing Covered Health Services for the Plan Year span of any Insured. When this maximum is reached, coverage for such Member will end for such Non-Essential Health Benefits.

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

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

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

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

Chemotherapy Associated Agents: Any medication used as supportive therapy for Cancer Chemotherapy administered at the time of chemotherapy administration. Medications used as supportive therapy not administrated at the time of chemotherapy infusion will be covered only as described in Section 3*, What is Covered, Prescription Drug Services*, of this Contract.

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

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

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

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

Complications of Pregnancy: Medical conditions that require inpatient care before the end of the pregnancy or that endanger the pregnancy or that are aggravated by the pregnancy. Complications of Pregnancy are conditions requiring diagnoses that are distinct from pregnancy but that are adversely affected by pregnancy, including but not limited to:

- Acute nephritis;
- Nephrosis;
- Cardiac decompensation;

- Missed abortion;
- Termination of pregnancy by non-elective cesarean section;
- Termination of ectopic pregnancy;
- Spontaneous termination of pregnancy when a viable birth is not possible; and
- Similar medical and surgical conditions of comparable severity.

The following conditions are not considered Complications of Pregnancy:

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

Complications of Pregnancy are treated as any other Illness.

Compound Medications: When two or more drugs or chemicals are combined to make one medicinal product.

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

Contract Year: The 12-month period beginning with the effective date of the Plan and each succeeding 12-month period thereafter that the Plan is effective.

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

Cost-Sharing Reduction (CSR): Subsidies that reduce Out-of-Pocket liability for Members who meet certain financial criteria and select “silver” health plans on the Exchange.

Covered Drugs means those medications prescribed by a Physician that, under state or federal law, may be dispensed only by a Prescription Order for a Medically Necessary condition, and active ingredient(s) is/are FDA approved Legend Drug(s) or insulin. The maximum amount dispensed will not exceed an amount required for 30 consecutive days. Some medications for chronic conditions may be filled up to a 90-day supply.

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

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

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

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

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

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

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

Diabetic Equipment means blood glucose monitors, including those designed to be used by blind individuals, insulin pumps and associated attachments, insulin infusion devices, and podiatric appliances for the prevention of diabetic complications. As new or improved diabetes equipment become available and are approved by the United States Food and Drug Administration, such equipment shall be covered if determined to be Medically Necessary and appropriate by a treating Physician or other practitioner through a written order.

Diabetic Supplies means test strips for blood glucose monitors, visual reading and urine test strips, lancets and lancet devices, insulin and insulin analogs, injection aids, syringes for administering insulin, oral agents available with or without a prescription for controlling blood sugar levels, and glucagon emergency kits. As new or improved diabetes supplies, including improved insulin or another prescription drug, become available and are approved by the United States Food and Drug Administration, such supplies shall be covered if determined to be Medically Necessary and appropriate by a treating Physician or other practitioner through a written order.

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

Diagnostic Mammogram means an imaging examination designed to evaluate a subjective or objective abnormality detected by a physician 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.

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

Emergency Services: As required by the Insurance Code §1271.155 (concerning Emergency Care), emergency services include emergency transport in an emergency medical services vehicle licensed under Health and Safety Code Chapter 773 (concerning Emergency Medical Services), which is considered emergency care if it is provided as part of the evaluation and stabilization of medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the individual's condition, sickness, or injury is of such a nature that failure to get immediate care through emergency transport could place the individual's health in serious jeopardy, result in serious impairment to bodily functions, result in serious dysfunction of a bodily organ or part, result in serious disfigurement, or for a pregnant woman, result in serious jeopardy to the health of the fetus. Emergency services are covered up to the point of stabilization when they are medically necessary and needed immediately to treat a condition that meets the definition of an emergency condition as described above or a provider directs the patient to go to an emergency care facility. Emergency services are no longer payable as emergency services at the point of the patient's stabilization (as defined in this section).

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

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

Exchange (also known as health insurance marketplace) means a governmental agency or non-profit entity that meets the applicable Exchange standards, and other related standards established under applicable law, and makes Qualified Health Plans (QHPs) available to qualified individuals and Qualified Employers (as these terms are defined by applicable law). Unless otherwise identified, the term Exchange refers to the Federally-facilitated Exchange on which FirstCare offers this QHP.

Experimental or Investigational means any drug, device, treatment or procedure that would not be used in the absence of the Experimental or Investigational drug, device, treatment or procedure. We consider a drug, device, treatment or procedure to be Experimental or Investigational if:

- It cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time it is provided; or
- It was reviewed and approved by the treating Facility's Institutional Review Board or similar committee, or if federal law requires it to be reviewed and approved by that committee. This exclusion also applies if the informed consent form used with the drug, device, treatment or procedure was (or was requested by federal law to be) reviewed and approved by that committee; or
- Reliable evidence shows that the drug, device, treatment or procedure is the subject of ongoing Phase I or Phase II clinical trials; is the research, experimental, study or investigational arm of ongoing Phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness, or its effectiveness compared to a standard method of treatment or diagnosis;
- The safety and/or efficacy has not been established by reliable, accepted medical evidence; or
- Reliable evidence shows that the prevailing opinion among experts is that further studies or clinical trials of the drug, device, treatment or procedure are needed to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness, or its effectiveness compared to a standard method of treatment or diagnosis.

  *"**Reliable evidence**"* includes only published reports and articles in authoritative medical and scientific literature, and written protocols and informed consent forms used by the treating Facility or by another Facility studying substantially the same drug, device, treatment or procedure.

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

Facility means a health care or residential treatment center licensed by the state in which it operates to provide medical inpatient, residential, day treatment, partial hospitalization, or outpatient care. Facility also means a treatment center for the diagnosis and/or treatment of Chemical Dependency or Mental Illness.

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

Formulary is a list of Covered Drugs selected by FirstCare Health Plans in consultation with a team of health care professionals that represents the prescription therapies believed to be a necessary part of a value based high quality treatment program.

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

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

Grace Period: A period of 31 days after a Premium Due Date, during which premiums may be paid to FirstCare without lapse of Your coverage and that of Your Dependents, if any, under an Evidence of Coverage. If payment is not received within the 31 days, coverage will be canceled and You will be responsible for any cost of services received during the grace period. If You receive advance payment of the premium tax credit and Your premiums are delinquent while at least one month's premium has been paid in full during the benefit year, We must provide a three-month grace period before terminating coverage.We may terminate coverage effective on the first day of the second month of the grace period.

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

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

Hybrid Injectables: Any injectable defined as a Pharmacy Injectable required to be administered at the time of dialysis or Cancer Chemotherapy infusion. If these medications are not administered at the point of service, and they are Pharmacy Injectables, they are covered as described in Section 3*, What is Covered, Prescription Drug Services*, of this Contract. These drugs will be defined by the Pharmacy and Therapeutics Committee

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

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

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

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

Maintenance Drug means medication prescribed for a chronic, long-term condition and is taken on a regular, recurring basis.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Neurobiological Disorder: An illness of the nervous system caused by genetic, metabolic or other biological factors.

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

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

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

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

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

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

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

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

Non-Participating Provider; A Physician, medical group, Hospital or other health care provider who has not contracted with FirstCare to provide Covered Health Services to Members of Your Plan, also known as an out-of-network provider. We strongly encourage You to use FirstCare Participating Providers to assure the highest quality and lowest cost. Use of Non-Participating Providers may result in additional charges to You that are not covered under Your health plan. Requests for services, equipment, or supplies performed by or at Non-Participating Providers may be denied if there are Participating Providers in the FirstCare network who can provide the service, equipment or supplies.

Non-Participating Provider Reimbursement (NPPR): The amount we will fully reimburse at the usual and customary rate or at an agreed rate. Usual and customary rate means the amount based on a percentage of available rates published by Centers for Medicare and Medicaid Services (CMS) or a benchmark developed by CMS for the same or similar services within a geographical area; and that have been negotiated with one or more Participating Provider in a geographical area for the same of similar services. The amount payable may be increased by a fixed percentage for certain services or facilities as agreed to by the Plan.

Open Enrollment: The annual period each year in which You can make changes to Your Plan benefits. If You purchased this Plan through the Exchange or directly from FirstCare, the “Open Enrollment Period” is the period each year during which You may enroll or change coverage in a Qualified Health Plan (QHP) made available through the Exchange.

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

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

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

Participating Pharmacy means a pharmacy that has been approved by FirstCare to provide Prescription Drugs to Members.

Participating Provider: A Physician, medical group, Hospital or other health care provider who has contracted with FirstCare to provide Covered Health Services to Members of Your Plan. For more information on the network of Participating Providers available to You, check the provider directory We give

to You, ask Your PCP or call Us. Please remember that the list of Participating Providers in the directory is subject to change Please visit www.FirstCare.com and the myFirstCare Self Service secure Member web portal for the most current provider information.

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

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

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

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

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

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

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

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

Premium Tax Credits: (Applicable to Plans Purchased Through the Exchange): A refundable premium tax credit an eligible individual may receive for taxable years ending after December 31, 2013, to the extent provided under applicable law, where the credit is meant to offset all or a portion of the Premium paid by the individual for coverage obtained through an Exchange during the preceding Calendar Year.

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

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

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

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

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

If your child is an enrollee in a plan that provides for designation of a Participating primary care provider for a child, the Plan will permit designation of an available physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider.

For the names of PCPs, please visit www.FirstCare.com and the myFirstCare Self Service secure Member web portal.

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

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

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

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

Qualified Health Plan (QHP): A health care benefit plan that has in effect a certification that it meets the applicable government standards, issued or recognized by each Exchange through which such plan is offered. This Plan has been certified by the Exchange.

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

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

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

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

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

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

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

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

Specialty Pharmacy Drug means any prescription drug regardless of dosage form, identified as a Specialty Pharmacy Drug on the drug formulary, or a drug which requires at least one of the following in order to provide optimal patient outcomes:

- specialized procurement handling; distribution, or is administered in a specialized fashion;
- complex benefit review to determine coverage;
- complex medical management requiring close monitoring by a physician or clinically trained individual;
- FDA mandated or evidence-based medical-guideline determined comprehensive patient and/or physician education; or
- has any dosage form with a total cost greater than $1,000 per retail's maximum days supply.

Stabilization: The point at which no material deterioration of a condition is likely, within reasonable probability, to result from or occur during Your transfer.

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

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

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

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

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

Us, We or Our: FirstCare.

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

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

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

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

You or Your: A covered Member.

SECTION 12 – REQUIRED DISCLOSURES

NOTICE OF SPECIAL TOLL-FREE COMPLAINT NUMBER

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

1-800-832-9623

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

NOTICE OF OUT-OF-NETWORK COVERAGE

28 TAC §11.1612(c)

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

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

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

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

You may obtain a current directory of network physicians and providers at the following website: www.firstcare.com/FindAProvider or by calling 1-855-572-7238 for assistance in finding available network physicians and providers. If you relied on materially inaccurate directory information, you may be entitled to have a claim by an out-of-network physician or provider paid as if it were from a network physician or provider, if you present a copy of the inaccurate directory information to the HMO, dated not more than 30 days before you received the service.

BALANCE BILLING NOTICE

28 TAC §1456.003

A Facility-based physician or other health care practitioner may not be included in FirstCare's provider network. The non-network Facility-based physician or other health care practitioner may balance bill FirstCare HMO members for amounts not paid by FirstCare due to the provider being out-of-network. If the member receives a balance bill from a Facility-based physician or other health care practitioner, contact FirstCare Customer Service at 1-855-572-7238.

SECTION 13 – MANDATORY BENEFIT NOTICES

The following notices are to advise You of certain coverage and/or benefits provided by Your contract with FirstCare Health Plans.

MASTECTOMY OR LYMPH NODE DISSECTION
28 TAC §21.2106(b)(1)

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.

COVERAGE AND/OR BENEFITS FOR RECONSTRUCTIVE SURGERY AFTER MASTECTOMY-ENROLLMENT
28 TAC §21.2106(b)(2)

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
28 TAC §21.2106(b)(3)

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

EXAMINATIONS FOR DETECTION OF PROSTATE CANCER
28 TAC §21.2106(b)(4)

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.

INPATIENT STAY FOLLOWING BIRTH OF A CHILD
28 TAC §21.2106(b)(5)

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.

Since we provide in-home post-delivery care, we are not required to provide the minimum number of hours outlined above unless (a) the mother's or child's physician determines the inpatient care is medically necessary, or (b) the mother requests the inpatient stay.

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.

COVERAGE FOR TESTS FOR DETECTION OF COLORECTAL CANCER
28 TAC §21.2106(b)(6)

Benefits are provided, for each person enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include the covered person's choice of:

a) a fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years, or
b) a colonoscopy performed every 10 years.

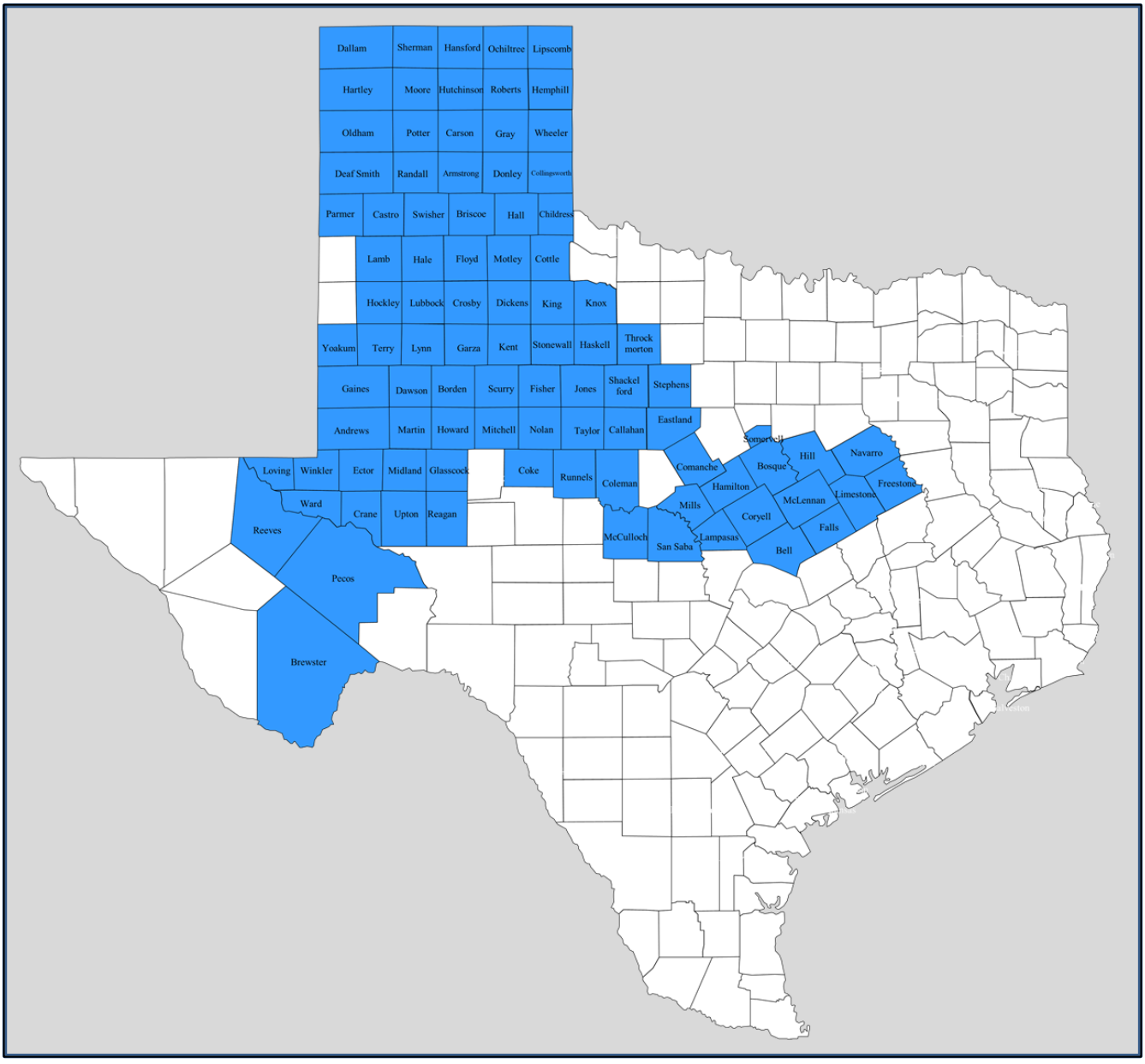
COVERAGE OF TESTS FOR DETECTION OF HUMAN PAPILLOMAVIRUS, OVARIAN CANCER, AND CERVICAL CANCER
28 TAC §21.2106(b)(7)

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 ovarian and cervical cancer.

Coverage required under this section includes a CA 125 blood test and, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the FDA, alone or in combination with a test approved by the FDA for the detection of the human papillomavirus.

If any person covered by this plan has questions concerning the above, please call FirstCare Health Plans at 1-855-572-7238, or write us at 1901 W. Loop 289, Suite 9, Lubbock, TX 79407.

FirstCare HMO Service Area



Language Assistance/ Asistencia de idiomas

FirstCare HEALTH PLANS

English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-884-4901 (TTY: 711).

Spanish:
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-884-4901 (TTY: 711).

Vietnamese:
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-884-4901 (TTY: 711).

Chinese:
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-884-4901 (TTY：711)。

Korean:
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-884-4901 (TTY: 711) 번으로 전화해 주십시오.

Arabic:
يرجى الانتباه: إذا كنت تتكلم اللغة العربية، فإن خدمات المساعدة اللغوية تتوفر لك مجاناً. اتصل بالرقم 1-800-884-4901 (رقم الهاتف المخصص للصم وضعاف السمع: 711).

Urdu:
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال 1-800-884-4901 (TTY: 711). کریں

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-884-4901 (TTY: 711).

French:
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-884-4901 (ATS : 711).

Hindi:
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध है। 1-800-884-4901 (TTY: 711) पर कॉल करें।

Persian:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-884-4901 (TTY: 711) تماس بگیرید.

German:
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-884-4901 (TTY: 711).

Gujarati:
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-884-4901 (TTY: 711).

Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-884-4901 (телетайп: 711).

Japanese:
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-884-4901 (TTY: 711) まで、お電話にてご連絡ください。

Laotian:
ໂປດຊາບ: ຖ້າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-884-4901 (TTY: 711).

Southwest Life & Health Insurance Company is a wholly owned subsidiary of SHA, LLC d/b/a FirstCare Health Plans (a wholly owned subsidiary of Scott and White Health Plan). PPO plans are offered by Southwest Life & Health Insurance Company. HMO, Medicaid and Medicare plans are offered by SHA, LLC.

FirstCare™
HEALTH PLANS

Nondiscrimination Notice

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-884-4901 (TTY: 711).

SHA, LLC d/b/a FirstCare Health Plans and Southwest Life & Health Insurance Company comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. FirstCare Health Plans and Southwest Life & Health Insurance Company do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

FirstCare Health Plans and Southwest Life & Health Insurance Company:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Written information in other formats (large print and accessible electronic formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Compliance Officer at 1-214-820-8888 or send an email to SWHPComplianceDepartment@BSWHealth.org.

If you believe that FirstCare Health Plans and Southwest Life & Health Insurance Company have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Compliance Officer
1206 West Campus Drive, Suite 151
Temple, Texas 76502

Compliance HelpLine; 1-888-484-6977 or https://app.mycompliancereport.com/report.aspx?cid=swhp.

You can file a grievance in person or by mail, online, or email. If you need help filing a grievance, the Compliance Officer is available to help you.

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/civil-rights/filing-a-complaint/index.html.

FirstCare™
HEALTH PLANS

Aviso de No Discriminación

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-884-4901 (TTY: 711).

SHA, LLC d/b/a FirstCare Health Plans y Southwest Life & Health Insurance Company cumplen con las leyes federales de derechos civiles aplicables y no discriminan por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. FirstCare Health Plans y Southwest Life & Health Insurance Company no excluyen a las personas ni las trata de forma diferente debido a su origen étnico, color, nacionalidad, edad, discapacidad o sexo.

FirstCare Health Plans y Southwest Life & Health Insurance Company:

- Proporcionan asistencia y servicios gratuitos a las personas con discapacidades para que se comuniquen de manera eficaz con nosotros, como los siguientes:
  - Información escrita en otros formatos (letra grande y formatos electrónicos accesibles)
- Proporcionan servicios lingüísticos gratuitos a personas cuya lengua materna no es el inglés, como los siguientes:
  - Intérpretes capacitados
  - Información escrita en otros idiomas

Si necesita estos servicios, comuníquese con el Oficial de Cumplimiento al 1-214-820-8888 o envíe un correo electrónico a SWHPComplianceDepartment@BSWHealth.org.

Si cree que FirstCare Health Plans y Southwest Life & Health Insurance Company no han proporcionado estos servicios o ha sido discriminado de otra manera por motivos de raza, color, nacionalidad, edad, discapacidad o sexo, puede presentar una queja formal con:

Compliance Officer
1206 West Campus Drive, Suite 151
Temple, Texas 76502

Línea de ayuda de cumplimiento; 1-888-484-6977 o https://app.mycompliancereport.com/report.aspx?cid=swhp.

Puede presentar una queja en persona o por correo, en línea o por correo electrónico. Si necesita ayuda para presentar un reclamo, el Oficial de Cumplimiento está disponible para ayudarlo.

También puede presentar un reclamo de derechos civiles ante la Office for Civil Rights (Oficina de Derechos Civiles) del Department of Health and Human Services (Departamento de Salud y Servicios Humanos) de EE. UU. de manera electrónica a través de Office for Civil Rights Complaint Portal, disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o bien, por correo postal a la siguiente dirección o por teléfono a los números que figuran a continuación:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Puede obtener los formularios de reclamo en el sitio web
https://www.hhs.gov/civil-rights/filing-a-complaint/index.html.