FirstCare – Health Plans that Work for Texans

FIRSTCARE MYSERIES PLANS

INDIVIDUAL myHMO PLAN

OUTLINE OF COVERAGE

myHMO VII – HC09I007

Individual HMO Plan $2,000 per Member Deductible
INDIVIDUAL HEALTH MAINTENANCE ORGRANIZATION (HMO)
COMPREHENSIVE MAJOR MEDICAL PLAN

THE INDIVIDUAL HMO PLAN DESCRIBED IN THIS OUTLINE PROVIDES COMPREHENSIVE MAJOR MEDICAL COVERAGE

READ YOUR PLAN CAREFULLY. This written Plan description provides a very brief description of the important features of your Plan. This is **not** the insurance Policy and only the actual Plan provisions will control. The Plan itself sets forth, in detail, the rights, and obligations of both you and FirstCare. It is therefore, important that you **READ YOUR PLAN CAREFULLY!**

This is not a policy of Worker's Compensation insurance. The employer does not become a subscriber to the Workers' Compensation system by purchasing this Plan, and if the employe is a non-subscriber, the employer loses those benefits that would otherwise be accrued under the Workers' Compensation laws. The employer must comply with the Workers' Compensation law as it pertains to the non-subscribers and the required notifications that must be filed and posted.

A. Coverage Provider

Coverage is provided by SHA L.L.C. dba FirstCare, an Health Maintenance Organization (HMO).

B. Additional Information

To **obtain additional information**, including provider information, write to the following address or call the toll-free number:

FirstCare Health Plans
12940 N. Highway 183
Austin, TX 78750
(800) 240-3270

C. Individual HMO Schedule of Copayments

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. The following is a summary of the Copay amounts You and any Dependents must pay when receiving the services listed below. These services must be performed, prescribed, or directed by Your Primary Care Physician or designated OB/GYN Physician. Please refer to Your Policy for a detailed explanation of covered and non-covered services.

COVERED SERVICE	COPAYMENT
CALENDAR YEAR DEDUCTIBLE	**$2,000 per Member**
OUT-OF-POCKET MAXIMUM (Does NOT include Deductible)	**$2,500 per Member**
AGGREGATE LIFETIME MAXIMUM	**$1,000,000**

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COVERED SERVICE	COPAYMENT
INPATIENT SERVICES	
Inpatient Services Include: • Semi-Private Room and Board Charges • Surgical Procedures • Pre-Admission Testing • Physician Hospital Visits • Intensive Care & Coronary Care Units • Operating/Recovering Room • Newborn Delivery Room and Nursery • Physician Services • Skilled Nursing Facility: *Limited to 30 days per Calendar Year* • Laboratory Tests and X-ray • Reconstructive Surgery	20% Copay – After Deductible
Observation Unit	20% Copay – After Deductible
OUTPATIENT SERVICES	
Outpatient Services/Surgery Include: • Facility Charges • Surgical Procedures • Physician Services	20% Copay – After Deductible
Acute/Non-Chronic/Short-Term Mental Illness: *Limited to 20 Outpatient days per Calendar Year*	50% Copay – After Deductible
Laboratory Tests and X-ray performed in an outpatient setting	20% Copay – After Deductible
MRI, CT Scans, Sleep Study, Nuclear Stress Tests and PET Scan performed in an outpatient setting	20% Copay – After Deductible
PHYSICIAN OFFICE SERVICES	
Physician Office Services Include: • Physician Office Visits • Medications, supplies and materials administered in the office • Second Surgical Opinion	\$30 per visit to the PCP – Deductible Waived \$45 per visit to the Specialist – Deductible Waived
Laboratory Tests and X-Ray performed in the Physician's office	20% Copay – After Deductible
MRI, CT Scans, Sleep Study, Nuclear Stress Tests and PET Scan performed in the Physician's office	20% Copay – After Deductible
Allergy Services • Office Visits	\$30 per visit to the PCP – Deductible Waived \$45 per visit to the Specialist – Deductible Waived
• Allergy Testing • Serum • Injection Administration	50% of the Allowable Amount – After Deductible 50% of the Allowable Amount – After Deductible 50% of the Allowable Amount– After Deductible

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COVERED SERVICE	COPAYMENT
Maternity Care, including Pre- and Post-Natal Obstetrical Care	$30 per office visit – Deductible Waived
Surgical Procedures performed in the Physician's Office	20% Copay – After Deductible
PREVENTIVE SERVICES Preventive Services Include: • Annual Routine Physicals • Well Baby and Well Child Care • Routine Eye, Speech and Hearing Screenings for Children when performed during an office visit • Routine Immunizations for ages 6 and older • Examinations and Testing for the detection of Prostate Cancer • Routine Laboratory and X-Ray	$30 per visit to the PCP – Deductible Waived $45 per visit to the Specialist – Deductible Waived
Immunizations for Newborns (birth to 6-years of age)	No Copay – Deductible Waived
Newborn Child Hearing Screenings (birth to 30-days old)	No Copay – Deductible Waived
Well Woman Exam including Routine Annual Physicals and low dose mammography screenings.	$30 per office visit – Deductible Waived
Preventive Diagnostics and Testing: • Non-routine screening mammograms including Digital, X-ray and Ultrasound • Screening for the detection of Colorectal Cancer (*If other procedures are needed during the screening, additional Copayments, Deductible, and/or Coinsurance will apply.*) • Bone Mass Measurement	20% Copay – After Deductible
FAMILY PLANNING SERVICES Family Planning and Counseling	$30 per visit to the PCP – Deductible Waived $45 per visit to the Specialist – Deductible Waived
Contraceptive Devices, Implants and Injections including: • Diaphragm • IUD • Subdermal Contraceptive Implants & Removal • Depo-Provera™ Injections	50% of the Allowable Amount for all charges – After Deductible. Applies to materials, procedures, and services.
<u>STERILIZATION PROCEDURES</u> (Vasectomy & Tubal Ligation) • When performed in an Outpatient Facility • When performed in the Physician's Office • When performed in an Inpatient Facility	20% Copay – After Deductible 20% Copay – After Deductible See Inpatient Services
DIABETIC SERVICES Diabetic Self-Management Education	$30 per visit to the PCP – Deductible Waived $45 per visit to the Specialist – Deductible Waived

COVERED SERVICE	COPAYMENT
Insulin and Diabetic Insulin	
• 30 Day Supply	
o 1st tier - Generic Drugs	$20 per prescription – After Deductible
o 2nd tier - Brand name drugs on drug list	$50 per prescription – After Deductible
o 3rd tier - Brand name drugs not on drug list	$100 per prescription – After Deductible
• Mail Order (up to 90- day supply)	
o 1st tier - Generic Drugs	$60 per prescription – After Deductible
o 2nd tier - Brand name drugs on drug list	$150 per prescription – After Deductible
o 3rd tier - Brand name drugs not on drug list	$300 per prescription – After Deductible
Test Strips	
• Level 1 Strips	10% per item – After Deductible
• Level 2 Strips	20% per item – After Deductible
Other Diabetic Supplies and Equipment (30 Day Supply)	20% per item – After Deductible
SPECIALTY SERVICES/PHARMACY	
Specialty Services/Pharmacy Include: • Medical Injectable Drugs (excluding Depo-Provera™ injectables) • Defined Hybrid Injectables • Radiation Therapy • Transplant Anti-rejection Therapy • Home Infusion Medications (excluding "self-injectable" drugs) • Specified Cancer Chemotherapy • Defined Associated Agents	• When covered service cost is $500 or less: *See physician office services, outpatient services/surgery, or inpatient services for applicable copayments.* • When covered service cost is more than $500: *30% Copay – After Deductible, not to exceed $3,000 Out-of-Pocket Maximum for these specific services. See Section 10, Definitions in Your Evidence of Coverage*
EMERGENCY ROOM SERVICES	
Emergency Room	20%– After Deductible *Emergency Room Copay is waived if admitted to Hospital*
Minor Emergency/Urgent Care Center	20% Copay – After Deductible
Ambulance	20% Copay – After Deductible
OTHER HEALTH CARE SERVCES	
Limited Accidental Dental Care and Medically Related Oral Surgeries: *Limited to $1,000 Calendar Year Maximum Benefit*	20% Copay – After Deductible
Therapy Services: *Limited to 20 visits per Therapy Service per Calendar Year* • Rehabilitation Therapy • Speech Therapy • Occupational Therapy • Physical Therapy	$30 per visit to the PCP – Deductible Waived $45 per visit to the Specialist – Deductible Waived
Hospice Care: *Lifetime Maximum of $10,000*	20% Copay – After Deductible

COVERED SERVICE	COPAYMENT
Spinal Manipulation*: Limited to 10 visits per Calendar Year*	$45 per visit – Deductible Waived
Pain Management Services	Included in the physician office services, outpatient services/surgery, or inpatient services copayment.
Durable Medical Equipment (DME): *DME is limited to $2,000 per Calendar Year. DME used in the treatment of diabetes, oxygen and monitoring devices are not included in the $2,000 maximum.*	50% of the Allowable Amount per piece of equipment or supply – After Deductible
Medical Supplies	50% of the Allowable Amount per piece of equipment or supply – After Deductible
Prosthetics: External Devices: *Lifetime Maximum of $4,000 per Device/Limb*	50% of the Allowable Amount per device – After Deductible
Orthotics	50% of the Allowable Amount per device – After Deductible
Internal Implantable Devices	50% of the Allowable Amount per device – After Deductible
Dialysis Services (Inpatient & Outpatient)	Included in the physician office services, outpatient services/surgery, or inpatient services copayment.
Organ Transplant Services (Inpatient & Outpatient) *Lifetime Maximum of $300,000*	Included in the physician office services, outpatient services/surgery, or inpatient services copayment.
Home Health Services: *Limited to 20 visits per Covered Service per Calendar Year* • Includes treatment of covered illness or injury in your home • EXCLUDES speech, physical, and occupational therapy	20% Copay – After Deductible

D. Covered Services

This section describes:

- The health care services covered under Your Plan; and
- Restrictions and limitations related to a specific type of health care service, including whether We must pre-approve the service for it to be covered. Your Copayment (if any) can be found in the *Schedule of Copayments* above.

A. Outpatient 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.

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

2. Physician Services At Home

We cover Physician services provided to You in Your home, 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.

3. Laboratory Services
We cover medically necessary laboratory services when the PCP, a Plan Provider, or other authorized Physician prescribes them.

4. Radiology Services
We cover x-rays and other radiology services 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 Plan surgical facility, it must meet the requirements for outpatient surgery (including Copayment and pre-approval by Us). 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, and are administered or applied during an office visit. Such covered materials or supplies include but are not limited to those necessary for:

- Inhalation therapy and other medically necessary respiratory therapies;
- The administration of medications or Injectable Drugs; and
- Dressings, casts, and splints (where splints are commonly used instead of casts).

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 medically 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 administered in Your Physician's office or in an outpatient facility. Refer to the *Schedule of Copayments* for details.

Injectable Medications recognized by the FDA as appropriate for self-administration (referred to as "self-injectable" drugs), regardless of the enrollee's ability to self-administer, are not covered in these medical benefits.

8. Pre-Natal and Post-Natal Obstetrical Care
We cover Physician services for pre-natal and post-natal office visits. We also cover amniocentesis and chorionic villus sampling when medically indicated.

9. Rehabilitation, Speech, Occupational, and Physical Therapy
We cover medically necessary outpatient rehabilitation including, speech, cardiac rehabilitation, occupational and physical therapy 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.

Pre-Authorization is required for these services. Your coverage is limited to services that continue to meet or exceed the treatment goals established for You. For a physically disabled person, treatment goals may include maintenance of functioning or prevention of or slowing of other deterioration.

10. 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 in plan specialist orders or arranges the surgery; and
- We pre-approve the service.

11. Pain Management Services

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

- Your PCP or in 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; and
- Services must be pre-approved by Us.

12. Allergy Testing and Injections

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

13. 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, at the time services are provided;
- There must be clear evidence of interference with developmentally appropriate social, academic, or occupational functioning manifesting itself predominately in at least two settings, for example, at home and at school or work;
- The services must be for evaluation or crisis intervention; and
- The behavioral health provider must pre-approve the services.

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.

Treatment for certain mental illnesses is not covered. See What Is Not Covered below.

B. Preventive Health Care 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 18 years of age or older. 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 through age 18. 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 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 Center for Disease Control (CDC). Immunizations must be properly ordered and directed by Your PCP.

4. Well-Woman Examinations

For women who are Plan Members, We cover one well-woman gynecological examination per Calendar Year. You may choose to have Your PCP or Your designated obstetrician/gynecologist perform the well-woman examination.

Annually, for women who are Plan Members age 18 and over, we cover a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus. A screening test required under this section must be performed in accordance with the guidelines adopted by the American College

of Obstetricians and Gynecologists or another similar national organization of medical professionals recognized by the State of Texas.

5. Screening Mammogram
We cover screening mammograms (non-diagnostic) to detect breast cancer according to guidelines as developed by the American College of Obstetrics and Gynecology (ACOG). Mammograms may be obtained by referral from Your PCP or Plan obstetrician/gynecologist, whether or not a well-woman examination is performed at the same time.

6. Bone Mass Measurement
These services include bone mass measurement 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 by Your PCP to detect prostate cancer, including a physical examination and a prostate-specific antigen (PSA) test. Not all men need this examination; however, You are eligible for this benefit if You are at least 50 years old, or at least 40 years old with a family history of prostate cancer or other recognized prostate cancer risk factors.

8. Screening for Detection of Colorectal Cancer
We cover screening examinations and procedures for Plan Members 50 years old or older and at a normal risk for developing colon cancer. These examinations include fecal occult blood tests performed annually, a flexible sigmoidoscopy performed every five years, or a colonoscopy performed every 10 years.

9. Routine Sight, Speech and, Hearing Screening
We cover routine screenings of vision, speech, and hearing for Plan Members through age 18, when performed by the Member's PCP. We also cover one hearing screening every Calendar Year for all Members when performed by Your PCP. 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.

We *do not* cover eye exams to prescribe glasses or contact lenses, even after vision surgery (except for Keratoconus).

C. Family Planning 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 provided through the Prescription Drug Benefits.

D. Inpatient Services
To be covered, all admissions must be to a Plan Hospital, skilled nursing facility, or other inpatient facility and be pre-approved by Us. The only exceptions to this requirement are admissions covered under *Emergency and Out-of-Area Urgent Care Services* below**.** Inpatient services must be prescribed, directed or arranged by Your PCP or in plan specialist. If We determine that medically necessary services cannot be performed at one of Our participating inpatient facilities, We will approve admissions to out-of-plan facilities.

We will approve inpatient admissions only for the length of time that is medically necessary. We will, however, approve inpatient admissions for obstetrical services and mastectomy or related procedures in accordance with the standards described below. If You stay longer than the time We authorize, You will have to pay the charges for Your additional stay.

- ***Obstetrical Services.*** 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 determined to be medically necessary by Your Physician or requested by You and Your Physician.

  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 a post-delivery outpatient visit. The post-delivery visit 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 medically necessary and 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.

- ***Mastectomy or Related Procedures.*** We cover inpatient care following a mastectomy or related procedures for the treatment of breast cancer for a minimum of 48 hours 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 reconstruction of a breast incident to mastectomy, including surgical reconstruction to restore or achieve breast symmetry or balance of a breast on which mastectomy surgery has not been performed.

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

   We cover special diets during inpatient care, if they are medically necessary and prescribed by a Physician. We cover special duty nursing only in exceptional cases. Your Physician must recommend it and We must pre-approve it.

2. **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;
   - X-ray, 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.

3. **Observation Unit Admission**
   We cover admissions to the observation unit of a Hospital, or other approved facility if the following conditions are met:
   - The admission for observation is ordered by Your PCP or in plan specialist; and
   - We pre-approve such admission.

4. **Rehabilitation, Speech, Occupational, and Physical Therapy**
We cover inpatient rehabilitation, speech, occupational, and physical therapy services, including cardiac rehabilitation services that meet all of these conditions:
- Your PCP or in plan 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; and
- We pre-approve the services.

Your coverage is limited to services that continue to meet or exceed the treatment goals established for You. For a physically disabled person, treatment goals include maintenance of functioning or prevention of or slowing of further deterioration.

5. **Skilled Nursing Facility**
We cover inpatient care in a skilled nursing facility if it meets all of these conditions:

- If You were not admitted to a skilled nursing facility, You would need acute care hospitalization;
- The skilled nursing services are of a temporary nature and will lead to rehabilitation and increased ability to function;
- Your PCP or attending in plan specialist refers You; and
- We pre-approve services.

We *do not* cover custodial care as described in the *What Is Not Covered* section below.

E. Other Health Care Services

1. Home Health Care
We cover medically necessary services for the care and treatment of a covered illness or injury provided in Your home. Covered home health care services must meet all of these conditions:
- The services can only be provided by a health professional;
- The services must be provided by a participating home health agency;
- Your PCP refers You or arranges the services; and
- We pre-approve the services.

However, we *do not* cover custodial care as described in the *What Is Not Covered* section below.

2. Home Infusion Therapy
Home Infusion Therapy is the administration of medication (including chemotherapy), fluids or nutrition by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the Member's home. Home infusion therapy medications are covered under "Medicial 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 not covered, unless You have purchased the prescription drug Rider or coverage is otherwise specified in this document. Refer to Your prescription drug benefits for details.

3. Non-Emergency Ambulance Transport Service
We cover non-emergency ambulance transport (for example, a Member is discharged from an inpatient facility and needs to be moved to a skilled nursing facility). Non-emergency ambulance transport must meet these conditions:
- It is medically necessary; and
- We pre-approve the service.

Ambulance transport services for convenience are not covered.

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

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 a congenital anomaly that was present at birth in a child who is younger than 18 years of age;
- Restore normal physiological functioning following an accident, injury or disease;
- Perform breast reconstruction necessitated by a partial or complete removal of breast for cancer. Reconstruction of the unaffected breast will be covered when necessary to achieve symmetry and prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy. Initial breast reconstruction resulting from a mastectomy that occurred prior to the Effective Date of coverage is a covered benefit.
- Conduct Surgery for a child who is younger than 18 years of age for craniofacial abnormalities to improve the function of, or to attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infection or disease.

5. Spinal Manipulation

Your plan may include coverage for spinal manipulation services. Services may be rendered by a participating in plan provider. All services must be pre-authorized by the Medical Services Department. Refer to the *Schedule of Copayments* above for benefit details.

6. Prosthetics and Orthotics

We cover standard external, non-cosmetic prosthetic or orthotic devices if We pre-approve them. Examples of covered devices include artificial arms, legs, hands, feet, eyes, breast prostheses, and surgical brassieres after mastectomy for breast cancer.

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

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

7. 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 What is Not Covered below.

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

NOTE: Only certain brands/types of internal implantable devices are covered and must be pre-approved by Us.

8. Dorsal Column Stimulators

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

9. 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, lymphadema pumps, traction devices, canes, Continuous Passive Motion (CPM) devices, infusion pumps, phototherapy light, alternating pressure pads and pumps.

Coverage is provided for the medically necessary DME meeting the following conditions:

- DME must be ordered or prescribed by a health care provider and provided by a contracted supplier;
- Services must be pre-authorized. DME must be medically necessary as determined by the Medical Director;
- DME may be purchased or rented, whichever is most cost effective, as determined by the 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.

The following items are not included in the DME limitation:

- Oxygen and mechanical equipment necessary for treatment of chronic or acute respiratory failure;
- Durable medical equipment used for the treatment of diabetes; and
- Monitoring devices, such as apnea monitors, glucose monitors and uterine monitors, for use in the home when prescribed and directed by a health care provider and approved by FirstCare.

10. Medical Supplies

The following medical supplies are covered.

- Medical supplies used for the treatment of diabetes are covered. Examples of these supplies include test strips, lancets, and lancet devices.
- 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 Plan Provider. Supplies that can be purchased over-the-counter without a Physician order are not covered. See What is Not Covered below.
- Disposable Home Infusion Therapy supplies
- Allergy syringes.

11. Diabetic Services

For those Members diagnosed with diabetes, elevated blood glucose levels induced by pregnancy or other medical conditions associated with elevated blood glucose levels, diabetic supplies, equipment, medications, and self-management education for the treatment of diabetes are covered. An annual eye examination is also covered for Members or Dependents with diabetes.

Diabetic 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.

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.

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

Diabetic Self-Management Education

Diabetes self-management training programs are covered when ordered by Your Physician and provided by a licensed Plan Provider 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.

12. Limited Accidental Dental-Related Services

a. 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:
   - 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.

b. 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;
   - Both the injury and treatment occur while Your coverage under the Plan is in effect;
   - You seek treatment within **48 hours** of the time of the accident;
   - Restoration or replacement is completed within 6 months of the date of the injury;
   - We pre-approve the service.

c. Removal of cysts of the mouth (except for cysts directly related to the teeth and their supporting structures), if:
   - We pre-approve the service.

d. 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.

e. Medically necessary services performed in a Plan outpatient facility and are required for the delivery of necessary and appropriate dental services when the dental services cannot be safely provided in a dentist's office due to the Member's physical, mental, or medical condition. The services must meet all of these requirements:
   - We pre-approve the services.

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

13. 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 must pre-approve services before You receive treatment.

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

14. Dialysis Services

Dialysis Services are covered. Pre-authorization is not required if the services are received by a contracted provider. Pre-authorization is required for these services if they are received by an out-of-plan provider.

15. Organ Transplants

We cover the following transplants:

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

The above list of covered transplants must meet the following conditions or they will not be covered:

- A contracted and/or nationally recognized 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; and
- We pre-approve the services.

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. We do not cover any other donor expenses, including any transportation costs.

The only types of transplants covered by this Plan are the above listed transplants. We do not cover mechanical organ replacement devices, such as artificial hearts.

16. Chemotherapy

We cover chemotherapy services if the services are provided by a Plan Provider or a provider approved by FirstCare.

17. Radiation Therapy

We cover radiation therapy services if the services are provided by a Plan Provider or a provider approved by FirstCare.

18. Blood and Blood Products

Whole blood, blood plasma, blood derivatives, or blood components and their administration are covered in an inpatient or outpatient setting.

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 Plan physician has certified that the Member has a limited life expectancy of 6 months or less due to a terminal illness;
- We pre-approve the services.

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.

EMERGENCY AND OUT-OF-AREA URGENT CARE SERVICES

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

A. Emergency Care

1. What is Emergency Care

Emergency care means health care services provided in a Hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine 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 or comparable facility, if approved by Us, provided that We must approve or deny coverage within one hour of a request for approval by the treating Physician or the Hospital emergency room.

2. Requirements for All Emergency Care

To be covered, emergency care must meet all of these conditions:

- You must obtain the services immediately, or as soon as possible, after the emergency condition occurs;
- As soon as possible after the emergency occurs and You seek treatment, You (or someone acting for You) must contact Your PCP for advice and instructions. In any event, You must contact the Plan within 24 hours, unless it is impossible to do so; and
- You must be transferred to the care of Plan Providers as soon as this can be done without harming Your condition. We do not cover services provided by out-of-plan providers after the point at which You can be safely transferred to the care of a Plan 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. After an emergency condition has been stabilized, Your Physician must pre-authorize continued treatment or it may not be covered.

B. 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 All Out-of-Area Urgent Care

To be covered, out-of area 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. In any event, You (or someone acting for You) must contact Us within 24 hours, unless it is impossible to do so; and
- 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. In any event, You (or someone acting for You) must contact Us within 24 hours, unless it is impossible to do so.

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

FOR IN-AREA URGENT CARE: If You urgently need services while inside the FirstCare Service Area, but 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. Please remember that We will not cover urgent care inside the Service Area from an out-of-plan provider**.**

3. **Services and Copayments**

As long as the requirements described above are satisfied, We will cover the following services:

- Hospital emergency room services, including an initial medical screening examination;
- Services in an outpatient emergency or urgent care center. We will also cover emergency services in a comparable facility;
- Emergency ambulance service to the nearest medical facility able to provide appropriate care. For non-emergency ambulance transport services, see *What is Covered* above; and
- Any other covered health care services detailed in *What is Covered* above. 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* above.

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 out-of-plan provider.

4. **Payment Procedures**

Payment for emergency care received from out-of-plan providers, inside or outside Our Service Area, and out-of-area urgent care is provided in one of two ways:

- We will pay the Usual, Customary and Reasonable (UCR) Amount for care received from out-of-plan providers; or
- We will arrange to pay those providers directly at rates negotiated with the provider by FirstCare.

5. **Medically Necessary Services**
If medically necessary covered services are not available through network physicians or providers, We will, on the request of a network physician or provider, within a period not to exceed five business days, shall allow referral to a non-network physician or provider and shall fully reimburse the non-network physician or provider at the Usual, Customary and Reasonable amount. We must provide for a review by a specialist of the same specialty or a similar specialty as the type of physician or provider to whom a referral is requested before We may deny a referral.

6. **FirstCare Review**
We will cover the initial medical screening evaluation necessary to determine whether an emergency medical condition exists; however, We have the right to review all other services that were provided to You to determine whether they satisfy all the conditions for coverage of emergency or Out-of-Area urgent care specified above, if permitted by law. If We decide that they did not satisfy one or more of these conditions, We will require You to pay for the services. An initial medical screening will be a covered service subject to the applicable Copayment described above. If You disagree with Our decision, You can appeal Our decision by using the procedures described in *Member Complaint and Appeal Procedures* below.

E. Prescription Drug Benefits

FirstCare is pleased to offer you an additional benefit for Prescription Drug Coverage for the following copayments per prescription or refill:

ANNUAL MAXIMUM BENEFIT **$1,000 per Member**

ANNUAL DEDUCTIBLE **$100 per Member**

	PARTICIPATING RETAIL PHARMACY Standard Drugs 30-day supply	PARTICIPATING RETAIL PHARMACY Maintenance Drugs* 30-day supply	 90-day supply	PARTICIPATING HOME DELIVERY PHARMACY Maintenance Drugs* 90-day supply
Tier I	$20 per Prescription	$26 per Prescription	$78 per Prescription	$60 per Prescription
Tier II	$50 per Prescription	$65 per Prescription	$195 per Prescription	$150 per Prescription
Tier III	$100 per Prescription	$130 per Prescription	$390 per Prescription	$300 per Prescription
****Tier IV**	30% per Prescription	40% per Prescription – 30 or 90 day supply		30% per Prescription
Tier V	50% per Prescription	65% per Prescription – 30 or 90 day supply		50% per Prescription

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

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

WHAT THESE PRESCRIPTION DRUG BENEFITS COVER

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

- Medically Necessary Prescription Drugs including Generic drugs and drugs listed in the FirstCare DCL. When a Generic Drug is available and the Brand Name is dispensed, You will be responsible for the Generic Drug Copayment plus the difference between the cost of the Generic Drug and the cost of the Brand Name Drug. However, if the prescription is written "Dispense as written", then you will only pay the necessary copay for the Brand Name Drug as it is listed on the DCL.
- Compound medications must contain at least one covered Legend Drug.
- Legend Pre-natal vitamins.
- Growth hormone therapy for the treatment of documented growth hormone deficiency in children and adults.
- Formulas necessary for the treatment of Phenylketonuria (PKU) or other Heritable Disease.
- Contraceptive legend drugs and devices.
- Injectable medications recognized by the FDA as appropriate for self-administration (referred to as "Self-Injectable" drugs), regardless of the Insured's ability to self-administer.

LIMITATIONS

- Certain medications are subject to dispensing limitations based upon generally accepted medical practice, including but not limited to, medications contained in the FirstCare DCL.
- Certain medications are subject to prior authorization, including but not limited to, medications contained in the FirstCareDCL.
- New FDA approved medications (unique chemical entities) will require prior authorization until they have been reviewed by the FirstCare P&T committee, and their coverage status is determined.
- Medications covered under these Benefits are limited to a 30-day supply. Maintenance medications for chronic conditions may be filled up to a 90-day supply through Participating Retail Pharmacies or through the Home Delivery Pharmacy program.
- Prescriptions must be written by a Plan Provider or authorized referral Prescriber and filled at a Participating Pharmacy. Prescriptions written by non-Plan Providers, or filled by non-Participating Pharmacies will not be covered, except in cases of medical emergency.
- Prescription Drugs that are dispensed by an out-of-network Pharmacy are not covered unless authorized for emergency purposes. Refills or new prescriptions must be filled at a Participating Pharmacy.
- Prescriptions will not be refilled until 75% percent of the prescription has been used.
- Medications prescribed for non-FDA approved indications, referred to as off-label drug use, *are not covered*. This includes experimental and investigational drugs, used to treat, any disease or condition that is excluded from coverage under these Benefits, or that the FDA has determined to be contraindicated for treatment of the current indication. Off-label drug use may be covered if the drug is approved by the FDA for at least one indication, and is recognized by reproducible studies for treatment of the indication for which the drug is prescribed in substantially accepted peer-reviewed national medical professional journals and a nationally recognized medical technology evaluation service.
- One vacation override is allowed each annual year.

WHAT IS NOT COVERED

- Medications not listed on the DCL.
- Drugs that by law do not require a prescription unless listed in the DCL.
- Prescriptions written in connection with any treatment or service that is not a covered benefit unless listed in the DCL.
- Devices of any kind, even those requiring a prescription, including but not limited to therapeutic devices, health appliances, hypodermic needles or similar items, except for prescribed contraceptive devices and those used in the treatment of diabetes.
- Any medication that is not Medically Necessary. Denials for medications that are not medically necessary are subject to the Member Complaint and Appeal Procedures outlined in the Policy.
- Over-the-counter vitamins and mineral supplements.
- Appetite suppressants, anti-smoking aids (e.g. Nicorette gum and nicotine patches), medications used for any cosmetic improvement, including wrinkles, uncomplicated nail fungus regardless of ambulation or pain, hair loss, growth or removal, idiopathic non-growth hormone deficiency short stature, and DESI Drugs.

- Growth hormone drugs for persons 18 years of age or older. However, growth hormone therapy for the treatment of documented growth hormone deficiency in children for which epiphyseal closure has not occurred, are covered when services are pre-authorized.
- Prescriptions or refills that replace lost, stolen, spoiled, expired, spilled or are otherwise misplaced or mishandled by the Member.
- Prescriptions written for the treatment of infertility.
- Any medication covered under Your medical plan.

GENERAL PROVISIONS

- The monthly premium rate charged for these Benefits are included in the monthly premium charged for the Individual Contract. The applicable rate is specified on the rate schedule attached to the Individual Agreement and You agree to remit to FirstCare the Prescription Drug Benefit premium due, along with and on the same date as its regular premium.
- In the event any Member's coverage under the Individual Contract terminates, these Benefits will terminate automatically without further action or notice unless otherwise prohibited by applicable law.
- Until further notice, all terms, limitations, exclusions and conditions of the Individual Contract Evidence of Coverage remain unchanged except as provided in these Benefits.
- For High Deductible Health Plans (HDHP), the deductible and out-of-pocket maximum of the Plan will apply to these Benefits. Also, copayments under these Benefits will count toward the Plan's deductible and out-of-pocket maximum.
- If We place a medication on a higher tier during the plan year, you will continue to pay the copayment for the drug at the lower cost tier until Your next plan renewal date.

DEFINITIONS

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

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

Copayment means the amount that will be charged to the Member by the Participating Pharmacy or Home Delivery Pharmacy for dispensing or refilling any Prescription Order.

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

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

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

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

- It cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time it is provided; or
- It was reviewed and approved by the treating Facility's Institutional Review Board or similar committee, or if federal law requires it to be reviewed and approved by that committee. This exclusion also applies if the informed consent form used

with the drug, device, treatment or procedure was (or was requested by federal law to be) reviewed and approved by that committee; or

- Reliable evidence shows that the drug, device, treatment or procedure is the subject of ongoing Phase I or Phase II clinical trials; is the research, experimental, study or investigational arm of ongoing Phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness, or its effectiveness compared to a standard method of treatment or diagnosis;
- The safety and/or efficacy has not been established by reliable, accepted medical evidence; or
- Reliable evidence shows that the prevailing opinion among experts is that further studies or clinical trials of the drug, device, treatment or procedure are needed to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness, or its effectiveness compared to a standard method of treatment or diagnosis.

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

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

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

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

Member means either the Subscriber or his eligible Dependents covered under the Plan.

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

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

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

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

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

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

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

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

F. 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.

1. **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 is required to diagnose, treat, or prevent a covered illness or injury, or a medical condition, such as pregnancy;
- If You have a covered illness or condition, it is a service You need in order to improve Your condition or to keep Your condition from getting worse;
- It is generally accepted as safe and effective under standard medical practice in Your community; and
- The service is provided in the most cost-efficient way, while still giving You an appropriate level of care.

Not every service that fits this definition is covered under Your Plan. To be covered, a medically necessary service must also be described in *What is Covered* above. For example, We *do not* cover any preventive, family planning services not specified in *What is Covered* above. *Just because 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 What is Not Covered* below.*)*

2. **PRIMARY CARE PHYSICIAN**

All Covered Health Services must be either provided by Your Primary Care Physician (PCP) or a Plan Provider.

Some services require Our pre-approval. The *What Is Covered* section above will tell You when Our pre-approval is required before services are received.

3. **YOUR RIGHT TO CHOOSE AN OBSTETRICIAN OR GYNECOLOGIST**

You are permitted to designate 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.

4. **PLAN 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.

"Plan 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 Plan Provider at the time the service is rendered.

There are special circumstances under which You may obtain Covered Health Services from providers who are not part of the FirstCare network:

- You may have to use out-of-plan providers for emergency or out-of-area urgent care services described in *Emergency and Out-of-Area Urgent Care Services* section above;
- 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 out-of-plan provider. However, for these services, We must approve the referral at least five days in advance;
- Out-of-plan providers may be used in cases of court-ordered coverage for Dependent children who live outside of FirstCare's Service Area. However, We must approve services that normally require a referral (e.g. inpatient and outpatient procedures, rehabilitation, speech, occupational, or physical therapies) in advance or it will not be covered. Please refer to the specific benefit coverage detailed in *What Is Covered* section above;
- When We agree to continue coverage for the services of a provider who stops participating in the FirstCare network, You may only use an out-of-plan provider in accordance with the *Continuity of Coverage* provision in this section, when these arrangements have been pre-approved by Us; or

- In all cases, out-of-plan providers will be reimbursed the Usual, Customary and Reasonable (UCR) Amount for care received or We will arrange to pay those providers directly at rates negotiated with the provider by FirstCare.

5. **ANCILLARY PROVIDERS**
An Ancillary Provider is a provider with whom a PCP may be required to consult and/or coordinate referrals for certain Covered Health Services on Your behalf. Your PCP may be required to consult with an Ancillary Provider on Your behalf to provide certain services, such as mental health services.

6. **CONTINUITY OF COVERAGE**
You will be notified if You are under the care of a Plan Provider and he or she stops participating in the FirstCare network. Special circumstances may exist where We will continue to provide coverage for that provider's services even though he or she is no longer a Plan Provider with Us. Special circumstances may include a person with a disability, an acute condition, a Life-Threatening illness, or who is past the 24th week of pregnancy. We will continue to provide coverage only if all the following conditions are met:

- The provider submits a written request to Us for continued coverage of Your care. The request must (a) identify the condition for which You are being treated and (b) indicate that the provider reasonably believes that discontinuing his or her treatment of You could cause You harm; and
- The provider agrees to continue accepting the same rate of reimbursement that applied when he or she was still a Plan Provider, and agrees not to seek payment from You for any amounts for which You would not be responsible if the provider were still participating in the FirstCare network.

The continuity of coverage available under this section shall not exceed 90 days beyond the date the provider's termination takes effect, except for Members who are past the 24th week of pregnancy at the time the provider's termination takes effect. Coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six weeks of delivery. You will continue to be responsible for appropriate Copayments.

For members who have been diagnosed with a terminal illness at the time of the Provider's termination from the plan, coverage will extend no more than a nine-month period after the effective date of the termination.

7. **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 *What is Covered* above.

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

9. **OUT-OF-POCKET MAXIMUM**
Out-of-Pocket Maximum means the total amount You must pay each Calendar Year before We pay benefits at 100% of the contract rate for Plan Providers and 100% of Usual, Customary and Reasonable (UCR) Amount for approved out-of-plan Providers. Out-of-Pocket Maximum amounts are amounts for which You and each Dependent are responsible for during a Calendar Year and are limited to a total of 200% of the total annual premium cost which is required to be paid by You or on Your behalf. Your Copayments count toward the Out-of-Pocket Maximum amount. The Out-of-Pocket Maximum *does not* include charges for non-covered services, prescription drug Copayments, and any amounts owed over Usual, Customary and Reasonable (UCR) Amount. You are responsible for informing Us when You have reached your Out-Of-Pocket Maximum.

10. **OUT-OF-POCKET MAXIMUM FOR SPECIFIC SERVICES**
The total amount You or Your Dependents are responsible to pay for Medical Injectable Drugs, Defined Hybrid Injectables, Radiation Therapy, Transplant Anti-rejection Therapy, Home Infusion Medications (excluding "self-injectable" drugs), Chemotherapy and Defined Associated Agents per Calendar Year. Once You reach Your Out-of-Pocket Maximum amount for

these specific medically necessary services (as listed in Your *Schedule of Copayments*), We will pay 100% of Our contracted rate for the remainder of the Calendar Year.

11. **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.

G. 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 the *What Is Covered* section. If a service is not listed, it is not covered.
- You must always meet the conditions for coverage described in 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 the Member's failure to follow a Plan Provider's medical orders.

2. The following types of **Alternative Services,** therapy, counseling and relates services or supplies:
   - Acupuncture, naturopathy, hypnotherapy or hypnotic anesthesia, Christian Science Practitioner Services or biofeedback;
   - For or in connection with marriage, Family, child, career, social adjustment, finances, or medical social services;
   - Psychiatric therapy on Court Order or as a condition of parole or probation.
   - Nutritional counseling, except for the treatment and self-management of diabetes.
   - Lifestyle Eating and Performance (LEAP) program.

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

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

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

6. **Acquired Brain Injury**.

7. **Biofeedback** services, except for the treatment of acquired brain injury and for rehabilitation of acquired brain injury.

8. **Chemical Dependency Treatments** including but not limited to Inpatient and Outpatient settings.

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

10. 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.

11. 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.

12. The following **Cosmetic**, plastic, medical or surgical procedures, and cosmetic therapy and related services or supplies, including, but not limited to Hospital confinements, prescription drugs, diagnostic laboratory tests and x-rays or other reconstructive procedures (including any related prostheses, except breast prosthesis following mastectomy), unless specifically provided in the *What Is Covered* section. 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.

13. PolarCare™ devices for **cryotherapy**.

14. 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.

15. 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 18, correction of malocclusion, and any non-surgical dental care involved in the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome, such as oral appliances and devices;
    - Treatment of dental abscess or granuloma;
    - Treatment of gingival tissues (other than for tumors);
    - Surgery or treatment for overbite or underbite and any malocclusion associated thereto, including those deemed congenital or developmental anomalies; and
    - Orthodontics, such as splints, positioners, extracting teeth, or repairing damaged teeth.

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

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

16. 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 *Emergency and Out-of-Area Urgent Care Services* section. Complication of a pregnancy or delivery is treated as any other illness.

17. The following **devices**, **equipment, and supplies** are excluded:
    - Corrective shoes, shoe inserts, arch supports, and orthotic inserts, except as provided for under Diabetic Services;
    - 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, unless prior approval is obtained from the Medical Director for Medical Necessity.
    - 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.

18. The following **drugs, equipment, and supplies**, except immunizations and prescribed treatment of Phenylketonuria (PKU) and diabetes:
    - Outpatient prescription drugs, unless the Certificate is amended to provide coverage;
    - Medications for use outside of the Hospital or other inpatient facility, including take-home and over-the-counter drugs, except those used in the treatment of diabetes or if otherwise covered by a Rider.
    - Experimental drugs and agents; or
    - Drugs used to treat cosmetic conditions.
    - DESI Drugs

19. **Educational testing** and therapy, motor or language skills, or services that are educational in nature or are for vocational testing or training except in cases of Acquired Brain Injuries as described in the *What Is Covered* section.

20. **Electron Beam Tomography (EBT).**

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

22. Weekend admission charges for non-**Emergency Care** services.

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

24. **Equine or Hippo therapy.**

25. **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.

26. **Fabry Disease** medical and drug treatment.

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

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

29. **Growth hormone** drugs for persons 18 years of age or older. However, growth hormone therapy for the treatment of documented growth hormone deficiency in children for which epiphyseal closure has not occurred, are covered when services are pre-authorized by Us and if Your group has purchased the Prescription Drug Rider.

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

31. **Hemophilia** medical and drug treatment.

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

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

34. **Illegal acts**: Charges for services received as a result of Injury or Sickness caused by or contributed to by the covered person engaging in an illegal act or occupation; by committing or attempting to commit a crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. This exclusion does not apply if the Injury resulted from an act of domestic violence or medical condition (including both physical and mental health).

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

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

37. 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.

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

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

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

41. 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.

42. **Medications** prescribed for non-FDA approved indications, referred to as off-label drug use, are not covered. This includes experimental, investigational, and any disease or condition that is excluded from coverage under this Evidence of Coverage; or that the FDA has determined to be contraindicated for treatment of the current indication. Off-label drug use may be covered if the drug is approved by the FDA for at least one indication; and is recognized 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.
43. **Medications** for use outside of the Hospital or other inpatient facility, including take-home and over-the-counter drugs, except those used in the treatment of diabetes or if otherwise covered by a Rider.

44. **Mental health** services for the following conditions: mental retardation; gender identity disorders; senile deterioration, such as progressive dementia of Alzheimer's and Alzheimer's like diseases; sleep disorders and factitious disorders. Treatments for Serious Mental Illness are not covered in either Inpatient or Outpatient settings. Inpatient services for short-term mental health are not covered. Marriage counseling, court ordered evaluation, diagnosis, and treatment for mental conditions are excluded unless this Evidence of Coverage would otherwise cover such services. Court ordered testimony is not a covered health service.

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

46. Implanted **neurological stimulators**, including but not limited to spinal or dorsal column stimulators for Parkinson's, movement disorders, or seizures, except for stimulators implanted for relief or neurogenic pain as approved by FirstCare's Medical Technology Assessment Committee and when meeting established clinical criteria; and except for neurogenic bladder.

47. 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.

48. **Nutritional** counseling, testing and diet planning, unless We have pre-approved it. We do not cover the Lifestyle Eating and Performance (LEAP) program and/or mediator release testing.

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

50. **Orthotic** devices, except for the treatment of diabetes and those described in *What is Covered*.

51. **Orthotripsy** and related procedures.

52. **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.

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

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

55. All internal and external **prosthetic items and devices**, except for those specified in *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.
56. **Pulmonary Arterial Hypertension** medical and drug treatment.

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

58. **Reduction mammoplasty**, except for surgical reconstruction related to treatment of breast cancer.

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

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

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

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

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

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

65. **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.

66. Volunteer **services**, which would normally be provided at no charge to the Member.

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

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

69. All **services or supplies** provided while the Member is not covered under this Policy; either before the effective date of coverage or after this Evidence of Coverage ended.

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

71. Procedures, services or supplies for or related to **Sex-change** surgery, transformation or reassignment; modification surgery and services, any treatment of gender identity disorders, or any treatment or surgery related to sexual dysfunction or inadequacies including but not limited to: hormone therapy, impotency, regardless of medical necessity.

72. Anti-**smoking** treatments and programs including but not limited to tobacco abuse and smoking cessation programs and nicotine patches.

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

74. **Sports** cords and TENS units.

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

76. 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.

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

78. 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.

79. **Transplants:** Any and all transplants of organs, cells, and other tissues, except for the Transplants listed specifically covered under *What is Covered* or provided by a Rider.

80. **Transportation**, except for ambulance or air ambulance 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).

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

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

83. **Vision Care Services:** Eyeglasses, (including eyeglasses and contact lenses prescribed following vision surgery) contact lenses, except for treatment of Keratoconus, and any other items or services for the correction of Your eyesight, including but not limited to: orthoptics, vision training, vision therapy, radial keratotomy (RK), automated lamellar keratoplasty (ALK or LK), astigmatic keratotomy (AK), laser vision corrective surgery and photo refractive keratectomy (PRK-laser) unless specifically provided in *What Is Covered,* or provided by a Rider.

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

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

H. 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 Determination, the denial, reduction or termination of a service for reasons not related to medical necessity, the way a service is provided, or disenrollment decisions. The term does not include a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the Member and does not include a Plan Provider's or Member's oral or written dissatisfaction or disagreement with an Adverse Determination. A Complaint filed concerning dissatisfaction or disagreement with an Adverse Determination constitutes an appeal of that Adverse Determination.

1. **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. If the Complaint was received orally, We will enclose a one-page Complaint form clearly stating that the Complaint form must be returned to Us for prompt resolution.

   Complaints should be directed to the Customer Service Department at (800) 884-4901 or in writing to:

   SHA, L.L.C. dba FirstCare
   ATTN: Coordinator of Complaints & Appeals
   1901 West Loop 289
   Suite 9
   Lubbock, Texas 79407

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

   Your Complaint concerning an emergency or denial of continued stay for hospitalization will be resolved in one business day of receipt of Your Complaint. The investigation and resolution shall be concluded in accordance with the medical immediacy of the case.

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

2. **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 prior determination that resulted in the appeal.

In all other cases, 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. The notice of final decision will address the specific medical determination, clinical basis, and contractual criteria used to reach the final decision. The notice will also include the toll-free telephone number and address of the Texas Department of Insurance.

3. **Adverse Determination Appeal Procedure**

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

- The principal reasons for the Adverse Determination.
- The clinical basis for the Adverse Determination.
- A description or source of the screening criteria that were utilized as guidelines in making the determination.
- Notification of the right to appeal an Adverse Determination to an Independent Review Organization.
- Notification of the procedures for appealing an Adverse Determination 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.

You, a person acting on Your behalf, Your Physician, or Plan Provider may appeal an Adverse 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 one business day after Your request for appeal.

Due to the ongoing emergency or continued Hospital stay, and at Your request, 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.

4. **Filing Complaints with the Texas Department of Insurance**

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

Texas Department of Insurance
P.O. Box 149104
Austin, 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.

5. **Appeals to an Independent Review Organization (IRO)**

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 Determination.

We shall permit any party whose appeal of an Adverse Determination is denied by Us to seek review of that determination by an Independent Review Organization assigned to the appeal as follows:

- We shall provide to You, Your designated representative, or Your provider of record, information on how to appeal the denial of an Adverse Determination to an Independent Review Organization.
- We must provide such information to You, Your designated representative, or Your provider of record at the time of the denial of the appeal.
- We shall provide to You, Your designated representative, or Your provider of record the prescribed form.
- You, Your designated representative, or Your provider of record must complete the form and return it to Us to begin the independent review process.
- In Life-Threatening situations, You, Your designated representative, or Your provider of record may contact Us by telephone to request the review and provide the required information.

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.

L. Premiums and Termination of Coverage

1. **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. Premiums may be paid quarterly or monthly and may be paid by automatic deduction from a personal checking account (bank draft). Due date is the first day of the month or quarter for which the payment is due.

a. **Premium Rate Changes**

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

b. **Failure to Render Premium Payments**

- All Premium payments not received on or before the due date will be subject to a late charge at a rate equal to 18% per year.
- Failure to make Premium payments within the 31-day 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.

c. **Reinstatement Provisions**

A Member and/or a Member's Dependents shall not be reinstated automatically if coverage is terminated. To be reinstated, a Member must provide evidence of insurability to FirstCare.

d. **Returned Checks**

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

2. **Termination of Coverage**

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

For a Member, in the case of:

- Nonpayment of amounts due, including any applicable Copayments, under this Evidence of Coverage may be canceled after not less than 30 days written notice; except that no written notice will be required for failure to pay premiums;
- Fraud or intentional material misrepresentation, coverage may be canceled after not less than 15 days written notice; subject to the incontestability provisions outlined in the primary EOC for this plan*;*
- Fraud in the use of services or facilities, coverage may be canceled after not less than 15 days written notice;
- Failure to meet eligibility requirements, coverage will be canceled immediately, subject to continuation of coverage and conversion privileges, if applicable;
- Misconduct detrimental to safe Plan operations and the delivery of services, coverage may be canceled immediately;
- Failure of the enrollee and a Plan Physician to establish a satisfactory patient/provider relationship, provided We have made a good faith effort to provide the Member with the opportunity to select an alternative Plan Provider, and further provided that We have notified the Member in writing at least 30 days in advance that We consider such Member's patient/provider relationship to be unsatisfactory and specified the changes that are necessary in order to avoid termination, and thereafter the Member has failed to make such changes, then coverage may be canceled at the end of the 30 days; and
- Failure of the Subscriber and/or covered Dependent to live or work in the Service Area, coverage may be canceled immediately. This provision only applies if coverage is terminated uniformly without regard to any health status-related factor of Members. Coverage for a child who is the subject of a medical support order cannot be canceled solely because the child does not live or work in the Service Area.
- Termination by discontinuance of a particular type of individual coverage by FirstCare in that Service Area. This provision only applies if coverage is terminated uniformly without regard to any health status-related factor of Members. Coverage may be canceled after 90 days written notice, in which case We must offer to each enrollee on a guaranteed issue basis any other individual basic health care coverage offered by FirstCare in that Service Area. This applies only if coverage is discontinued uniformly without regard to health status-related factors of Members and Dependents of Members who may become eligible for coverage. Coverage may be canceled after 180 days written notice to the 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 at the last coverage not renewed.

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

3. **Automatic Termination**
   The coverage of any Member who ceases to be eligible shall automatically terminate on the date on which eligibility ceases, and such termination of coverage shall also apply to each Dependent of such Member whose coverage so terminates, for whatever reason, including the death of such Member. If this Evidence of Coverage is terminated for nonpayment of premium, a Member's coverage shall be terminated retroactively to the date through which premium payment was received.

4. **Termination of Benefits**
   Upon the effective date of a termination of coverage, the Member shall not be entitled to any further benefits hereunder after such effective date. Neither FirstCare nor any Plan Provider shall have any further obligation to provide services or facilities pursuant to this benefit Plan.

5. **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 Plan 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.