SOUTHWEST LIFE & HEALTH INSURANCE COMPANY
FIRSTCARE PREFERRED CHOICE
INDIVIDUAL PPO PLAN – SelectHC V
An Embedded Deductible, Qualified High Deductible Health Plan (HDHP)

OUTLINE OF COVERAGE

Individual PPO Plan $5,000 per Insured Deductible, $10,000 per Family Deductible
INDIVIDUAL PREFERRED PROVIDER OPTION (PPO) PLAN COMPREHENSIVE MAJOR MEDICAL PLAN

THE INDIVIDUAL PPO PLAN DESCRIBED IN THIS OUTLINE PROVIDES COMPREHENSIVE MAJOR MEDICAL COVERAGE, WITH SUPPLEMENTAL BENEFITS AVAILABLE THROUGH THE PURCHASE OF RIDERS.

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 Southwest Life & Health Insurance Company. 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 is provided by Southwest Life & Health Insurance Company, an insurance company providing Preferred Provider Option (PPO) benefits.

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

Southwest Life & Health Insurance Company
12940 N. Highway 183
Austin, TX 78750
(800) 240-3270

C. A **Preferred Provider Plan** enables the Insured to incur lower medical costs by using providers in the Southwest Life & Health Insurance Company (SWL&H) network for this Plan.

A **Preferred Provider** has a signed agreement for this Plan with SWL&H at the time services are rendered to accept previously negotiated rates as payment in full for covered services.

A **Non-Preferred Provider** is a physician or other health care provider who has not entered into an agreement for this Plan with SWL&H at the time the services were rendered. Covered Expenses for Non-Preferred Providers are based on Usual, Customary and Reasonable (UCR) amounts that may be less than actual billed charges. Non-Preferred Providers can bill you for amount exceeding Covered Expenses.

D. Covered Services and Benefits

The **Annual Deductible** is $5,000 per Insured, and $10,000 per Family per Policy Year.

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The **Out-of-Pocket Maximum** means the total amount an Insured must pay each Policy Year before We pay benefits at 100% of the contract rate for Preferred Providers and 100% of the Usual, Customary, and Reasonable (UCR) amount for Non-Preferred Providers. Out-of-Pocket Maximum amounts are $0 per Insured, and $0 per Family, for In-Network Providers. Amounts for Out-of-Network Providers are $20,000 per Insured, and $40,000 per Family. Coinsurance amounts count toward the Out-of-Pocket Maximum. However, the Out-of-Pocket Maximum *does not* include Office Visit Copayments, Deductibles, any amounts owed over UCR amounts and Pre-certification penalties.

E. MEDICAL SCHEDULE of BENEFITS

COVERED SERVICE	PREFERRED PROVIDER (In-Network Benefits)	NON-PREFERRED PROVIDER (Out-of-Network Benefits)
POLICY YEAR: CALENDAR		
DEDUCTIBLE[1] (Applies toward the Out-of-Pocket Maximum)	$5,000 per Insured $10,000 per Family	$10,000 per Insured $20,000 per Family
OUT-OF-POCKET MAXIMUM[2]	$0 per Insured $0 per Family	$20,000 per Insured $40,000 per Family
PRE-AUTHORIZATION PENALTY	Failure to Pre-authorize reduces benefits by 50% or $500, whichever is less.	
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 • Acquired Brain Injury • Laboratory Tests and X-ray • Reconstructive Surgery • Observation Unit • Physician Services • Skilled Nursing Facility - *Limited to a combined 30 In-/Out-of-Network days per Policy Year*	100% after Deductible	70% after Deductible
OUTPATIENT SERVICES Outpatient Services/Surgery include: • Facility Charges • Surgical Procedures • Physician Services	100% after Deductible	70% after Deductible
Laboratory Tests and X-ray in an Outpatient Setting	100% after Deductible	70% after Deductible
MRI, CT Scans, Sleep Study, Nuclear Stress Tests and PET Scan	100% after Deductible	70% after Deductible

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COVERED SERVICE	PREFERRED PROVIDER (In-Network Benefits)	NON-PREFERRED PROVIDER (Out-of-Network Benefits)
PHYSICIAN OFFICE SERVICES Physician Office Services Include: • Physician Office Visits • Medications, supplies and materials administered in the office • Second Surgical Opinion	100% after Deductible	70% after Deductible
Laboratory Tests and X-Ray	100% after Deductible	70% after Deductible
MRI, CT Scans, Sleep Study, Nuclear Stress Tests and PET Scan performed in the Physician's office	100% after Deductible	70% after Deductible
Allergy Services: • Office Visit • Allergy Testing • Serum • Injection Administration	100% after Deductible	70% after Deductible
Surgical Procedures performed in the Physician's Office	100% after Deductible	70% after Deductible
PREVENTIVE SERVICES ***Limited to a combined $500 In-/Out-of-Network benefit per Insured per Policy Year.***		
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 Labs and X-Rays* • Routine Immunizations (ages 6 and older)* • Examinations and testing for the detection of Prostate Cancer* • Well Woman Exam including Routine Annual Physicals and low-dose mammography screenings*	$40 Copayment - Deductible waived	70% after Deductible
Immunizations for Newborns (birth to 6-years of age)	Covered in full	Covered in full
Newborn Child Hearing Screenings (birth to 30-days old)	$40 Copayment - Deductible waived]	70% after Deductible

COVERED SERVICE	PREFERRED PROVIDER (In-Network Benefits)	NON-PREFERRED PROVIDER (Out-of-Network Benefits)
Preventive Diagnostics and Testing: • Non-routine mammograms including Digital, X-ray and Ultrasound • Screening for the detection of Colorectal Cancer *(If other procedures are done during screening, additional copays, deductibles, and/or coinsurance will apply)* • Bone Mass Measurement	$40 Copayment - Deductible waived	70% after Deductible
FAMILY PLANNING		
Family Planning and Counseling	100% after Deductible	70% after Deductible
Contraceptive Devices, Implants and Injections including: • Diaphragm • IUD • Subdermal Contraceptive Implants & Removal • Depo-Provera™ Injections	100% after Deductible	70% after Deductible
Sterilization Procedures: (Vasectomy & Tubal Ligation) • When performed in an Outpatient Facility • When performed in the Physician's Office • When performed in an Inpatient Facility	100% after Deductible	70% after Deductible
DIABETIC SERVICES		
Diabetic Self-Management Education	100% after Deductible	70% after Deductible
Insulin and Diabetic Medication: • 30-day Supply • Mail Order (up to 90-day supply)	100% after Deductible 100% after Deductible	70% after Deductible 70% after Deductible
Test Strips: • Level 1 Strips • Level 2 Strips	100% after Deductible	70% after Deductible
Other Diabetic Supplies and Equipment (30-day Supply)	100% after Deductible	70% after Deductible

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COVERED SERVICE	PREFERRED PROVIDER (In-Network Benefits)	NON-PREFERRED PROVIDER (Out-of-Network Benefits)
OUTPATIENT PHARMACY] *Limited to a combined $4,000 In-/Out-of-Network, Policy Year Maximum* 30-day Supply Mail Order (up to 90-day supply)	100% after Deductible 100% after Deductible	The claim is paid at 70% of the actual charges, after they are first reduced by the sum of the applicable In-Network pharmacy Copayment and any required difference in the cost between a Brand Name medication and a Generic medication.
SPECIALTY SERVICES/PHARMACY Specialty Services/Pharmacy includes: • Medical Injectable Drugs *(excluding Depo-Provera™ injectables)* • Defined Hybrid Injectables • Radiation Therapy • Transplant Anti-Rejection Therapy • Specified Cancer Chemotherapy • Defined Associated Agents Home Infusion Therapy *(excluding "self-injectable" drugs)*	• When Covered Service cost is $500 or less: No additional Coinsurance taken after Deductible. *See the office visit, outpatient surgery or inpatient hospital section(s) for applicable charges.* • When Covered Service cost is more than $500: 30% coinsurance after Deductible, not to exceed $3,000 Out-of-Pocket Maximum for these specific services. *See Your Policy for further details.* 100% after Deductible	70% after Deductible 70% after Deductible
EMERGENCY ROOM SERVICES Emergency Room	100% after Deductible	
Minor Emergency/Urgent Care Facilities	100% after Deductible	70% after Deductible
Ambulance	100% after Deductible	70% after Deductible
OTHER HEALTH CARE SERVCES Limited Accidental Dental Care and Medically Related Oral Surgeries – *Limited to a combined $1,000 In-/Out-of Network Maximum Benefit per Policy Year.*	100% after Deductible	70% after Deductible

COVERED SERVICE	PREFERRED PROVIDER (In-Network Benefits)	NON-PREFERRED PROVIDER (Out-of-Network Benefits)
Therapy Services: • Rehabilitation Therapy, Occupational Therapy, & Physical Therapy *(Limited to a combined 20 In-/Out-of-Network visits per Policy Year)* • Speech Therapy *(Limited to 20 In-/Out-of-Network visits per Policy Year)*	100% after Deductible	70% after Deductible
Hospice Care – *Limited to a combined $10,000 In-/Out-of-Network Lifetime Maximum Benefit.*	100% after Deductible	70% after Deductible
Spinal Manipulation – *Limited to a combined 10 In-/Out-of-Network visits per Policy Year.*	100% after Deductible	70% after Deductible
Pain Management Services	100% after Deductible	70% after Deductible
Durable Medical Equipment (DME) – *Limited to a combined $2,000 In-/Out-of-Network Maximum Benefit per Policy Year. This limit applies to both Outpatient & Home Health Care services. DME used in the treatment of diabetes, oxygen and monitoring devices are not included in the $2,000 maximum.*	100% after Deductible	70% after Deductible
Medical Supplies	100% after Deductible	70% after Deductible
Prosthetics: External Devices: *Combined In-/Out-of-Network Lifetime Maximum of $4,000 per Device/Limb*	100% after Deductible	70% after Deductible
Orthotics	100% after Deductible	70% after Deductible
Internal Implantable Devices	100% after Deductible	70% after Deductible
Dialysis Services *(Inpatient & Outpatient)*	100% after Deductible	70% after Deductible
Organ Transplant Services *(Inpatient & Outpatient) – Limited to a combined $300,000 In-/-Out of Network Lifetime Maximum*	100% after Deductible	70% after Deductible
Home Health Care Services include: *Limited to a combined 20 In-/Out-of-Network visits per Covered Service per Policy Year* • Skilled nursing services provided by a registered nurse or vocational nurse; supervised by one registered nurse and one physician	100% after Deductible	70% after Deductible

COVERED SERVICE	PREFERRED PROVIDER (In-Network Benefits)	NON-PREFERRED PROVIDER (Out-of-Network Benefits)
• Home health aide services; supervised by a registered nurse • Medical equipment/supplies other than drugs and medicines: *Limited to the combined dollar amount listed under Durable Medical Equipment (DME) for both Outpatient & Home Health DME services.*		
ALL OTHER COVERED SERVICES	100% after Deductible	70% after Deductible

*[1] **Embedded Deductible** is when the Individual Deductible amount must be met by every Insured covered, each Policy Year. If Dependents are covered, all charges applied to the Individual Deductible amount will be applied towards the Family Deductible amount. When the Family Deductible is reached, no further Individual Deductibles will have to be met for the remainder of that Policy Year. No Insured will contribute more than the Individual Deductible amount to the Family Deductible amount.*

*[2] **Out-of-Pocket Maximum** is the total amount that must be paid each Policy Year before benefits are covered at 100%, up to the Usual, Customary and Reasonable (UCR) amount. Deductibles do count towards the Out-of-Pocket Maximum.*

The **AGGREGATE LIFETIME MAXIMUM** payable under this Policy is $2,000,000 for You and each of Your covered Dependents, is shown in the *Schedule of Benefits*. When an Insured reaches this Aggregate Lifetime Maximum amount, coverage for such Insured will end.

F. COVERED HEALTH SERVICES

Southwest Life & Health Insurance Company will pay benefits for treatment of an Illness or Injury covered under the Policy upon receipt of proper proof of loss. See the Policy for details.

COVERED HEALTH SERVICES

Benefits are paid for the Usual, Customary, and Reasonable (UCR) amount for the following Medically Necessary treatments, services, and supplies for Covered Health Services:

I. Inpatient Services

- Semi-Private Room and Board Charges - Hospital room and board, including regular daily medical services and supplies, will be payable as shown on 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.
- Inpatient Services for the Treatment of Breast Cancer - Inpatient services required to diagnose and treat breast cancer are provided for a minimum 48-hour inpatient stay following a mastectomy and a 24-hour inpatient stay following a lymph node dissection. The inpatient stay may be less than the minimum hours of inpatient care, if the Insured and the Insured's treating Physician determine that a shorter period of inpatient care is appropriate.

- Other Hospital Services and Supplies - We cover other Hospital Services and Supplies, including, but not limited to: general nursing care; medications and biologics; anesthesia and oxygen; the administration of whole blood or blood products; laboratory tests and x-rays; special foods or diets when Medically Necessary; use of operating, recovery, and delivery rooms; radiation, inhalation, chemotherapy, and short-term physical/occupational therapy.

II. Outpatient Services

Covered Health Services include treatment performed in a Facility other than a Hospital for a covered Illness or Injury, if the treatment is:

- Provided by a Health Care Provider whose services would be covered under the Policy if the treatment were performed in a Hospital;
- Medically Necessary; and
- Provided as an alternative to inpatient treatment in a Hospital.

Other covered outpatient care services include:

A. Health Care Provider Services

Covered Health Care Services include the following:

- Inpatient and outpatient surgery;
- Physician hospital visits;
- Physician office and home care;
- Allergy testing, serum, services, and treatment of allergy symptoms.

B. Outpatient Surgery

Covered Health Services include scheduled outpatient surgery in a Hospital, outpatient Facility, or other Facility covered under the Policy.

C. Laboratory and Radiology Services

Covered Health Services include, but are not limited to: x-rays, fluoroscopy, electrocardiograms, blood, urine, and other laboratory tests, Digital & X-Ray Mammography, Breast Ultrasound, radium, radioactive, and isotope therapy, Magnetic Resonance Imaging (MRI), CT scan, and preadmission testing.

III. Preventive Health Care Services

1. *Annual Routine physical exams* for adults based on age, sex, and medical history includes history, physical examination, laboratory, x-rays, and PAP tests.

2. *Well-baby and well-child preventive care* for children through age 18. Well-child care visits at the following intervals: birth, 2 months, 4 months, 6 months, 9 months, 12 months, 18 months, 2 years, and annually thereafter.

3. *Immunizations* for all Insureds according to generally accepted medical practice standards, including “preventive health” immunizations & vaccines (e.g. flu, pneumonia, tetanus, etc.),

and for those immunizations approved by the Center for Disease Control for travel outside the United States.

4. *Ophthalmologic examinations* for infants at risk for eye problems.

5. *Routine sight, speech, and hearing screenings* for children through age 18. One hearing screening per Policy Year is covered for all Insureds. Speech and hearing services include care or treatment of a speech or hearing impairment or loss; services necessary to restore speech loss; services provided to correct a congenital malformation for which corrective surgery has been performed.

6. *Screening Test for Hearing Impairment* in newborns from birth through the date the child is 30 days old, and necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old.

7. *Screening mammograms* (non-diagnostic) for women age 35 and older to detect breast cancer. In addition to routine screening, mammograms are covered when prescribed by a Physician as Medically Necessary to diagnose or treat Illness.

8. *Screening for Detection of Colorectal Cancer* includes screening examinations and procedures for Insureds 50 years old or older and at a normal risk for developing colon cancer. These annual exams include fecal occult blood tests, a flexible sigmoidoscopy performed every five years, or a colonoscopy performed every 10 years.

9. *Bone mass measurement* services include bone mass measurement for the detection of low bone mass and to determine the risk of osteoporosis and fractures associated with osteoporosis.

10. *Prostate cancer testing (annually)* 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.

11. *Pap Smear Screen (annually)*, for women who are insured under this plan and are 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.

IV. Family Planning

Family Planning Services

We cover these Family planning services:

- Physical exams, related laboratory tests, and medical supervision;
- Information and counseling on contraception;
- Materials and services to insert or remove an intrauterine device (IUD);
- Materials and services to fit a diaphragm contraceptive;

- Materials and services to insert or remove a birth control device implanted under the skin (such as Norplant); and
- Vasectomy and tubal ligation (voluntary sterilization).
- Depo-Provera™ Injections

V. Other Health Care Services

1. Spinal Manipulation Services

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, or these services will be subject to the Pre-Authorization Penalty.

2. Rehabilitative Services

Covered Health Services for short-term Physical/Occupational (PT/OT) Therapy are covered when directed and monitored by a Health Care Provider. Short-term is defined as 2 months or less. The services provided must be expected to result in significant improvement within two months from the start of treatment and is limited to a maximum treatment period, as listed in the Schedule of Benefits, from the start of therapy for each Injury or diagnosis.

Benefits are paid for charges billed by a Physician or by a licensed or certified physical or occupational therapist, for therapy that is:

- Furnished to an Insured, on an outpatient or inpatient basis, in a Facility covered under this Policy; and
- Provided in accordance with a specific written treatment plan which:
  a. details the treatment, including frequency and duration;
  b. provides for on-going reviews; and
  c. only allows renewal of the treatment plan if the therapy remains Medically Necessary.

3. Reconstructive Surgery

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 is 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.

4. Prosthetics and Orthotics

We cover standard external, non-cosmetic prosthetic or orthotic devices if We pre-authorize them. If these devices are not pre-authorized, they will be subject to the Pre-Authorization Penalty. Examples of covered devices include artificial arms, legs, hands, feet and 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 an Insured 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 authorized by Us.

For more information, see the Schedule of Benefits for further benefit details.

5. 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 the Policy. All such devices must be pre-authorized by Us. If these devices are not pre-authorized, they will be subject to the Pre-Authorization Penalty.

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 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 types of internal implantable devices are covered and must be pre-authorized by Us.

6. Dorsal Column Stimulators

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

7. Pain Management Services

We cover Medically Necessary pain management treatment and related services. All Covered Health Services must meet these conditions:

- Services must be ordered by Physician Services and can be expected to meet or exceed treatment goals established for You by Your Physician;
- Services are scientifically proven and evidenced-based to improve Your medical condition; and
- All services must be pre-authorized prior to receiving treatment to receive the maximum benefit, or they will be subject to the Pre-Authorization Penalty.

8. Acquired Brain Injury

We provide coverage for certain benefits related to acquired brain injury. Coverage includes the following services:

- Cognitive rehabilitation therapy;
- Cognitive communication therapy;
- Neurocognitive therapy and rehabilitation;
- Neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment;
- Neurofeedback therapy;
- Remediation required for and related to treatment of an acquired brain injury
- Post-acute transition services; or
- Community reintegration services, including outpatient day treatment services, or other post-acute care treatment services necessary as a result of and related to an acquired brain injury.
- Pre-Authorization is required for these services (see the Policy for further information). If these services are not pre-authorized, they will be subject to the Pre-Authorization Penalty.

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

- Has incurred an acquired brain injury;
- Has been unresponsive to treatment; and
- Becomes responsive to treatment at a later date.

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

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

9. Second Surgical Opinion

We cover services for second surgical opinions.

10. 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. If these services are not pre-authorized, they will be subject to the Pre-Authorization Penalty.

11. Organ Transplant Services

Covered Health Services include the services necessary to procure the organ, all Physician, and Hospital services for the following Organ Transplants:

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

Covered Health Services include organ acquisition fees and the Medically Necessary surgical expenses of a person who is acting as a donor for an Insured. Organ Transplants not listed above are excluded.

12. Durable Medical Equipment

The following Durable Medical Equipment are covered:

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

Your DME benefit is limited as shown in your Schedule of Benefits.

Coverage is provided for the Medically Necessary DME meeting the following conditions:

- DME must be ordered or prescribed by a Health Care Provider;
- DME must be Medically Necessary as determined by Us;
- DME must be pre-authorized, or it is subject to the Pre-Authorization Penalty;
- DME may be purchased or rented, whichever is most cost effective, as determined by Us;

- Coverage is provided for the initial equipment only; and
- Only the standard equipment is covered. Special features which 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 Our property. 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;
- DME used for the treatment of diabetes; and
- Monitoring devices, such as apnea, glucose and uterine monitors, for use in the home when prescribed and directed by a Health Care Provider.

13. 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. For a more complete listing of these supplies, see the definition of Diabetes Supplies in the Policy.
- 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. Supplies, which can be purchased over-the-counter without a Physician order, are not covered. See the Policy for further details.
- Allergy syringes.

14. Limited Accidental Dental – Related Services

We provide limited coverage for dental services that would otherwise be excluded from coverage but are determined by 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 or neck

We provided 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 this 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-authorize the service. If these services are not pre-authorized, they are subject to the Pre-Authorization Penalty.

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

- We pre-authorize the service. If these services are not pre-authorized, they are subject to the Pre-Authorization Penalty.

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

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

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 Insured's physical, mental, or medical condition. The services must meet all of these requirements:

- We pre-authorize the services If these services are not pre-authorized, they are subject to the Pre-Authorization Penalty.

The services described above are the only dental-related services covered under Your Plan. See the Policy for further details.

15. Temporomandibular Joint Disorder

We cover the diagnosis and surgical treatment of disorders of, and conditions affecting the temporomandibular joint, which includes the jaw and the craniomandibular joint resulting from an accident, a trauma, a congenital defect, a developmental defect, or a pathology. Surgical treatments must be pre-authorized, or else they will be subject to the Pre-Authorization Penalty.

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 the Policy for further details.

16. Blood and Blood Products

Covered Health Services are provided for both inpatient and outpatient care.

17. Home Health Care Services

Covered Health Services include:

- Skilled nursing by a registered nurse or licensed vocational nurse under the supervision of at least one registered nurse and at least one Physician;
- The service of a home health aide under the supervision of a registered nurse; and

- The furnishing of medical equipment and medical supplies other than drugs and medicines.

Home Health Care is limited to health services provided on a part-time or intermittent basis to an Insured who is confined to his home due to Injury or Illness for a condition that would require hospitalization in the absence of Home Health Care. The Home Health Care visit limitation can be extended in the event that it would result in not having to admit the Insured to a Facility for continued Medical Care.

18. Skilled Nursing Facility Services

We cover Semi-Private Room and Board, and charges for other Facility services and supplies. Private room charges that exceed Semi-Private Room rates are not covered. If the Facility does not have Semi-Private Rooms, benefits are limited to the most common rate for Semi-Private Rooms charged by similar Facilities located in the surrounding geographical area. Covered charges are limited to a maximum of 60 days per Policy Year.

19. Hospice Care

We cover all care provided by a hospice to a terminally ill patient. Terminally Ill Patient means an Insured who does not have a reasonable prospect for cure and who has a life expectancy of six months or less. The attending Physician must authorize that the Insured is terminally ill.

The services may be provided in the Insured's home or in the hospice. Covered Health Services include:

- Inpatient care - room and board, not to exceed the Semi-Private Room rate, and other necessary services and supplies; and
- Outpatient care - part-time nursing care by or under the supervision of a registered nurse (R.N.); home health aide services; nutrition services; and medical supplies, drugs, and medicines that are prescribed by a Health Care Provider and that can be administered only by a licensed health professional, but only to the extent that such items or services would have been covered under this Policy if the Insured had been confined in a Hospital or Skilled Nursing Facility.

20. Medical Injectable Drugs, Defined Hybrid Injectables, Radiation Therapy, Transplant Anti-rejection Therapy, Chemotherapy and Defined Associated Agents

We cover medically injectable drugs, defined hybrid injectables, radiation therapy, specified transplant anti-rejection therapy, specified cancer chemotherapy and defined associated agents administered in Your Physician’s office or in an outpatient facility. Refer to the Schedule of Benefits for details.

21. Home Infusion Therapy

We cover the administration of medication (including chemotherapy), fluids or nutrition by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the Insured's home. Home infusion therapy includes:

- Medical Injectable Drugs and IV solutions;

- Pharmacy charges;
- Equipment and supplies needed to administer the therapy;
- Delivery services;
- Related nursing services; and
- Patient 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 Rider for details.

22. Treatment of Diabetes

a. Diabetic Medications

We cover the following medications for insured persons diagnosed with diabetes, elevated blood glucose levels induced by pregnancy, or another medical condition associated with elevated blood glucose levels:

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

Medications are limited to a 30-day supply when purchased through a retail Plan pharmacy or a 90-day supply when purchased through a Participating Mail Service pharmacy. For information on participating pharmacies, see the Provider Directory or call Our Customer Service Department at (800) 240-3270.

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

b. Diabetic supplies, equipment and self-management education

We cover Diabetic Supplies and Equipment as defined in the Policy. Diabetes Self-Management Training programs are covered as Basic Plan Benefits under the following circumstances:

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

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. Call the SWL&H Customer Service Department at (800) 240-3270 for more information.

VI. Emergency and Urgent Care Services

1. Emergency Care

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. You, Your Physician, or Family member must notify Us if You are admitted to the Hospital.

See the definition of Emergency Care in the Policy.

2. Ambulance Services

Covered Health Services include professional ambulance service to transport the Insured directly to the nearest Hospital equipped to treat the Illness or Injury. Air ambulance services are covered when Medically Necessary.

3. Urgent Care Services

If You urgently need Covered Health Services while You are inside Our Service Area, but Your condition is not serious enough to be a medical emergency, You may seek care through one of Our Preferred Providers or Facilities. Call Our Customer Service Department at (800) 240-3270, or go to Our website at www.FirstCare.com to locate a Preferred Provider.

If You are not able to go to a Preferred Provider, You may seek Medically Necessary urgent care services from a Non-Preferred Provider. If You had no choice but to receive services from a Non-Preferred Provider, You will receive benefits at the In-Network level. If there was a choice between seeing a Preferred Provider or a Non-Preferred Provider, and You opted for the Non-Preferred Provider, You will be responsible for the higher Non-Preferred Provider Deductible, Out-of-Pocket Maximum, and Coinsurance amounts listed on Your Schedule of Benefits.

Urgent care means medical services that:

- Do not meet the requirements necessary to be considered "Emergency Care" described above in the Policy;
- You urgently need such services, and if You are outside Our Service Area, You could not reasonably have anticipated needing such services before You left the SWL&H Service Area; and
- If treatment is delayed, the urgent medical condition could become worse or result in a more serious condition.

Preferred Providers:
We will pay Preferred Providers at their contracted rate, less all applicable Coinsurance and Deductible amounts for urgent care services. Refer to Your Schedule of Benefits for details.

Non-Preferred Providers:
Payment for urgent care received from Non-Preferred Providers is provided in one of two ways:

- We will pay the Usual, Customary, and Reasonable (UCR) amount (see the Policy for further details) for care received from Non-Preferred Providers; or
- We will arrange to pay those providers at rates negotiated with the provider by Us.

G. HOW BENEFITS ARE PAID

We will pay benefits at the Coinsurance rate after any applicable Deductible, as shown in the Schedule of Benefits. All benefits are subject to the definitions, benefit limitations, and general provisions listed in this Policy.

1. Deductible

Each covered Insured is responsible for the Deductible amount of $5,000 for In-Network Providers and $10,000 for Out-of-Network Providers. Each covered Family is responsible for the Deductible amount of $10,000 for In-Network Providers and $20,000 for Out-of-Network Providers. The annual Deductible means the amount of Covered Health Services which You must incur each Policy Year before benefits are paid under this Policy. The Deductible applies to all Covered Health Services. The Deductible *does apply* towards the Out-of-Pocket Maximum.

2. Coinsurance

The Coinsurance rate is the Insured's share of a covered medical expense that each Insured must pay. All Coinsurance percentage amounts are 100% after Deductible for In-Network Providers, and 70% after Deductible of Non-Preferred Providers and are listed in the Insured's Schedule of Benefits. The Coinsurance rate is a percentage of the contracted Allowable Amount We pay to Preferred Providers or the UCR amount We pay to Non-Preferred Providers. The Coinsurance amount applies toward the Out-of-Pocket Maximum. You are responsible for all amounts above the Usual, Customary, and Reasonable (UCR) amount.

H. WHAT IS NOT COVERED (*Exclusions & Limitations*)

Exclusions are named medical conditions or health services that are not covered under this Policy. In addition to any specific limitations or exclusions listed elsewhere, no benefits are paid under this ***INDIVIDUAL PPO PLAN*** for the following:

1. **Additional expenses** incurred as a result of the Insured's failure to follow a Plan Provider's medical orders.

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

3. **Assistant surgeons**, unless determined to be Medically Necessary.

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

5. **Biofeedback** service, except for the treatment of acquired brain injury and for rehabilitation of acquired brain injury.

6. **Chemical Dependency Services** including but not limited to Inpatient and Outpatient settings.

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

8. Personal **comfort,** hygiene or **convenience** items, services or supplies not directly related to the Insured's care, including, but not limited to: guest meals, accommodations, telephone charges, admission kits, radio, television, beauty/barber services, wigs, clothing, take-home supplies, travel or travel time, even if prescribed by a Physician.

9. 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 relates prosthesis, except breast prosthesis following mastectomy), unless specifically provided in the Policy. Among the procedures that We do not cover are:

    - Excision or reformation of any skin on any part of the body, hair transplantation, removal of port wine stains *(except for newborns)*, 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 *(except for newborns)*; and
    - Rhinoplasty and associated surgery.

10. In the absence of **Creditable Coverage**, any charges incurred during the first 24 consecutive months of the Insured's coverage under SWL&H Policy, which are due to Pre-Existing Conditions.

11. PolarCare™ devices used in **Cryotherapy**.

12. **Custodial Care**, respite, or domiciliary care. Custodial care is caring that:

    - Primarily helps with or supports daily living activities (such as, cooking, eating, dressing and eliminating body wastes. bathing, dressing); 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.

13. 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, peridontium) 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 Insureds 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 the Policy.

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

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

    - Corrective shoes, shoe inserts, arch supports, orthotic inserts and devices except for those described in the Policy, or for the treatment of diabetes.
    - Comfort or convenience items, such as bathtub chairs, whirlpool tubs, safety grab bars, stair gliders or elevators, over-the-bed tables, bed boards, saunas, exercise equipment, and institutional equipment, such as air fluidized beds and diathermy machines.
    - Environmental control equipment such as air purifiers, air conditioners, humidifiers, dehumidifiers, electrostatic machines, and heat lamps.
    - Foam cervical collars;
    - Stethoscopes, sphygmomanometes, and recording or hand-held oximeters;
    - Hygienic or self help items or equipment;
    - Electric, deluxe and custom wheelchairs or auto tilt chairs;
    - Sequential lymphedema compression devices, except for treatment after a mastectomy.

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

    - Outpatient prescription drugs, unless the Policy 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

16. **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 Policy.

17. Special **education,** counseling, therapy, care, evaluation, training, and treatment of learning disabilities, disorders, deficiencies, or behavioral problem.

18. **Electron Beam Tomograph**y (EBT)

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

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

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

22. **Equine** or Hippo therapy.

23. The following **equipment and supplies,** except as provided for the treatment of diabetes:
    - All Durable Medical Equipment, except as provided herein; and
    - 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 (except for formulas necessary to treat phenylketonuria or other heritable diseases).

24. **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; 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;
    - Reliable evidence shows that the drug, device, treatment, or procedure is the subject of ongoing Phase I or Phase II clinical trials; the research is an experimental study or investigational arm of ongoing Phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, toxicity, safety, effectiveness, or 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, toxicity, safety, effectiveness, or 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.

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

26. 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 the Policy.

27. **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.

28. **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. If these services are not pre-authorized, they will be subject to the Pre-Authorization Penalty.

29. **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.

30. **Hemophilia** medical and drug treatment.

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

32. All charges for inpatient **Hospital** days that exceed the medically recommended length of stay for the diagnosis.

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

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 felony or to which a contributing cause was the Insured's being engaged in an illegal occupation. 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. **Illness or Injury** incurred as a result of war or any act of war, whether declared or undeclared, and whether or not the Insured served in the military.

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

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

38. 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 will You are in the custody of any government authority, and any care that is required by law to be given in a public facility.

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

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

41. **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.

42. **Maternity** and Obstetrical care, including but not limited to Inpatient Maternity Services, including newborn nursery and delivery room services, and Physician services for both pre- and post-natal care.

43. **Medications** prescribed for non-FDA approved indications, referred to as off-labeled drug use, and are not covered. This includes experimental, investigational, any disease or condition that is excluded from coverage; or that the FDA has determined to be contraindicated for treatment of the current indication. Off-labeled 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.

44. **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.

45. 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, except when prescribed for the treatment of diabetes

46. **Mental health services** for the following conditions: mental retardation; gender identity disorder; senile deterioration, such as progressive dementia of Alzheimer's and Alzheimer's like diseases; sleep disorders and factitious disorders. Treatments for Serious Mental Illness and Acute/Non-Chronic/Short Term Mental Health Services are not covered in either Inpatient or Outpatient settings. Marriage counseling is not a covered health service. Court ordered evaluation; diagnosis and treatment for mental conditions are excluded unless this Policy would otherwise cover such services. Court ordered testimony is not a covered health service.

47. Charges for **missed appointments** and charges for completion of Claim forms.

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

49. If a service is **not covered** under this Policy, 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.
    - All care related to services that are not covered, including direct complications and pre or post care except for complications of pregnancy.

    For example, if an Insured 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 Policy.

50. **Nutritional counseling**, (except for the treatment and self-management of diabetes) testing and diet planning, unless We have pre-authorized it. We do not cover Lifestyle Eating and Performance (LEAP) program and/or mediator release testing.

51. Services intended primarily to treat **obesity**, such as gastric bypasses and balloons, vertical banding, stomach stapling and jaw-wiring, 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 Insured 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.

52. Any **Organ Transplant** not specifically listed unless the Organ Transplant Rider has been purchased, all artificial organs, and services when the Insured acts as a donor, unless We also cover the recipient.

53. **Orthotripsy** and related procedures.

54. **Outpatient services** received in federal Facilities or any items or services provided in any institutions operated by any state government or agency when an Insured 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.

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

56. **Physical examinations**, health reports, and treatments and/or evaluations required for employment, flight clearance, camp, insurance, school, sports, or legal proceedings.

57. **Physicals** are limited to one per Policy Year unless Medically Necessary.

58. 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.

59. All internal and external **prosthetic items and devices,** except for those specified in the Policy. We do not cover splints unless they are needed for urgent or emergency treatment and/or in lieu of castings or surgery.

60. **Pulmonary Arterial Hypertension** medical and drug treatment.

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

62. **Reduction mammoplasty**; breast augmentation, correction of breast asymmetry, and cosmetic procedures, except as stated under reconstructive surgery after a mastectomy.

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

64. **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 coverage is otherwise specified in this document.

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

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

67. All **services or supplies** provided while the Insured is not covered under this Policy; either before the Effective Date of coverage or after this Policy ended.

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

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

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

71. **Services,** except Dental services that are supplied by a person who ordinarily resides in Insured's home or is a Family member of the Insured.

72. **Services** received while not under the care and treatment of a Physician.

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

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

75. Volunteer **services**, which would normally be provided at no charge to the Insured

76. The following types of therapy, counseling, and related **services, or supplies**:

- For or in connection with marriage, Family, child, career, social adjustment, finances, or medical social services;
- Acupuncture, naturopathy, psychosurgery, megavitamin, and nutritionally based alcohol therapy;
- Hypnotherapy or hypnotic anesthesia, or biofeedback; or
- Psychiatric therapy on Court Order or as a condition of parole or probation.

77. Procedures, services, or supplies for or related to **sex change**, 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.

78. Anti-**smoking** programs including but not limited to, tobacco abuse and smoking cessation programs.

79. 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.)

80. Reversal of a **sterilization** procedure regardless of Medical Necessity.

81. Infertility drugs, reversal of voluntary **sterilization**; gamete intra-fallopian transfer (GIFT); zygote intra-fallopian transfer (ZIFT); in vitro fertilization (IVF) unless the Insured has subscribed to the In-Vitro Fertilization Rider; any costs related to surrogate parenting; infertility services required because of a sex change by the Insured or the Insured's partner; or any assisted reproductive technology or related treatment that is not specified in the Policy.

82. **Sports cords** and TENS units.

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

84. **Transportation**, except for ambulance or air ambulance used for transport in a medical emergency or when We have pre-authorize services for medical transport purposes only (e.g. from a Hospital to a skilled nursing Facility).

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

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

87. **Vision** exams, eye exercises, training, orthoptics, or multiphase testing. 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) and photo refractive keratectomy (PRK-laser) unless specifically provided in the Policy, or as provided by a Rider.

I. CONTINUITY OF TREATMENT

Upon termination of a Preferred Provider's contract, Insureds currently being treated by the Preferred Provider will be notified of the termination. Unless the Preferred Provider was terminated for reason of medical incompetence or unprofessional behavior, the Preferred Provider may request to continue treatment of an Insured with special circumstances. Special circumstances means a condition such that the treating Preferred Provider reasonably believes that discontinuing care by the treating Preferred Provider could cause harm to the Insured.

Special circumstances may include a person who has a disability, an acute condition, or a Life-threatening Illness, or who is past the 24th week of pregnancy. The period of continued treatment may not exceed 90 days from the Effective Date of termination, or beyond nine months in the case of an Insured who at the time of termination has been diagnosed with a terminal Illness. Coverage for an Insured, who at the time of termination is past the 24th week of pregnancy, will extend through delivery of the child, immediate post-partum care, and the follow-up checkup within the first six weeks of delivery. The Preferred Provider must agree to accept the contracted payment rates in effect prior to the termination.

J. COMPLAINT RESOLUTION PROCEDURES

If You notify Us orally or in writing of a Complaint, We will no 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 Services Department at (800) 240-3270 or in writing to:

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

Filing Complaints with the Texas Department of Insurance

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

Texas Department of Insurance

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:

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

K. SERVICE AREA

The Southwest Life & Health Insurance Company Preferred Provider Service Area is the geographic area where or within which Preferred Providers that have contracted with Us are located. Refer to the attached Service Area map in this Policy to determine if You live in Our Service Area.

L. TERMINATION OF COVERAGE

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

- The date of Your death;
- The date the Maximum Benefit amount under this Policy has been paid to You or on Your behalf;
- Nonpayment of Premium;
- Fraud or intentional material misrepresentation, coverage may be canceled after not less than 15 days written notice; subject, however to the Time Limit on Certain Defenses provision described in the Policy; or
- Termination by discontinuance of a particular type of individual coverage by Southwest Life & Health Insurance Company in that Service Area. This provision only applies if coverage is terminated uniformly without regard to any health status-related factor of Insureds. Coverage may be canceled after 90 days written notice, in which case We must offer to each Insured on a guaranteed issue basis any other individual basica health care coverage offered by Southwest Life & Health Insurance Company in that Service Area. This applies only if coverage is discontinued uniformly without regard to health status-related factors of Insured who may become eligible for coverage. Coverage may be canceled after 180 days written notice to the commissioner and the Insureds, in which case Southwest Life & Health Insurance Company may not re-enter the individual market in that Service Area for five (5) years beginning on the date of discontinuance at the last coverage not renewed. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.
- You no longer reside, live, or work in an area in which SWL&H is authorized to provide

coverage, but only if all Policies are not renewed or not continued.

If coverage terminates due to the death of the Policyholder, the spouse of the Policyholder will become the named Policyholder, provided the spouse is an Insured under the Policy on the date of death.

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.

M. AUTOMATIC TERMINATION

The coverage of any Insured who ceases to be eligible under the Policy, shall automatically terminate at 12:01 a.m. on the date on which eligibility ceases, and such termination of coverage shall also apply to each Insured whose coverage so terminates, for whatever reason, including the death of such Insured. If this Policy is terminated for nonpayment of premium, an Insured's coverage shall be terminated retroactively to the date through which premium payment was received.

If You moves out of the Southwest Life & Health Insurance Company Service Area, You may continue coverage under this Policy. However, all health care services received from Non-Preferred Providers require the higher Non-Preferred Provider Deductible, Out-of-Pocket Maximum and Co-insurance amounts listed on Your Schedule of Benefits.

N. PREMIUMS

The premium applicable to this Policy is determined by the Plan You select, Your age and Your place of residence on each premium due date.

You must notify Us in writing of any change in Your place of residence within 30 days of the date of change. Your place of residence means the address where You principally reside and regularly maintain physical presence.

Premium rates are set out in the Premium Rate Schedule. The Insured 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.

Change In Premium Upon Notice:

- 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 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 birthday.