COMMUNITY FIRST HEALTH PLANS, INC.

ADMINISTRATIVE OFFICES
12238 Silicon Drive, Suite 100
San Antonio, Texas 78249
TELEPHONE 210-227-2347

or

1-800-434-2347

This Certificate of Group Health Care Coverage provides for voluntary arbitration of certain disputes pursuant to the Texas Arbitration Act. Please refer to the section entitled "Arbitration" for specific information. The table of contents will provide the relevant section number.

THIS EVIDENCE OF COVERAGE IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

The Evidence of Coverage under which this certificate is issued is not a policy of workers' compensation insurance. You should consult your employer to determine whether your employer is a subscriber to the workers' compensation system.

IMPORTANT NOTICE

To obtain information or make a complaint:

You may contact your Member Services Representative at (210) 358-6262.

You may call Community First's toll-free telephone number for information or to make a complaint at:

1-800-434-2347

You may also write to Community First at:
12238 Silicon Drive, Suite 100 San Antonio, Texas 78249

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

1-800-252-3439

You may write the Texas Department of Insurance

P.O. Box 149104
Austin, TX 78714-9104
Fax (512) 490-1007
Web:http://www.tdi.texas.gov
E-Mail: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact Community First first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para presentar una queja:

Usted puede comunicarse con su Member Services Representante al (210) 358-6262.

Usted puede llamar al número de teléfono gratuito de Community First para obtener información o para presentar una queja al:

1-800-434-2347

Usted también puede escribir a Community First:
12238 Silicon Drive, Suite 100 San Antonio, Texas 78249

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compaňias, coberturas, derechos, o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

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

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES: Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con Community First primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas .

ADJUNTE ESTE AVISO A SU PÓLIZA: Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

NOTICE OF SPECIAL TOLL-FREE COMPLAINT NUMBER

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

1-800-832-9623

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

AVISO DE NUMERO TELEFONICO GRATIS ESPECIAL PARA QUEJAS

PARA SOMETER UNA QUEJA ACERCA DE UN HOSPITAL PSIQUIATRICO PRIVADO, DE CENTRO TRATAMIENTO PARA LA DEPENDENCIA QUIMICA, DE SERVICIOS PSIQUIATRICOS O DE DEPENDENCIA QUIMICA EN UN HOSPITAL GENERAL, LLAME A:

1-800-832-9623

Su queja será referida a la agencia estatal que regula la Hospital o centro de tratamiento para la dependencia química.

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COMMUNITY FIRST HEALTH PLANS, INC.
CERTIFICATE OF GROUP HEALTH CARE COVERAGE

COMMUNITY FIRST HEALTH PLANS, INC. (COMMUNITY FIRST) certifies that it will provide Group Health Benefit Coverage to You and Your Dependents, in accordance with the terms of the Group Contract. If the Group Contract or Certificate of Coverage contains any provision not in conformity with the Insurance Code Chapter 1271 or other applicable laws, it shall not be rendered invalid but shall be construed and applied as if it were in full compliance with the Insurance Code Chapter 1271 and other applicable laws.

The Group Contract includes the following documents:
- This Certificate of Coverage and any riders attached to the Certificate;
- The Schedule of Copayments attached to this Certificate;
- The forms You and Your Employer filled out to obtain this coverage and
- The Group Contract document provided to the Group Contract Holder, which is Your Employer or an Associated Company of Your Employer.

This form, applications, if any, and any attachements, constitute the entire contract between the parties and that to be valid, any change in the form must be approved by an officer of the HMO and attached to the affected form and that no agent has the authority to change the form or waive any of the provisions.

Covered Employee: You are eligible to become covered under the Group Contract if You are in the "Covered Classes" shown below and meet ERS' rules governing eligibility for coverage. See Part I, Rules Governing Eligibility. ERS also determines when your coverage ends. Rules governing when coverage ends are described generally in Part VIII.G, "When Your Coverage Ends".

Contract Holder: Employees Retirement System of Texas

Group Contract No.: 0010180000

Certificate Date: September 1, 2015, this Certificate describes the benefits under the Group Health Care Coverage as of the Certificate Date.

Covered Classes: All eligible Employees of the Contract Holder, who live, work or reside in the Service Area. All Retirees, who live or reside in the Service Area. All eligibility is determined by The Employees Retirement System of Texas.

Limiting Age for Age 26 for children. An eligible Dependent also includes a child age 26 or over who lives with or has care

Dependents:	provided by the Subscriber, and has been determined to be mentally or physically incapacitated, or a child who is at least 26 years of age and who is unmarried on the date of and following the expiration of the child's continuation coverage under COBRA. This child may continue coverage as a Former COBRA Unmarried Child.	
Service Area:	See Attachment A	
Community First's Address:	Mailing Address:	12238 Silicon Drive, Suite 100 San Antonio, Texas 78249
	Physical Address:	12238 Silicon Drive, Suite 100 San Antonio, Texas 78249
Community First's Telephone Number:	210-227-2347	
Member Services Number:	210-358-6262 or 1-877-698-7032	
Arbitration Provision:	See Section VIII.A.5 of the Certificate.	
Cost of the Coverage:	Your contribution is based on the amount marked below:	

[ ] Both Employee and Dependent Coverage is Contributory Coverage. You will be informed of the amount of Your contribution when You are asked to enroll.

[ ] Both Employee and Dependent Coverage is Non-contributory Coverage. The entire cost of the Coverage is being paid by the Contract Holder.

[X] The Employee Coverage is Non-contributory Coverage.

[X] The Dependent Coverage is Contributory Coverage. You will be informed of the amount of Your contribution when You enroll in the plan.

I. RULES GOVERNING ELIGIBILITY

All determinations and interpretations of membership eligibility and effective dates of coverage for You and Your Dependents shall be made solely by ERS in accordance with the Rules and Regulations of the Board of Trustees of ERS (ERS Rules). Please refer to the definitions of "Eligible Employee," "Dependent" and "Eligible Retiree" in the Definitions section of this Certificate. In general:

- Eligible Employees that reside or work in the Service Area, and Eligible Retirees that reside in the Service Area, may enroll themselves and their Dependents in Community First, in accordance with ERS Rules.

- It is the responsibility of ERS to inform Community First of all changes that affect Member Eligibility, including, but not limited to, marriage of a Dependent, death, address change, birth or adoption of a Dependent, etc.

Please contact Your benefits coordinator concerning all enrollments questions.

II. GROUP HEALTH CARE COVERAGE

A. FOR YOU AND YOUR DEPENDENTS

1. **In General**: This Coverage provides benefits for many of the services and supplies needed for care and treatment of Your or Your eligible Dependents' Illnesses and Injuries, or to maintain Your or Your eligible Dependents' good health, as determined by Your eligible Dependents' respective Primary Care Physician. Not all services and supplies are eligible; some are eligible only to a limited extent.

2. **Primary Care Physician (PCP) Selection**: Once You have chosen Community First, Your next step is to select who will provide the majority of Your and Your eligible Dependents' health care services. Your PCP will be the one You call when You need medical advice, when You are ill and when You need preventive care such as immunizations. Each Covered Person may select his or her own PCP from the Community First Participating Provider directory. However, if You do not choose a PCP, one will be chosen for you. Primary medical care includes the following medical specialties: internal medicine, general, pediatrics and family practice.

   Should You have a chronic, disabling, or Life-Threatening Illness, You may apply to Community First's Medical Director to utilize a

Participating Specialty Physician as a PCP, provided that (1) the request includes information specified by Community First, including certification of medical need, and is signed by You and Participating Specialty Physician interested in serving as the PCP; (2) the Participating Specialty Physician meets, and agrees to abide by the Community First requirements for PCPs; and (3) the Participating Specialty Physician is willing to accept the coordination of all of Your health care needs.

If such request is denied, You may Appeal the decision through Community First's established Complaint and Appeals process. Should such request be approved, the new designation shall not be retroactive and shall in no way reduce the amount of compensation owed to the original PCP prior to the date of the new designation.

3. **OB/GYN Selection.** A female enrollee entitled to coverage shall be permitted direct access without a referral from the female enrollee's PCP or preauthorization from Community First to obtain health care services of a participating obstetrician or gynecologist.

   Please see Community First's Provider Directory on ERS' website at http://www.cfhp.com/ERS

4. **Changing Your Primary Care Physician**: Community First believes that a strong PCP/Member relationship is critical. However, we also realize that there may be a need for a Member to change his/her PCP. If You must change Your PCP, You may do so by calling Community First's Member Services Department. Requests for changes received on or before the 15th of the month will be effective the following month. Requests for changes received after the 15th will take effect the first day of the second month following the change request.

   For example, if You request a change on or before October 15th, the change will become effective November 1st. If You request a change on or after October 16th, the change will become effective December 1st.

B. COVERED SERVICES AND SUPPLIES

1. **In General**: Community First will arrange or provide for benefits for the Covered Services and Supplies set forth in Section 3 of this Part B. Moreover, some services and supplies require an authorization from Community First before services are rendered, which should be handled by your PCP. Member Services is available to assist to determine if services require authorization.

Some services, such as hospital confinements, also require Pre-authorization by Community First.

Emergency Care does not require a referral or preauthorization by Community First; however, some specialists require a referral from your PCP to administer services. You should consult with your PCP to determine if a referral is required to see a particular specialist.

Services that do not ever require a referral include: services from a properly credentialed, participating obstetrician or gynecologist, services received from a participating behavioral health Provider, Vision exams from a participating optometrist, and Family planning services from a participating provider.

All Covered Services rendered by Non-Participating Providers, except in the case of a Medical Emergency, require Pre-authorization by Community First. Pre-authorization is granted on the condition that the Member is eligible for Covered Services at the time the Covered Services are received. Pre-authorization will be denied if the requested supply or service is not a Covered Service or Supply. If You have any questions about whether a Covered Service or Supply requires Pre-authorization, contact Your PCP or Community First's Member Services Department.

Covered Services are those services and supplies furnished to Members as described in the paragraph below. Some Covered Services and/or Supplies below may require review for Medical Necessity prior to Pre-authorization.

a. Covered Services: All Covered Services must be furnished to a Member:

(1) by a PCP;

(2) by a Non-participating Provider if referred by a PCP and authorized by Community First;

(3) by a Participating Specialty Care Physician approved by Community First's Medical Director to perform the services of a PCP pursuant to a request of a Member with a chronic, disabling or Life-Threatening illness; or

(4) by a Participating Obstetrician or Gynecologist as described in II.A.3 above or a Participating behavioral health Provider as described in II.B.1. above.

Pre-authorization may be required to obtain specific services or supplies from a Specialty Care Physician or prior to undergoing hospitalization, outpatient surgery or diagnostic procedures.

If Medically Necessary Covered Services are not available through a Participating Provider, Community First will, at the request of a Participating Provider, and within a reasonable time period, but not to exceed five business days, allow referral to a Non-Participating Provider and shall reimburse the Non-Participating Provider at the Usual and Customary rate or at a negotiated rate. Before such a requested referral can be denied, Community First must have the request reviewed by a specialist of the same or similar specialty as the Physician or provider to whom the referral is requested.

b. After Hours Care: Illnesses and Injuries often do not happen during normal office hours. You may call Your PCPs office 24 hours a day, 7 days a week and You should contact him or her if You need after hours care. If the call is not placed during office hours, You will be assisted by an answering service that will notify the physician on call and advise You on how to proceed.

c. Urgent Care Services:

(1) Urgent Care in the Service Area. In the event of an urgent situation (Illness or Injury) that is severe or painful enough to require assessment and/or treatment within 24 hours, You should contact Your PCP who will direct You to a contracted facility.

(2) Urgent Care Outside the Service Area. Community First will cover Urgent Care obtained from a Physician or licensed facility outside our Service Area if the services cannot safely be delayed until You come back to the service area to obtain care through your PCP. Please see Community First's Provider Directory on ERS' website at http://www.cfhp.com/ERS

You must obtain the services immediately after the urgent condition occurs, or as soon as possible afterward. Community First has 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 for the

non-covered services.

Exceptions to these requirements for Covered Services furnished in connection with Emergency Care for medical conditions occurring inside or outside the Service Area are set forth below.

d. <u>Medical Emergency</u>: Services for a Medical Emergency are covered anywhere in the world 24 hours a day. If a Medical Emergency occurs, Members should go to the nearest participating or non-participating medical facility.

Necessary Emergency Care services will be provided to Members, including the treatment and stabilization of a Medical Emergency, and any medical screening examination or other evaluation required by state or federal law which is necessary to determine if a Medical Emergency exists.

If it is determined that a Medical Emergency does exist, Community First will pay for Emergency Care services performed by non-Participating Providers at negotiated or Usual and Customary rates for the services performed. Community First will approve or deny coverage of post-stabilization care, as requested by a treating provider, within the timeframe appropriate to the circumstances, but in no case to exceed one hour.

Community First will have Pre-authorization staff on duty at phones during regular business hours. If You have received Emergency Care and the Provider who treated You indicates that You will need follow-up care to complete the treatment, the follow-up care must be rendered by a Network provider. The Member, or someone acting on the Member's behalf, should contact the Member's PCP within 24 hours, or as soon as reasonably possible, so that he or she may arrange for follow-up care. All Covered Services rendered by a Non-Participating Provider, except in the case of a Medical Emergency, require Pre-authorization.

Members should not use the Emergency Room or Urgent Care facility for routine or non-emergent services. If you choose to use the Emergency Room or Urgent Care facilities for routine or non-emergent services, then You will be responsible for all billed charges relating to the services. You can use Community First's Complaint and Appeal Process to resolve a dispute regarding Emergency Care.

2. **Member Financial Responsibility**. When accessing authorized Covered Services from a Participating Provider, You will only owe a Copayment and/or Percentage Copayment to that Provider. It is the Member's responsibility to ensure that the Providers from whom You receive services are contracted with Community First.

All services received from a Non-Participating Provider require pre-authorization except for emergency and urgent care. You will be liable for all charges if services are not pre-authorized. If You receive pre-authorized services from a Non-participating Provider, and that Provider has not agreed to a negotiated rate from Community First, then Community First may pay the Usual and Customary charge for the services provided, and You may be responsible for the difference between the amount paid by Community First and the amount of the full charge billed by the Non-participating Provider.

If You pay up front and seek reimbursement for the pre-authorized services you received from a Non-Participating Provider, You will be reimbursed the Usual and Customary charge less the Copayment and/or Percentage Copayment.

You should ask about the contract status of the Providers from whom you receive treatment if You are referred by your PCP to a Specialty Care Physician and when You receive services at a Participating Hospital, as some facility based physicians or other health care practitioners such as anesthesiologists, pathologists, neonatologist, emergency room physicians, and radiologists may not be included in Community First's network. If medically necessary covered services are not available through network physicians or providers, the Health Maintenance Organization shall fully reimburse the non-network physician or provider at the usual and customary rate or at an agreed rate. **If you receive a bill from any Participating Provider asking you to pay for something other than a Copayment or Percentage Copayment, please notify Community First's Member Services Department immediately.**

a. **Premiums:** Members may pay a premium for Plan coverage. The premium amount and payment arrangements are made through Your Employer. A 60 day written notice pursuant to the Insurance Code Chapter 1254 is required prior to any premium modifications.

b. **Copayments:** In addition to any payroll deduction Your Employer may impose, You will be responsible for

appropriate Copayments. The Copayments that apply to certain Covered Services, as well as out-of-pocket maximums, are described in the Schedule of Copayments attached to and made a part of this Certificate. Community First's Participating Providers will look only to Community First and not to You for payment of Covered Services, except for payment of applicable Copayments and Percentage Copayments.

c. **Percentage Copayment:** The portion of the cost of benefits that a Member must pay for certain benefits. For example, if Community First pays for 80% of a covered benefit, Your Percentage Copayment is 20% of the covered benefit. See the Schedule of Copayments.

d. **Services or Supplies that are not Covered under this Certificate of Group Health Care Coverage.** If You receive health care services or supplies that are not Covered Services and Supplies. You will be financially responsible for the entire cost of service.

e. **Unauthorized Services.** You will be financially responsible for the entire cost of service if you:

(1) Obtain health care services, in circumstances other than a Medical Emergency or urgent care, from a Non-participating Provider without preauthorization from Community First; or

(2) Obtain services from a Non-Participating Provider except for the following services, which do not require a referral or Pre-authorization:

(a) Emergency Care;

(b) Accessing care from a Participating Provider who is an obstetrician or gynecologist;

(c) Accessing care from a Participating Provider who is a behavioral health specialist.

3. **Covered Services**: The Covered Services are those that are in the list below. Section 4 of this Part B ("Limitations") describes any modification of these Covered Services for certain Illnesses. A service or supply is not a Covered Service or Supply if excluded. It is excluded to the extent it falls outside any limits described in Section 4 of this Part B ("Limitations") or is described in Section 5 of

this Part B ("Exclusions"). Some Covered Services and/or Supplies below may require review for Medical Necessity prior to services being rendered.

a. **Acquired Brain Injury:** Cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing and treatment, neurofeedback therapy, and remediation required for and related to treatment of an acquired brain injury. Post-acute transition services, 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. Medically necessary treatment and services can be obtained at a hospital including an acute or post-acute rehabilitation hospital or an assisted living facility regulated under Chapter 247, Health and Safety Code.

   Also covered are reasonable expenses related to periodic reevaluation of the care provided to a member who has incurred an acquired brain injury, has been unresponsive to treatment and becomes responsive to treatment at a later date. Acquired Brain Injury Copayments/Percentage Copayments and limitations are covered the same as any other illness. See Definitions.

b. **Allergy and Treatment.** Medically Necessary allergy testing to evaluate and determine the cause of allergy and appropriate allergy treatments including injections and serum. Please see exclusions and Schedule of Copayments.

c. **Ambulance Services.** Emergency ground or air ambulance transportation when Medically Necessary.

d. **Amino Acid-Based Elemental Formula**. Medically necessary diagnosis and treatment is covered for the following diseases or disorders:

   (1) immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
   (2) severe food protein-induced enterocolitis syndrome;
   (3) eosinophilic disorders, as evidenced by the results of a biopsy; and

(4) impaired absorption of nutrients caused by disorders affecting the absorporation surface, functional length, and mobility of the gastrointestinal tract.

e. **Anesthetics** and their administration.

f. **Asthma.** Treatment, care and supplies related to asthma, as provided or prescribed by a Participating Physician or other qualified Participating Provider.

g. **Autism Spectrum Disorder.** The Plan will cover medically necessary services that are generally recognized services when prescribed by the members PCP or Network specialist. The plan will provide coverage at a minimum from the date of diagnosis only if the diagnosis was in place prior to the child's tenth birthday.
Generally recognized services may include:

(1) evaluation and assessment services;
(2) applied behavior analysis;
(3) behavior training and behavior management;
(4) speech therapy;
(5) occupational therapy;
(6) physical therapy; or
(7) medications or nutritional supplements used to address symptoms of autism spectrum disorder.

An individual providing treatment prescribed (under such statute) must be a health care practitioner who is licensed, certified, or an individual acting under the supervision of a licensed, certified health care practitioner; or registered by an appropriate agency of this state; whose professional credential is recognized and accepted by an appropriate agency of the United States; or who is certified as a provider under the TRICARE military health system. Autism Spectrum Disorder Copayments/Percentage Copayments and limitations are covered the same as any other illness. See Exclusions.

h. **Biofeedback therapy** is covered when it is reasonable and Medically Necessary for the individual for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness, and conventional treatments (heat, cold, massage, exercise, support) have not been successful. See Exclusions.

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i. **Blood and Blood Derivatives**. Including administration, when prescribed by a Participating Provider and determined to be Medically Necessary by Community First.

j. **Breast Cancer Treatment.** Diagnosis and treatment including coverage for inpatient care for a Member for a minimum of:

(1) 48 hours following a mastectomy; and
(2) 24 hours following a lymph node dissection for the treatment of breast cancer;

unless the Member and the attending physician determine that a shorter period of inpatient care is appropriate.

k. **Chemotherapy, Radiation Therapy.** Treatment by X-ray, radium or any other radioactive substance, or by chemotherapy.

l**.** **Clinical Trials:** Medically necessary routine patient care costs incurred in connection with a phase I, phase II, phase III, or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of a life-threatening disease or condition and is approved by:

(1) the Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
(2) the National Institutes of Health;
(3) the United States Food and Drug Administration;
(4) the United States Department of Defense;
(5) the United States Department of Veterans Affairs; or
(6) an institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

Routine patient care costs are any medically necessary health care service for which benefits are provided under the plan without regard to whether the member is participating in a clinical trial.

Routine patient care costs do not include:

(2) the cost of an investigational new drug or device that is not approved for any indication by the United States Food and Drug Administration, including a drug or device that is the subject of the clinical trial;
(3) the cost of a service that is not a health care service,

regardless of whether the service is required in connection with participation in a clinical trial;

(4) the cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

(5) a cost associated with managing a clinical trial;

(6) the cost of a health care service that is specifically excluded from coverage under a health benefit plan.

Community First will not cover benefits and services that are customarily paid for by the research institution conducting the clinical trial. Community First will not cover benefits and services conducted outside of our service area or the state of Texas unless authorized by Community First.

m. **Cochlear Implant.** See Schedule of Copayments, Prostheses.

n. **Chemical Dependency**. Medically Necessary care and treatment of Chemical Dependency will be covered the same as any other physical illness. Treatment could also include treatment under the direction and continued medical supervision of a doctor of medicine or doctor of osteopathy in a Residential Treatment and/or Psychiatric Day Treatment Facility.

o. **Dental Treatment:**

Services that Must Be Performed in a Hospital Setting. Community First will cover certain services provided to a Member who is unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental, or medical reason as determined by the Member's PCP or Network specialist, and the dentist. These services include the hospital or facility, and/or anesthesia charges only. The Dentist, Oral Surgeon and any assisting Dentist or Oral Surgeon charges are not covered.

Accidental Dental - restoration or replacement of dental work that was in place at the time of the injury, including, but not limited to, crowns, veneers, bridges, and implants, occurring while covered under the plan for services provided within 24 months of the date of the accident. Certain oral surgeries are covered.

p. **Diabetes Care**. Covered Services and Supplies include diabetes treatment, equipment, supplies, medications and self-management training prescribed or provided by a

Participating Provider. Diabetes equipment includes, but is not limited to, blood glucose monitors, including monitors designed to be used by blind individuals; insulin pumps and associated appurtenances; insulin infusion devices; and podiatric appliances for the prevention of complications associated with diabetes.

Biohazard disposal containers.

Repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer's warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump.

Diabetes supplies include, but are not limited to, test strips for blood glucose monitors; visual reading and urine test strips; lancets and lancet devices; injection aids; syringes; glucagon emergency kits and alcohol wipes. The supply of necessary disposable syringes for the insulin supply will be provided for one Copayment/ Percentage Copayments. Diabetic supplies will include up to a thirty (30) day supply for one Copayment/Percentage Copayment at a retail store or up to a ninety (90) day supply through mail order.

Diabetes medications include, but are not limited to, insulin and insulin analogs; prescriptive and non-prescriptive oral agents for controlling blood sugar levels. Up to a thirty (30) day supply of insulin will be provided for one Copayment/Percentage Copayment at a retail store or up to a ninety (90) day supply through mail order.

q. **Diagnostic Laboratory and Radiological Services** including professional fees. Such diagnostic services include mammography services and therapeutic radiology services. See High Tech Radiology.

r. **Durable Medical Equipment**. Rental or purchase that is Medically Necessary and approved by Community First. Coverage is provided for the initial equipment only and for standard equipment. Special features that are not part of the basic equipment are not covered, such as electric beds and electric wheelchairs, unless determined to be Medically Necessary. Benefits for rental are limited to, and will not exceed, the purchase price of the equipment. For equipment purchased at Community First's option, this item

includes repair if not due to neglect or abuse, and necessary maintenance of purchased equipment not provided under a manufacturer's warranty or a purchase agreement.

s. **Eye Exam.** One annual eye exam per plan year, including dilation of the eye, by a Doctor of Ophthalmology or a Doctor of Optometry which, when within the scope of their license, includes such services as:

(1) external examination of the eye and its structure;
(2) determination of refractive status; and
(3) Glaucoma screening test.

The Member is responsible for any additional charges for services associated with contact lenses, including but not limited to, contact lens eye exams, contact lens fittings and follow up care.

t. **Family Planning and Infertility Services** related to the diagnosis of infertility shall be provided as Medically Necessary and as prescribed and authorized by a participating provider and includes the following services:

(1) counseling;
(2) sex education instruction in accordance with medically acceptable standards;
(3) contraceptive devices;
(4) placement of contraceptive devices;
(5) diagnostic procedures to determine the cause of infertility and some natural curative treatments;
(6) vasectomies;
(7) tubal ligations and laparoscopies;
(8) infertility drugs – see Schedule of Copayments for limitations.

u. **Foot Care.** Services and supplies for the care and treatment of diseases of, or injuries to, the feet, when prescribed by the PCP or Network Specialist and determined to be Medically Necessary by Community First. Shoe orthotics, insoles, shoe inserts or other supportive devices of the feet are covered only when prescribed as part of a treatment plan for someone with a primary diagnosis of diabetes or circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency. Orthopedic shoes are covered only when the shoe is an integral part of a

medically necessary leg brace. Covered foot orthotics is limited to two per plan year and shoes are limited to two pair per plan year.

v. **Formulas.** Dietary formulas, including over-the-counter products and amino acid-based elemental formulas, if medically necessary for the treatment of Phenylketonuria and other Heritable Diseases for which a prescription is necessary for purchase. All other dietary over-the-counter formulas are excluded from coverage. See Exclusions.

w. **Genetic Testing and Counseling.**

x. **Habilitative Services for Developmental Delays.** Benefits are provided for habilitative services provided on an outpatient basis for Members with a congenital, genetic, or early acquired disorder when both of the following conditions are met:

(1) The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.
(2) The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Member to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Member reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed and that the Member's condition is clinically improving as a result of the habilitative service. When the treating provider anticipates that continued treatment is or will be required to permit the Member to achieve demonstrable progress, Community First may request a

treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

Rehabilitive and habilitive therapies for developmental delays does not prohibit or restrict payment for covered services provided to a child and determined to be necessary and provided in accordance with an individualized family service plan issued by the Interagency Council on Early Childhood Intervention.

For purposes of this benefit, the following definitions apply:

- **Habilitative services** means occupational therapy, physical therapy and speech therapy prescribed by the Member's treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.
- A **congenital or genetic disorder** includes, but is not limited to, hereditary disorders.
- An **early acquired disorder** refers to a disorder resulting from Sickness, Injury, trauma or some other event or condition suffered by a Member prior to that Member developing functional life skills such as, but not limited to, walking, talking, or self-help skills.

y. **Health Education**. Services including, but not limited to the following:

(1) Information about Community First's Covered Services, including recommendations on generally accepted medical standards for the use and frequency of such services;

(2) Diabetes self-management training provided by a Participating Provider who is licensed in Texas to provide such services. Self-management training includes, but is not limited to:

(a) training provided to a Member after the initial diagnosis of diabetes in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies;

(b) additional training required as a result of a significant change in the Member's symptoms or condition;

(c) periodic continuing education training when prescribed by a Participating Physician as warranted by the development of new techniques and treatments for diabetes;

(d) All diabetes self-management training is subject to Medical Director review.

(3) Other disease-specific health education programs provided by or approved by Community First;

(4) Prenatal education materials provided by Community First; and.

(5) Nutritional counseling and education provided by or approved by Community First.

z. **Hearing Aids and Batteries.** Benefit Limited to $1,000 per ear every three (3) years. Repairs not covered. Batteries are not subject to any dollar maximum. See Schedule of Copayments for limitations.

aa. **High Tech Radiology.** CT Scans, MRI's and nuclear medicine. See Schedule of Copayments.

ab. **Home Health Care Services.** Skilled nursing provided by or supervised by a registered nurse (R.N.). The services must be provided by a participating home health agency; your PCP or Network Specialist refers You or arranges the services and is pre-authorized by Community First. Services may include physical, occupational, speech or respiratory therapy; the service of home health aides under the supervision of an RN; medical social services under the supervision of an RN, and the provision of medical supplies.

ac. **Hospice Care Services and Supplies**. Covered if authorized by a Participating Physician as part of a Hospice Care Program for a member who is Terminally-ill.

(1) Hospice care services including pain relief, symptom management and supportive services to terminally ill Members and their immediate families on both an outpatient and inpatient basis; and

(2) Counseling Services provided by members of a Hospice Team.

ad. **Hospital Inpatient Services and Supplies.** Semi-private room and board. This includes general nursing care, meals

and special diets when medically necessary, use of operating room and related facilities, intensive care services, X-ray services, laboratory and diagnostic test, drugs, medications, biologicals, anesthesia, oxygen services, special duty nursing when medically necessary, radiation and inhalation therapy, administration of whole blood and blood plasma and short-term rehabilitation therapy services.

For any day on which a PCP or network specialist authorizes the person's stay in a private room in a Hospital that has no semi-private rooms, Hospital private room and board, including normal daily services and supplies will be included as eligible Services and Supplies. Hospital private room and board, including normal daily services and supplies, will also be included as eligible Services and Supplies for any day on which:

(1) the person is being isolated in a private room because of the person's communicable disease; or
(2) use of a private room is Medically Necessary, as determined by Community First, for treatment of the person's Illness or Injury.

ae. **Hospital Outpatient Services and Supplies**. Covered Services in connection with surgical treatment, including pre-admission testing and/or treatment room, operating room and treatment, medical supplies such as splints and casts, and non-experimental drugs and medications furnished by and administered at the Hospital or facility.

af. **Implantable Devices**. An object or device that is surgically implanted, embedded, inserted or otherwise applied and related equipment necessary to operate, program and recharge the implantable.

ag. **Inhalation therapy.**

ah. **Injectable / Specialty Medications**. Medically Necessary injectable drugs administered by a Participating Provider.

(1) Some medications are subject to age limitations. See Exclusions and Schedule of Copayments.

ai. **Inpatient Physician Care Services.** Services performed, prescribed, or supervised by physicians or other healthprofessionals including diagnostic, therapeutic,

medical, surgical, preventive, referral and consultative health care services.

aj. **Maternity Care.** The maternity benefit offers coverage for prenatal services, delivery and post delivery care for a mother and her newborn child in a health care facility.

The following coverage is provided for a mother and newborn for a minimum of:

(1) 48 hours following an uncomplicated vaginal delivery; and
(2) 96 hours following an uncomplicated delivery by caesarean section;

unless the Member and her attending physician determine that a shorter period of inpatient care is appropriate. Complications of pregnancy will not be treated differently than any other illness or sickness under the policy.

ak. **Special Dependent Coverage Rules for Newborn and Adopted Children**: A child born to You, an Adopted child or a child that is the subject of a suit for adoption by You while You are covered under your Group Health Coverage, will be covered from either the date of the child's birth for 31 days after the birth or suit for adoption commences for the child.

The coverage for the child will not continue beyond the end of that thirty-one (31) day period unless, before the end of that period, You have notified Community First of the birth and paid any additional monthly premium owe for the added dependent coverage. **If You do not provide notice to Community First of the birth, coverage for the Child terminates on the 32nd day after the birth.**

al. **Outpatient Mental Health.** Services performed, prescribed, or supervised by physicians as may be necessary and appropriate for short-term evaluative or crisis intervention mental health services or both. Covered as any other illness for inpatient mental health coverage, see the Mental or Emotional Illness or Disorder and Alternative Mental Health Treatment Rider.

am. **Outpatient Services.** Outpatient services covered include primary care and specialists services and services by other providers.

an. **Ophthalmological Services.** Covered Services and Supplies needed for the diagnosis and treatment of diseases of, or injury to, the eye.

ao. **Organ Transplant Services.** Covered medical services including evaluation and supplies for Medically Necessary and appropriate transplant services including:

(1) Heart transplant
(2) Lung transplant
(3) Heart/Lung transplant
(4) Kidney transplant
(5) Kidney/pancreas transplant
(6) Liver transplant
(7) Liver/small bowel transplant
(8) Pancreas transplant
(9) Small bowel transplant
(9) Corneal transplant
(10) Bone marrow transplant for aplastic anemia, leukemia, severe combined immuno-deficiency disease, and Wiskott Aldrich syndrome.

The costs of artificial organs are excluded from coverage. Services or procedures considered experimental and/or investigational under current medical policy guidelines also are excluded. See Exclusions.

Donor costs are covered. Community First will not require that a Member travel out-of-state to receive transplant services unless the informed consent of the Member has been obtained, which explains the benefits and detriments of in-state and out-of-state options.

If the Member satisfies medical criteria developed by Community First for receiving transplant services. Community First will provide a written authorization for care to a transplant facility selected by Community First from a list of facilities it has approved. If, after referral, either Community First or the medical staff of the referral facility determines that the Member does not satisfy its respective criteria for the services involved, Community First's obligation is limited to paying for Covered Services provided prior to such determination according to the Schedule of Copayments.

ap. **Orthotics (excluding foot orthotics/inserts, see Foot Care).** Prescribed by a Participating Provider and

determined to be Medically Necessary by Community First. Repair and replacement is covered unless due to misuse or loss. See Schedule of Copayments and Exclusions.

aq. **Oxygen and Rental of Equipment for use of Oxygen,** when Medically Necessary and prescribed by a Participating Physician.

ar. **Pain Management Services.** Medically Necessary pain management treatment and related services that are ordered by a participating provider and preauthorized by Community First. Services can be expected to meet or exceed treatment goals and are scientifically proven and evidence-based to improve Your medical condition.

as. **Physicians' Services** for surgical procedures and for other medical care.

at. **Preventive Health Services**. The following preventive health services are covered (this list is not exclusive).

Newborns

(1) Screening for hearing loss, hypothyroidism, sickle cell disease, and phenylketonuria (PKU)
(2) Gonorrhea preventative medication for eyes

General Health Screenings

(1) Well-baby and child care including childhood screening tests for hearing loss, as required by law, from birth through the date the child is 30 days old and any necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old.
(2) Annual eye and ear examination for members to determine the need for vision and hearing correction.
(3) General Health Screenings for children:
    a. Medical history for all children throughout development
    b. Height, weight and body mass index (BMI) measurements
    c. Developemental screening
    d. Autism screening (at age 18 months and 24 months)
    e. Behavioral assessment
    f. Visual acuity screening

g. Oral health risk assessment
h. Hematocrit or hemoglobin screening
i. Obesity Screening and weight management couseling
j. Lead screening
k. Dyslipidemia screening
l. Tuberculin testing
m. Depression screening
n. Alcohol and drug use assessment
o. Counseling to prevent sexually transmitted infections (STIs)
p. HIV screening
o. Blood pressure screening

(4) Pediatric and adult immunizations in accordance with Community First clinical guidelines and/or as required by law:
a. Diptheria, Tetanus, Pertussis
b. Haemophilus influenza type B
c. Hepatitis A and B
d. Human Papillomavirus (HPV)
e. Influenza (Flu)
f. Measles, Mumps and rubella
g. Meningoccal
h. Pneumococcal (pneumonia)
i. Inactivated Poliovirus
j. Rotavirus
k. Varicella (chicken pox)

(5) Periodic adult health screenings, including:
a. Annual well-woman exam including, but not limited to, periodic screening for breast (mammography) and cervical cancer for women 18 years of age or older. A conventional pap smear screening or a screening using liquid-based cytology methods alone or in combination with a test for the detection of the human papilloma virus. A ovarian cancer blood test (CA-125).
b. Annual diagnostic testing for the detection of prostate cancer. Coverage is provided for (a) a physical examination for the detection of prostate cancer, and (b) a prostate-specific antigen (PSA) test used for the detection of prostate cancer for each male who is at least 40 years of age.

(6) For eligible individuals, medically accepted bone mass measurement for the detection of low bone mass and to determine the risk of osteoporosis and

fractures associated with osteoporosis. Eligible individual means:

(a) postmenopausal woman who is not receiving estrogen replacement therapy;

(b) an individual with:

  (1) vertebral abnormalities;

  (2) primary hyperparathyroidism; or

  (3) a history of bone fractures; or

(c) an individual who is:

  (1) receiving long-term glucocorticoid therapy; or

  (2) being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

(7) Medically Necessary screenings for colorectal cancer for members 50 years of age or older and at normal risk for developing colon cancer. Members can choose from (1) a fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years or (2) a colonoscopy performed every ten years.

(8) Medically necessary screening for cardiovascular disease.

(9) Screening for cardiovascular disease for a male older than 45 years of age and younger than 76 or female older than 55 years of age and younger than 76 who is diabetic or has an intermediate or higher risk of developing coronary heart disease. Screening tests performed every 5 years to include (1) computed tomography (CT) scanning measuring artery calcification or (2) ultrasonography measuring carotid intima-media thickness and plaque.

(10) Blood Pressure screening

(11) Cholesterol screening

(12) Type 2 diabetes screening

(13) HIV and STI screenings

(14) For men, abdominal aortic aneurysm one-time screening

(15) For women:

  a. Osteoporosis screening

  b. Chlamydia infection screening

  c Gonorrhea and syphilis screening

  d. BRCA counseling about genetic testing

(16) Pregnant Women:

  a. Anemia screening for Iron deficiency

  b. Tobacco cessation counseling

  c. Syphilis screening

d. Hepatitis B screening
e. Rh incompatibility blood type testing
f. Bacteriuria urinary tract infection screening
g. Breastfeeing education

17. Doctors are encouraged to counsel patients about these health issues and refer them to appropriate resources as needed:
    a. Healthy diet
    b. Weight loss
    c. Tobacco use
    d. Alcohol misuse
    e. Depression
    f. Prevention of STIs
    g. Use of aspirin to prevent cardiovascular disease
    h. Immunizations
    i. Hepatitis A and B
    j. Herpes Zoster
    k. Human Papillomavirus (HPV)
    l. Influenza (flu)
    m. Measles, mumps and rubella
    n. Meningococcal
    o. Pneumococcal (pneumonia)
    p. Tetanus, Diptheria, Pertussis
    q. Varicella (chicken pox)

    Note: Under the Affordable Care Act, certain preventive health services are paid at 100% including, but not limited to: Well Woman exam, Tests for detection of colorectal cancer, coverage for cervical cancer, benefits or detection and prevention of osteoporosis at no cost to the member dependent upon physician billing and diagnosis. In some cases, you will be responsible for payment of some services. Specifically (1) if a recommended preventive service is billed separately from an office visit, then a plan may impose cost-sharing requirements with respect to the office visit, (2) if a recommended preventive service is not billed separately from an office visit and the primary purpose of the office visit is the delivery of a preventive service, then a plan may not impose cost-sharing requirements with respect to the office visit, and (3) if a recommended preventive service is not billed separately from an office visit and the primary purpose of the office visit is not the delivery of a preventive service, then a plan may impose cost-sharing requirements with respect to the office visit.

as. **Prostheses**. An external or removable artificial device that replaces a body part (e.g. prosthetic arms, legs and eyes) and is determined by Community First to be Medically Necessary. The benefit includes repair and replacement unless the repair or replacement is necessitated by misuse or loss by the member.See Schedule of Copayments.

at. **Reconstructive Surgery after Mastectomy**. Surgery to provide coverage for (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to achieve a symmetrical appearance; and (3) prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

au. **Reconstructive Surgery for Craniofacial Abnormalities in a Child younger than 18 years old.** Surgery determined by Community First to be Medically Necessary to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease. See Exclusions.

av. **Rehabilitative Services.** Including physical, occupational, hearing and speech therapy, dietary or nutritional evaluations when ordered by a Participating Physician. Rehabilitative services and therapies that are Medically Necessary in the opinion of the physician may not be denied, limited, or terminated if they meet or exceed treatment goals for the person needing such services.

For a physically-disabled person, treatment goals should include improvement or maintenance of functioning or prevention of or slowing of further deterioration. Covered Services for speech or hearing therapy are limited to therapy that is provided by a qualified speech therapist or audiologist for loss or impairment of speech or hearing.

Rehabilitive and habilitive therapies for developmental delays does not prohibit or restrict payment for covered services provided to a child and determined to be necessary and provided in accordance with an individualized family service plan issued by the Interagency Council on Early Childhood Intervention.

aw. **Renal Dialysis.** Services and supplies furnished in connection with dialysis for chronic renal disease.

ax. **Respiratory Therapy.**

ay. **Serious Mental Illness.** Acute inpatient and outpatient covered services/supplies for the treatment of serious mental illness. Covered as any other illness. See Schedule of Copayments.

az. **Sexually-transmitted Diseases (STD).** Education, diagnosis and treatment for STDs, including HIV, AIDS, and AIDS-related illnesses.

ba. **Skilled Nursing Facility Services.** Covered Services and Supplies for up to 60 days per plan year including:

(1) If You were not admitted to a Skilled Nursing Facility, You would need acute care hospitalization;

(2) The skilled nursing services are of a temporary nature and will lead to rehabilitation and increased ability to function; and

(3) Your PCP or other Network Specialist refers You and certifies that the Member needs 24-hour-a-day nursing care.

bb**.** **Smoking Cessation** service or supply furnished to assist with smoking cessation program. See Schedule of Copayments.

bc. **Speech and Rehabilitative Therapy.** Medically Necessary therapy to treat loss or impairment of speech and hearing are covered the same as any other physical Illness. Hearing aids and batteries are a covered benefit. See Schedule of Copayments.

bd. **Supplies.** Prescribed by a Participating Provider and determined to be Medically Necessary and appropriate by Community First. Medical supplies are non-reusable, disposable, and are not useful in the absence of Illness or Injury.

To be considered "Medically Necessary" or "appropriate" a medical supply must be determined by Community First to meet all of these conditions, and must not be listed under Exclusions. The supply (ies):

(1) must be part of a Participating Provider's treatment plan;
(2) must be based on current treatment protocols;
(3) must be obtained from a Participating Provider;
(4) must be required such that its omission would adversely affect the Member's health;
(5) must be recognized as safe and effective for its intended use; and
(6) must be used in a manner that is consistent with generally accepted United States medical standards or guidelines.

Examples of medical supplies may include, but not be limited to, diabetic supplies, ostomy supplies, Jobst stockings, sterile dressings and urinary catheters. See Exclusions.

be. **Telemedicine.** Services provided through Telehealth Services and Telemedicine Medical Services, to the extent that coverage is required by Section 1455.004 of the Texas Insurance Code.

bf. **Temporomandibular Joint (TMJ)**. Medically Necessary services for the diagnosis and/or medical/surgical treatment of conditions affecting the temporomandibular joint which includes the jaw or craniomandibular joint resulting from an accident, trauma, congenital defect, developmental defect or a pathology

bg. **Wigs** are covered when determined to be Medically Necessary.

4. **Limitations**: This Section describes limits for the Covered Services under Section 3 above. It also describes any modifications of those Covered Services for certain Illnesses.

a. *Major Disaster or Epidemic*. Community First will consistently make a good faith effort to provide or arrange for Covered Services, taking into account existing conditions and events. If there is a major disaster or an epidemic, Community First will provide or arrange for Covered Services to the extent possible or practical. Neither Community First nor any Participating Provider will have any liability or obligation on account of delay or failure to provide or arrange for Covered Services.

b. *Circumstances Beyond the Control of Community First or Participating Providers*. Due to circumstances not within the

control of Community First or Participating Providers, there may be a delay in providing or arranging for Covered Services or it may not be practical or possible to do so. Community First nor any Participating Provider will have any liability or obligation on account of delay or failure to provide or arrange for Covered Services if a good faith effort has been made to do so. Some examples of such circumstances are: complete or partial destruction of facilities because of war, riot, natural disasters or civil insurrection; the disability of a significant number of Participating Providers; and other similar causes.

c. *Continuity of Treatment in the Event of the Termination of a PCP*. Community First will notify You no less than thirty (30) days in advance if a Participating Physician or other provider treating You is going to be leaving the Community First network. If the Physician or other provider is treating You under a "special circumstance" and the treating Physician or provider makes the request, then Community First will continue to compensate the Physician or other provider, on Your behalf, for up to ninety (90) days. "Special circumstance" means a condition such that Your Physician or provider reasonably believes discontinuation of care could cause harm to You. Examples include:

(1) A person who has a disability;
(2) A person with an acute condition;
(3) A person with a Life-threatening Illness;
(4) A person who is past the twenty-fourth week of pregnancy at time of termination of the provider and until delivery of the child and immediate postpartum care and six-week checkup; or
(5) A person who has been diagnosed with a terminal illness at the time the provider terminated, Community First will reimburse the provider up to nine (9) months after the effective date of termination.

d. *Non-participating Provider and Out-of-Area Services and Benefits*. Only Emergency Care services are covered outside the Community First's network and/or Service Area, unless Medically Necessary Covered Services are not available through Community First's network of Participating Providers, or in the case of Court-Ordered Dependent Coverage. If Medically Necessary Covered Services are not available through Community First's Participating Providers, Community First will, at the request of a Participating Provider and within a reasonable time period, but not to

exceed five (5) business days, allow referral to a Non-Participating Provider.

5. **Exclusions**: All services and benefits for care and conditions within each of the following classifications shall be excluded from coverage:

   a. **Abortion Services.** Unless determined to be Medically Necessary to preserve the life of the mother.

   b**.** **Artificial Internal Organs and Animal Organs.**

   c. **Allergy Testing, treatment and sera (plural of serum) for food allergies.**

   d. **Allowable Cost of Covered Services.** Coverage normally provided for a Covered Service may not be applied toward the cost of a non-Covered Service or Supply.

   e. **Alternative Treatments** that includes but is not limited to accupressure, acupuncture, aromatherapy, hypnotism, massage therapy, rolfing, art therapy, music therapy, dance therapy and horseback therapy.

   f. **Ambulance Services.** Transport services for non-emergency conditions unless preauthorized.

   g**.** **Assisted Living Facility Room and Board** for Acquired Brain Injury when the participant is capable of living at home and only needs a structured day program and when 24 hour care is not medically necessary.

   h. **Autism Spectrum Disorder**. Services considered to be investigational or experimental are not covered if they fall outside the scope of generally recognized services.

   i. **Biofeedback Therapy.** Excluded for the treatment of ordinary tension and muscle-contraction headaches or psychosomatic conditions.

   j. **Charges for broken appointments.**

   k. **Charges for completion of any forms.**

   l. **Charges made by the Employer or a close relative**. Services or supplies furnished by:

(1) the Employer; or
(2) You, Your spouse, or a child, brother, sister, or parent of You or Your spouse.

m. **Chelation Therapy** except when used in the treatment of heavy metal poisoning.

n. **Chemical Dependency** aftercare services including but not limited to, AA/NA, support or education groups, and/or other services that primarily focus on relapse prevention to the Member who completed treatment and/or their family members.

o. **Chiropractic Care.** Services and supplies furnished in connection with correction, by manual or mechanical means, of subluxation of the spine.

p. **Clothing, Shoes and Diapers** unless specifically covered by this Certificate (e.g., correctional shoes or inserts associated with diabetes are covered, see Section II.B. Covered Services and Supplies, Foot Care.).

q**.** **Corrective Appliances and Artificial Aids**. Including, but not limited to, communications devices, eyeglasses or contact lenses of any type except for treatment of keratoconus and initial replacements for loss of the natural lens.

r**.** **Cosmetic Surgery**. Services and supplies, including cosmetic surgery and any complications therefrom, furnished mainly to change a person's appearance are excluded. This includes surgery performed to treat a mental, psychoneurotic or personality disorder through change in appearance, subject to review for Medical Necessity and appropriateness.

s. **Custodial Care.** Services or supplies furnished in connection with Custodial Care.

t. **Dental care, Oral Surgery or Treatment of Teeth or Periodontium.** Services and supplies not covered unless the services (i) are for Medically Necessary diagnostic and/or surgical treatment of the temporomandibular (jaw or craniomandibular) joint (TMJ); or (ii) are received in connection with an Injury to sound natural teeth or dental work that was in place at the time of the injury, including, but not limited to, crowns, veneers, bridges, and implants, occurring while covered under the plan for services provided

within 24 months of the date of the accident. This excludes an injury resulting from biting or chewing. See Section II.B, Covered Services and Supplies, Dental Treatment.

Dental braces or any treatment related to the preparation or fitting of dentures are not covered, unless covered by a Rider to the Group Contract. Oral appliances and devices to treat bruxism, or as part of an orthodontia care plan are not covered, unless covered by a Rider to the Group Contract. Dental implants are covered if needed after an injury.

Community First will not exclude a member from coverage who is unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental, or medical reason as determined by the Member's PCP or Network Specialist and the dentist.

u. **Diagnostic Tests** to establish paternity of a child and tests to determine sex of an unborn child.

v. **Educational Testing and Therapy**, motor or language skills or services that are educational in nature or are for vocational testing or training. See Section II.B Covered Services and Supplies, Autism Spectrum Disorder.

w. **Electric Beds and Electric Wheel Chair** Unless determined to be Medically Necessary.

x. **Environmental consultations and modifications**. Consultations of an environmental engineer, air conditioners, humidifiers, dehumidifiers, purifiers, elevators and chair lifts.

y. **Experimental or Investigational Services and Supplies.** Including new and emerging health care technologies that are determined by Community First to be Experimental or Investigational.

Community First may, however, deem an Experimental or Investigational service or supply covered for treating a Life-Threatening Illness or condition if it is determined by Community First, through an Ombudsman Program, that the Experimental or Investigational service or supply at the time of the determination:

(1) is proved to be safe with promising efficacy; and
(2) is provided in a clinically controlled research setting; and

(3) uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

See II.B. Covered Services and Supplies, Clinical Trials.

z. **Eye Surgery.** Services and supplies furnished in connection with eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).

aa. **Foot Care.** Routine foot care, treatment of flat feet and treatment of subluxations of the feet are excluded. Orthopedic shoes are not covered, except as part of an integral part of a medically necessary leg brace. This does not include treatment of fractures or other acute injuries. See Section II. B. Covered Services and Supplies, Foot Care.

ab. **Home and Automobile Modifications or Improvements** even when necessary to accommodate installation of Covered Services or to facilitate entrance or exit.

ac. **Hospital Private Room** unless determined to be Medically Necessary by Community First. See Section II.B. Covered Services and Supplies, Hospital Inpatient Services and Supplies.

ad. **Infertility Diagnosis and Treatment.** Services or supplies furnished in connection with any procedures which involve harvesting, storage and/or manipulation of eggs and sperm for in-vitro fertilization. Other procedures excluded, but are not limited to:

(1) In-vitro fertilization;
(2) Artificial insemination;
(3) Gamete or zygote intrafallopian transfer and similar procedures;
(4) Reversal of voluntarily induced sterility;
(5) Surrogate parent services and fertilizations;
(6) Donor egg or sperm;
(7) Embryo transfer; and
(8) Embryo freezing.

Infertility benefits also excluded from coverage include transsexual surgery, gender reassignment, and any services or supplies used in any procedures performed in preparation

for or immediately after any of the above-referenced excluded procedures.

ae. **Infertility Drugs.** Drug therapy for infertility which involves:

(1) non-FDA approved indications;
(2) non-standard dosages, length of treatment, or cycles of therapy; or
(3) in-vitro fertilization procedures.

af. **Injectable / Specialty Medications** which have not been proven safe and effective for a specific disease or approved for a mode of treatment by the Food and Drug Administration and the National Institute of Health.

ag. **Manipulative Therapy.** Services and supplies furnished in connection with correction, by manual or mechanical means, of subluxation of the spine.

ah. **Medical record charges** associated with copying or transferring medical records.

ai. **Military Service Connected Disabilities**. Care for military service-connected disabilities and conditions for which a member is legally entitled to services and for which facilities are reasonably accessible. Services that are provided to members of the armed forces and the National Health Service or to individuals in Veterans Administration facilities for military service-related illness or injury, unless a member has the legal obligation to pay.

aj. **Newborn Baby.** Any charges incurred by a non-enrolled newborn baby beyond thirty-one (31) days of its birth, unless the parent Member notifies Community First and the Contract Holder during the initial thirty-one (31) days after the birth of the child.

ak. **Obesity.** All treatment, services, surgical or invasive procedures or complications arising from or connected in any way, for treatment of obesity are excluded. Excluded services include, but are not limited to: services and supplies, furnished in connection with any weight loss program or food supplements used to achieve weight loss, liposuction, jejunal bypass and balloon procedures

al. **Over-the-counter Medications and Supplies.** Any care, treatment, service, supply or item that is available without a Physician's recommendation or written prescription, including a dietary formula, is excluded unless expressly covered by this Certificate of Group Health Care Coverage (e.g., over-the-counter diabetic supplies are covered and Copayments/Percentage Copayment will count toward Your out-of-pocket maximum, as are dietary formulas necessary for the treatment of Phenylketonuria, amino acid-based formulas, and other Heritable Diseases). Examples of over-the-counter items not covered: band-aids, tape, gauze bandages, ACE bandages, elastic joint supports, TED hose, paper towels, etc.

am. **Personal Comfort Items.** Including but not limited to, personal care kits provided on Admission, telephone, newborn infant photographs, meals for guests of the patient, cots, maternity and paternity kits, and other articles which are not determined to be Medically Necessary or appropriate for the specific treatment of the Illness or Injury.

an. **Physical Examinations** provided solely for the purposes of travel, employment or school.

ao. **Public Facility** Care for conditions that Federal, State or local law requires be treated in a public facility; care provided under federally or state funded health care programs, except the Medicaid and Children's Health Insurance program; care required by a public entity; care for which there would not normally be a charge.

ap. **Reconstructive Surgery for Craniofacial Abnormalities for anyone 18 years of age or older.** *See* Section II.B. Covered Services and Supplies**.**

aq**.** **Recreational and sleep therapy**, including any related diagnostic services.

ar. **Reduction Mammoplasty** for cosmetic purposes, except for post-mastectomy reduction of the unaffected breast to achieve a symmetrical appearance.

as. **School-based Therapy Services.**

at. **Services and Supplies** that meet the following conditions:

(1) Unnecessary services and supplies that are not Medically Necessary or appropriate for the diagnosis and/or treatment of an Illness or Injury. Examples are rubber sheets, incontinent pads, diapers, non-sterile rubber gloves, emesis basins, body powder, etc.
(2) Required by a court decree regarding a divorce action, a motor vehicle violation or other judgment not directly related to this Coverage, if they would not be covered in the absence of such a decree.
(3) Related to preservation and/or storage of body parts, fluids or tissues, except for autologous blood and related collection and storage costs in connection with covered non-experimental services and supplies.
(4) Not furnished or authorized by a PCP or Network Specialist.
(5) Furnished for Cosmetic Surgery except what is listed under Covered Services and Supplies.
(6) Over-the-counter supplies.
(7) Received from a Nurse which do not require the skill and training of a Nurse.

au. **Sex Changes.** All services, medications and/or supplies furnished in conjunction with the sex change process. This includes hormonal medications required before and after surgery.

av. **Sex therapy, sex counseling and sexual dysfunction** or inadequacies that do not have a physiological or organic basis.

aw**.** **Thermograms and thermography** measuring the temperature variations at the body surface.

ax. **Vocational Rehabilitation.** Education or training for the purpose of gaining employment.

ay. **Voluntary Sterilization Reversal.** Reversal of a previous Surgical Procedure intended to induce permanent infertility.

az**.** **Work Related Injury or Illness.** Services and supplies for any work-related injury if any other source of coverage or reimbursement which is in force and in effect 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.

C. SPECIAL COVERAGE RULES IN CASE OF AN INPATIENT CONFINEMENT.

Confined as an Inpatient: If You or Your Dependent are confined in a Hospital or other facility on the date that You or Your Dependent become enrolled for Group Health Care Coverage, you must notify Community First within two (2) days or as soon as reasonably possible and authorize Community First to assume responsibility for arranging for the confined person's health care.

If You fail to notify us of the hospitalization or to allow us to coordinate your care, Community First will not be obligated to pay for any expenses related to your hospitalization following the first two (2) days after your coverage begins.

The services are not covered if You or Your Dependent are covered by another health plan on that date and the other health plan is responsible for the cost of services. Community First will not cover any service that is not a Covered Benefit under this Group Health Care Coverage. To be covered, You must utilize Participating Providers and be subject to all the terms and conditions set forth in the Group Health Care Coverage.

Community First may transfer You or Your Dependent to a Participating Provider and/or a Participating Hospital if the Medical Director, in consultation with Your Physician, determines that it is medically safe to do so.

III. RIGHT OF SUBROGATION AND REIMBURSEMENT UNDER THE GROUP HEALTH CARE COVERAGE

A. Sometimes another person or entity may be liable to you for medical services covered by Community First under this Certificate. For example, if a Member is injured in an automobile accident caused by another driver, the other driver or that driver's automobile insurance carrier may be liable to the Member for medical expenses incurred because of the injuries. If Community First pays or provides medical benefits for an illness or injury that was caused by an act or omission of any person or organization, Community First will be **subrogated** to all rights of recovery of a Member to the extent of such benefits provided or the reasonable value of services or benefits provided by Community First. Community First, once it has provided any benefits, is granted a **lien** on the proceeds of any payment, settlement, judgment, or other remuneration received by the Member from any sources, including but not limited to:

(1) a third party or any insurance company on behalf of a third party, including but not limited to premises, homeowners, professional, DRAM shop, or any other applicable liability or excess insurance policy;
(2) underinsured/uninsured automobile insurance coverage regardless of the source;
(3) no fault insurance coverage, such as personal injury or medical payments protection regardless of the source;
(4) any award, settlement or benefit paid under any worker's compensation of law claim or award;
(5) any indemnity agreement or contract;
(6) any other payment designated, delineated, earmarked or intended to be paid to a Member as compensation, restitution, remuneration for injuries sustained or illness suffered as a result of the negligence or liability, including contractual, of any individual or entity;
(7) any source that reimburses, arranges, or pays for the cost of care.

B. PAYORS' RECOVERY LIMITED. (a) If an injured covered individual is entitled by law to seek a recovery from the third-party tortfeasor for benefits paid or provided by a subrogee as described by Section 140.004, then all payors are entitled to recover as provided by Subsection (b) or (c).

(b) This subsection applies when a covered individual is not represented by an attorney in obtaining a recovery. All payors' share under Subsection (a) of a covered individual's recovery is an amount that is equal to the lesser of:

(1) one-half of the covered individual's gross recovery; or

(2) the total cost of benefits paid, provided, or assumed by the payor as a direct result of the tortious conduct of the third party.

(c) This subsection applies when a covered individual is represented by an attorney in obtaining a recovery. All payors' share under Subsection (a) of a covered individual's recovery is an amount that is equal to the lesser of:

(1) one-half of the covered individual's gross recovery less attorney's fees and procurement costs as provided by Section 140.007; or

(2) the total cost of benefits paid, provided, or assumed by the payor as a direct result of the tortious conduct of the third party less attorney's fees and procurement costs as provided by Section 140.007.

ATTORNEY'S FEES IN RECOVERY ACTION. (a) Except as provided by Subsection (c), a payor of benefits whose interest is not actively represented by an attorney in an action to recover for a personal injury to a covered individual

shall pay to an attorney representing the covered individual a fee in an amount determined under an agreement entered into between the attorney and the payor plus a pro rata share of expenses incurred in connection with the recovery.

(b) Except as provided by Subsection (c), in the absence of an agreement described by Subsection (a), the court shall award to the attorney, payable out of the payor's share of the total gross recovery, a reasonable fee for recovery of the payor's share, not to exceed one-third of the payor's recovery.

(c) If an attorney representing the payor's interest actively participates in obtaining a recovery, the court shall award and apportion between the covered individual's and the payor's attorneys a fee payable out of the payor's subrogation recovery. In apportioning the award, the court shall consider the benefit accruing to the payor as a result of each attorney's service. The total attorney's fees may not exceed one-third of the payor's recovery.

(d) A payor of benefits may pursue recovery against uninsured/underinsured motorist coverage or medical payments coverage only if the covered individual or the covered individual's immediate family did not pay the premiums for the coverage.

Upon receiving any benefits from Community First, you are considered to have **assigned** your rights of recovery to Community First to the extent of such benefits. If you have retained an attorney to pursue your rights of recovery, Community First is not responsible for paying any portions of your attorney’s fees or costs. Community First’s rights will not be affected by any release that is entered into without the consent of Community First.

Each Member agrees to reimburse Community First as described in these provisions in return for Community First providing services, supplies or benefits for a Member’s Illness or Injury:

(1) for which another person, corporation, or other entity is considered responsible; or

(2) that arises out of, or in the course of, any work for wage or profit and is covered by any Workers’ Compensation law, occupational disease law, or similar law.

B. By providing benefits, Community First acquires the right to be reimbursed for the reasonable value of services or benefits provided to a Member and this right is independent and separate and apart from the subrogation, lien and/or assignment rights acquired by Community First and set forth herein.

Community First is also entitled to recover from Member the value of services

provided, arranged, or paid for, when Member was reimbursed for the cost of care by another party.

If a Member does not reimburse Community First from any settlement, judgment, insurance proceeds or other source of payment, Community First is entitled to reduce current or future medical or expense benefits payable to or on behalf of a Member until Community First has been fully reimbursed.

Community First in furtherance of the rights obtained herein may take any action it deems necessary to protect its interest, which will include, but not be limited to:

(1) place a lien against a responsible party or insurance company to the extent benefits have been paid;
(2) bring an action on its own behalf, or on the Member's behalf, against the person, entity or insurance company;
(3) cease paying the Member's benefits until the Member provides Community First with the documents necessary for Community First to exercise its rights and privileges; and
(4) Community First may take any further action it deems necessary to protect its Interest.

C. Workers' Compensation. If benefits are provided to Community First Members for Basic Health Care Services covered under Workers' Compensation benefits, Community First will seek reimbursement from the financially responsible party. The Member will cooperate with Community First to ensure that Community First is reimbursed for the actual cost paid for any benefits provided to the Member. The Member must complete forms and provide any information as may be necessary to assist Community First in obtaining reimbursement.

D. Community First will <u>not</u> be responsible for any expenses, fees, costs or other monies incurred by the attorney for the Member and/or his or her beneficiaries, commonly known as the common fund doctrine. The Member is specifically prohibited from incurring any expenses, costs or fees on behalf of the Plan in pursuit of his rights of recovery against a third-party or Plan's subrogation, lien, assignment or reimbursement rights as set forth herein. No court cost, filing fees, experts' fees, attorneys' fees or other cost of a litigation nature may be deducted from the Plan's recovery without prior, express written consent of the Plan.

A Member must not reimburse their attorney for fees or expenses before Community First has been paid in full. Community First has the right to be repaid first from any settlement, judgment, or insurance proceeds a Member receives. Community First has a right to reimbursement whether or not a portion of the settlement, judgment, Insurance proceeds or any other source or payment was identified as a reimbursement of medical expenses.

E. Community First's right of subrogation, lien, assignment or reimbursement as set forth herein will not be affected, reduced or eliminated by the **"made whole doctrine"** and/or any other equitable doctrine or law which requires that the Member be "made whole" before the Plan's rights are allowed. Community First has the right to be repaid first from any settlement, judgment, remuneration, insurance proceeds or other source of funds a Member receives. Community First has the right to be reimbursed first whether or not a portion of the settlement, judgment, remuneration, insurance proceeds or other source of funds are identified as a reimbursement for medical expenses**.** Community First has the right to be reimbursed first whether or not a Member makes a claim for medical expenses.

F. Member agrees to cooperate with Community First in order to protect Community First's subrogation and reimbursement rights. Member agrees to promptly furnish to Community First all information which Member has concerning Member's rights of recovery, including information on any claims made or suits filed, and to fully assist and cooperate with Community First in protecting and obtaining its reimbursement and subrogation rights. The Member involved will execute and deliver to Community First such documents, agreements and information requested by Community First in order to enforce its rights hereunder. The Member agrees to obtain the consent of Community First before settling any claim or suit or releasing a party from liability for payment of medical expenses resulting from the Illness or Injury. The Member also agrees to refrain from taking any action or making any statement to prejudice Community First's recovery rights under these provisions.

G. Nothing in these provisions requires Community First to pursue the Member's claim against any Party for damages or claims or causes of action that the Member might have against such Party as a result of the Illness or Injury.

H. In the event that the Member dies as a result of his/her injuries and a **wrongful death or survivorship claim** is asserted the Member's obligations become the obligations of the Member's wrongful death beneficiaries, heirs and/or estate.

I. Community First may designate a person, agency or organization to act for it in matters related to subrogation or reimbursement, and Member agrees to cooperate with such designated person, agency, or organization the same as if dealing with Community First itself.

IV. RULES FOR COORDINATION OF BENEFITS OF THE GROUP CONTRACT WITH OTHER BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one plan. Plan is defined below.
The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accord with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans equal 100 percent of the total allowable expense.

DEFINITIONS

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

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

(2) Plan does not include: disability income protection coverage; the Texas Health Insurance Pool; workers' compensation insurance coverage; hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage; supplemental benefit coverage; accident only coverage; specified accident coverage; school accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis; benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; a state plan under Medicaid; a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan; or other nongovernmental plan; or an individual accident and health insurance policy that is designed to fully integrate with other policies through a

variable deductible. Each contract for coverage under (a)(1) or (a)(2) is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

(b) "This plan" means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits. The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan. When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits equal 100 percent of the total allowable expense.

(c) "Allowable expense" is a health care expense, including deductibles, percentage copayments, and copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a health care provider or physician by law or in accord with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

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

(2) If a person is covered by two or more plans that do not have negotiated fees and compute their benefit payments based on the usual and customary fees, allowed amounts, or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

(3) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

(4) If a person is covered by one plan that does not have negotiated fees and that calculates its benefits or services based on usual and customary fees, allowed amounts, relative value schedule reimbursement

methodology, or other similar reimbursement methodology, and another plan that provides its benefits or services based on negotiated fees, the primary plan's payment arrangement must be the allowable expense for all plans. However, if the health care provider or physician has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the health care provider's or physician's contract permits, the negotiated fee or payment must be the allowable expense used by the secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, prior authorization of admissions, and preferred health care provider and physician arrangements.

(d) "Allowed amount" is the amount of a billed charge that a carrier determines to be covered for services provided by a nonpreferred health care provider or physician. The allowed amount includes both the carrier's payment and any applicable deductible, copayment, or percentage copayment amounts for which the insured is responsible.

(e) "Closed panel plan" is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of health care providers and physicians that have contracted with or are employed by the plan, and that excludes coverage for services provided by other health care providers and physicians, except in cases of emergency or referral by a panel member.

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

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

(a) The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.

(b) Except as provided in (c), a plan that does not contain a COB provision that is consistent with this policy is always primary unless the provisions of both plans state that the complying plan is primary.

(c) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this

supplementary coverage must be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

(d) A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

(e) If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan must pay or provide benefits as if it were the primary plan when a covered person uses a noncontracted health care provider or physician, except for emergency services or authorized referrals that are paid or provided by the primary plan.

(f) When multiple contracts providing coordinated coverage are treated as a single plan under this subchapter, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan must be responsible for the plan's compliance with this subchapter.

(g) If a person is covered by more than one secondary plan, the order of benefit determination rules of this subchapter decide the order in which secondary plans' benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan that, under the rules of this contract, has its benefits determined before those of that secondary plan.

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

> (1) Nondependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber, or retiree, is the primary plan, and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent, then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other plan is the primary plan. An example includes a retired employee.
>
> (2) Dependent Child Covered Under More Than One Plan. Unless there is a court order stating otherwise, plans covering a dependent child must determine the order of benefits using the following rules that apply.

(A) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

(ii) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

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

(i) if a court order states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.

(ii) if a court order states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of (h)(2)(A) must determine the order of benefits.

(iii) if a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of (h)(2)(A) must determine the order of benefits.

(iv) if there is no court order allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(I) the plan covering the custodial parent;

(II) the plan covering the spouse of the custodial parent;

(III) the plan covering the noncustodial parent; then
(IV) the plan covering the spouse of the noncustodial parent.

(C) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of

(h)(2)(A) or (h)(2)(B) must determine the order of benefits as if those individuals were the parents of the child.

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

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

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

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

(6) If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

(a) When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100 percent of the total allowable expense for that claim. In addition, the secondary plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

(b) If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a nonpanel provider, benefits are not payable by one closed panel plan, COB must not apply between that plan and other closed panel plans.

COMPLIANCE WITH FEDERAL AND STATE LAWS CONCERNING CONFIDENTIAL INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. Community First will comply with federal and state law concerning confidential information for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Each person claiming benefits under this plan must give Community First any facts it needs to apply those rules and determine benefits.

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

V. EFFECT OF MEDICARE ON THE GROUP HEALTH CARE COVERAGE

A. WHAT IS MEDICARE

Medicare is a federal program of health insurance. Part A, the basic hospital insurance plan, pays for most hospital, home health, hospice, and skilled nursing facility services. Part B is an optional supplementary medical insurance plan that pays a percentage of your doctors' bills, medical equipment, and certain outpatient services.

Under most circumstances, You are eligible for Medicare at age 65 if You have retired, or if still employed at age 65, upon retirement. Persons with certain severe health conditions, such as end stage renal disease, may be eligible for Medicare prior to turning 65.

B. COORDINATION WITH MEDICARE, PART A

If you are a Retiree enrolled in Medicare Part A, Community First will pay whatever you are responsible for (minus any Copayments/Percentage Copayments) after Medicare pays. If, for whatever reason, you are a Retiree not enrolled in Medicare Part A, Community First will be the primary payer.

C. COORDINATION WITH MEDICARE, PART B

1. **Employees Who Retired And Were Medicare Eligible Prior To September 1, 1992.**

   Community First will provide benefits secondary to Medicare Part B, if the Retiree is enrolled in Medicare Part B. As secondary Payor, Community First must pay the difference between the Medicare allowed amount and the Medicare paid amount, less the appropriate Copayment/Percentage Copayment, if the provider accepts Medicare assignment. If the provider does not accept Medicare assignment, Community First must pay the difference between the Medicare maximum allowable and the Medicare paid amount, less the appropriate Copayment.

   If the Retiree is not enrolled in Medicare Part B, Community First will pay primary benefits. Community First will not require Part B coverage as a condition of enrollment for those Retirees.

2. **Employees Who Retired And Became Medicare Eligible On Or After September 1, 1992.**

   Community First will provide benefits secondary to Medicare Part B, as described in Section 1, above, <u>whether or not the Retiree is</u>

enrolled in Medicare Part B. Thus, if You are eligible for Medicare Part B and choose not to enroll, you likely will be responsible for significantly more out-of-pocket costs. Community First shall provide only secondary benefits for any member eligible for Medicare coverage as a result of end-stage renal disease whether or not the member elects Medicare Part B coverage.

3. **Retirees under age 65 receiving Social Security Disability**

Community First shall pay benefits as if the retirees under age 65 who receive Social Security disability benefits purchased Medicare Part B. Community First shall provide only secondary benefits as if Part B coverage is in force, even if Part B is not purchased by the eligible participant. Community First will not require member to purchase Medicare Part B coverage in those instances where members are eligible for Medicare Part B, Community First shall pay benefits on a secondary basis as though the eligible member enrolled in Medicare Part B.

4. **Coordination of Benefits**

Any individual who has Medicare as the primary coverage will not have greater out-of-pocket expense than an individual who does not have Medicare as the primary coverage, with the exception of those who became Medicare eligible since September 1, 1992, in which case Community First will pay secondary benefits even if the member is not enrolled in Medicare Part B.

Part A: Community First will pay all of the Medicare Part A deductible, less any applicable Copayment/Percentage Copayment.

Part B: Community First will pay the difference between the Medicare allowed amount and the Medicare paid amount, less the appropriate Copayment/Percentage Copayment, if the provider accepts Medicare assignment.

VI. CLAIM RULES

These rules apply if a charge is made to a Member for any service or supply with respect to which benefits would be provided under the Group Health Care Coverage.

A. REIMBURSEMENT PROVISIONS FOR NON-PARTICIPATING PROVIDERS OR OUT-OF-AREA CLAIMS

Only Emergency Care is covered outside of Community First's network and/or Service Area, except in the case of Court-Ordered Dependent coverage, or unless Medically Necessary Covered Services are not available through Participating Providers. In these situations Community First will reimburse the Non-participating Provider at the negotiated or usual and customary rate for Medically Necessary Covered Services, requested by Participating Providers and approved by Community First within forty-five (45) days of Community First's receipt of a claim with the documentation reasonably necessary to process the claim, unless a different time frame is provided for by written agreement between the parties. Non-Participating Providers may require immediate payment for their services and supplies. If You pay a bill for Covered Services, submit a copy of the paid bill along with a completed claim form to Community First's Member Services Department requesting reimbursement (Claim forms may be obtained from the Member Services Department or on the website at www. cfhp.com/ERS. Include all of the following information on Your request:

1. The patient's name, address and the identification number and Group number and Your relationship to the Subscriber from Your identification card;
2. Name and address of the provider of Your service (if not on the bill);
3. If You receive a bill for authorized Covered Services from a Non-Participating Provider, You may ask Community First to pay the provider directly. Send the bill to Community First according to the procedures listed above.

Any bill or invoice submitted to Community First for payment or reimbursement will be evaluated and if Community First is obligated to pay the bill under this Certificate or applicable law, then Community First will pay the bill or reimburse Member for payments already made at the allowable rate. However, submitting a bill to Community First does not guarantee payment or reimbursement and Community First will only pay or reimburse what it is obligated to pay or reimburse.

B. PROOF OF LOSS

Community First must be given written proof of the loss for which claim is made under the Coverage. This proof must cover the occurrence, character and extent of that loss. It must be furnished within sixty (60) days after the date of the loss. However, it may not be reasonably possible to do so. In that case, the claim will still be considered valid if the proof is furnished as soon as reasonably possible. It is Your responsibility to notify Community First if you receive a billing statement from a provider. Community First is not responsible for bills that have not been submitted within one year of date of service.

C. WHEN BENEFITS ARE PAID

Benefits are paid when Community First receives written proof of the loss.

Allowed charges for a covered service or supply with respect to which benefits would be provided under the Group Health Care Coverage generally will be paid by Community First to the provider of the service or supply, except as stated below. If You furnish Community First satisfactory evidence that You have made payment to a provider with respect to allowed charges that are covered under this Certificate and are the obligation of Community First, reimbursement for those charges will be paid to You.

Any claims submitted by Member to Community First for reimbursement will be processed as follows:

1. Fifteen (15) days after receipt of claim, Community First shall:

    a. Acknowledge receipt of claim;
    b. Commence investigation of claim; and
    c. Request all information from claimant as deemed necessary by Community First. Subsequent additional requests may be necessary.

2. No later than fifteen (15) business days after receipt of all information reasonably necessary for Community First to process the claim Community First will:

    a. Notify claimant in writing of acceptance or rejection of claim. If the claim is rejected, the notice will state the reasons for the rejection; or
    b. Notify claimant in writing of the reasons Community First needs additional time.

3. No later than the 45th day after claimant has been notified of the need for additional time to make a decision, Community First will accept or reject the claim.

4. If Community First notifies claimant that claim will be paid, claim will be paid no later than five (5) Working Days after notice was made.

5. All claims must be submitted to Community First within sixty (60) calendar days from the date expenses are incurred or as soon as is reasonably possible to do so. Any claim submitted after sixty (60) days, will not be eligible for reimbursement, unless a written

statement requesting additional time (not to exceed forty-five (45) days) is received.

A benefit that is payable to You in accordance with the above paragraph but remains unpaid at the time of Your death will be paid to Your estate.

D. DAMAGES

If delaying payment of a claim following receipt of information required by Community First exceeds the period allowed above, Community First shall pay the claim amount and eighteen percent (18%) per annum of the amount of such claim as damages, together with reasonable attorney fees as may be required by the trier of fact.

E. PHYSICAL EXAM

Community First, at its own expense, has the right to examine the person whose loss is the basis of claim. Community First may do this when and as often as is reasonable while the claim is pending.

F. LEGAL ACTION

No action at law or in equity will be brought to recover on the Coverage until sixty (60) days after the written proof described above is furnished. No such action will be brought more than three (3) years after the end of the time within which proof of loss is required.

VII. INCONTESTABILITY OF COVERAGE

This section limits Community First's use of Your statements in contesting Your Coverage under the Group Health Care Coverage. These are statements made to persuade Community First to affect that coverage, and all such statements are considered representations and not warranties. They will be considered to be made to the best of Your knowledge and belief. These rules apply to each statement:

A. It will not be used in a contest to void Your coverage or reduce benefits under the Coverage unless:

1. It is in a written application signed by You; and
2. A copy of that application is or has been furnished to You, or in the event of Your death or incapacity, to Your personal representative.

B. Your coverage can be voided only in the event of a fraudulent misrepresentation of material fact on the enrollment application.

VIII. GENERAL INFORMATION

A. MEMBER COMPLAINT/COMPLAINT APPEAL PROCESS

1. **General.** Members are encouraged to submit Complaints through Community First's internal Complaint and Complaint Appeal process, which we have outlined for You below.

   Community First encourages the informal resolution of Complaints. Health plan staff will work to address and resolve your Complaint without the requirement that a written Complaint be submitted. In order to receive a written response, Complaints must be submitted in writing or on a Community First Complaint form. Community First will not retaliate against You or a Contract Holder, including cancellation of coverage or refusal to renew coverage, simply because the Contract Holder, You, or person acting on behalf of the Contract Holder or You, has filed a Complaint against Community First, or Appealed a decision of Community First.

   Community First will not retaliate against any Participating Physician or Provider, including termination of or refusal to renew a contract, simply because a Participating Physician or Provider has, on Your behalf filed a Complaint against Community First or Appealed a decision of Community First. At any time, You have the right to contact the Texas Department of Insurance at 1-800-252-3439 or in writing at P. O. Box 149104, Austin, Texas 78714-9104.

2. **Where to File a Complaint**. Complaints/Complaint Appeals should be directed to Community First's Member Services Department at 1-877-698-7032 or 210-358-6262 or in writing to 12238 Silicon Drive, Suite 100, San Antonio, Texas 78249.

3. **Process for Complaint Resolution.** Complaints will be handled in the following manner:

Step	Action
1.	You, or someone acting on Your behalf, notifies Community First orally, or in writing, of a Complaint.
2.	Within five (5) Working Days, Community First will send You an acknowledgement letter with the Complaint process and timelines. If the complaint is made orally, it will be accompanied by a one-page Complaint form, which must be returned to Community First for prompt resolution of the Complaint.

Community First will work to address and resolve oral Complaints without the requirement that a written Complaint be submitted, in order to receive a written resolution, Complaints must be submitted in writing, either in a letter or on a Community First Complaint form.

3. Community First will acknowledge receipt of a written Complaint within five (5) Working Days from the date of receipt of the Complaint and send You a written resolution within thirty (30) calendar days from the date we receive Your written Complaint or a completed Complaint form.

4. Investigation and resolution of Complaints relating to Emergency Care, or denials of continued Hospital stays shall be concluded in accordance with the medical or dental immediacy of the case, but will not exceed one (1) Working Day from the date the Complaint is received by Community First.

4. **Member Complaint Appeal Process.** Appeals will be handled in the following manner:

Step	**Action**
1.	If You are not satisfied with the resolution of Your Complaint, You may request a Complaint Appeal.
2.	Community First will send You an acknowledgement letter within five (5) Working Days of receipt of Your written request for a Complaint Appeal.
3.	Community First will schedule a hearing before a Complaint Appeal Panel. The Panel will consist of an equal number of Community First staff, Physicians or other Providers, and Members. None of the participants will have previous involvement in the disputed decision that is the subject of the Complaint Appeal. Physicians or other Providers serving on the Panel will have experience in the area of care that is in dispute and must be independent of the Physician(s) or Provider(s) who made any prior determination(s). Members serving on the Appeal Panel will not be employees of Community First.

4. You, or Your designated representative if You are a minor or disabled, are entitled to:

   a. Appear in person before the Appeal Panel;
   b. Present alternative expert testimony; and
   c. Request the presence of and question any person responsible for making the decision resulting in the Complaint Appeal.

5. The Appeal Panel will render a recommendation and Community First will notify You of Community First's decision regarding Your Complaint Appeal.

6. Community First will complete the Complaint Appeal process no later than thirty (30) calendar days after the date Your request for a Complaint Appeal is received by Community First.

7. At any time, You have the right to contact the Texas Department of Insurance at 1-800-252-3439.

5. **Arbitration.** If after completion of the process described above, You remain dissatisfied, You may exercise Your right to submit the matter to Arbitration which is final and binding. Then all claims, disputes, controversies and other matters in question related to any of the terms of this Certificate of Group Health Coverage shall be arbitrated and the arbitration proceeding will be conducted pursuant to the Texas Arbitration Act. **Arbitration is voluntary**.

   Notice of the demand for arbitration shall be made in writing and filed with Community First subject to this provision and the demand shall be made within a reasonable time not to exceed thirty (30) days after the process described in Sections 3 through 5 above has been exhausted.

   The award rendered by the arbitrators shall be final and binding on You and Community First and judgment may be entered upon it in accordance with applicable law in any federal or Texas Court having jurisdiction.

6. **Maintenance of Records.** Community First will maintain a record of each Complaint and/or Appeal as well as any proceedings and any actions taken on a Complaint and/or Appeal for three (3) years from the date of receipt of a Complaint. You may obtain a copy of the record on Your Complaint, Appeal and any proceedings.

7. **Process for Appealing an Adverse Determination.**

Adverse Determination is the determination by Community First that the health care services furnished or proposed to be furnished to a Member are not Medically Necessary or is experimental or investigational. A complaint filed concerning dissatisfaction or disagreements with an adverse determination constitutes an appeal of that adverse determination.

A Complainant (You, Your authorized representative, or a provider of record acting on Your behalf) may appeal an Adverse Determination orally or in writing. Appeals of Adverse Determinations will be handled in the following manner:

<u>Step</u>	<u>Action</u>
1.	Within five (5) Working Days from receipt of the Appeal, Community First will send the appealing party a letter acknowledging the date of Community First's receipt of the Appeal. This letter will include a reasonable list of documents needed to be submitted to Community First for the Appeal.
2.	When Community First receives an oral Appeal of an adverse determination, Community First will send the appealing party a one-page Appeal form.
3.	Emergency care denials, denials for care of life-threatening conditions and denials of continued stays for hospital patients may follow an expedited Appeal procedure, if requested. This procedure will include a review by a health care provider who has not previously reviewed the case, and who is of the same or a similar specialty as typically manages the medical condition, procedure, or treatment under review. The time frame in which such an expedited Appeal must be completed will be based on the medical or dental immediacy of the condition, procedure, or treatment, but will not exceed one (1) Working Day following the date that the Appeal is made to Community First.
4.	Adverse Determination Appeals will include a review by a health care provider who has not previously reviewed the case and who is not a subordinate of the initial

reviewer. Community First will notify You, Your designated representative and Your provider of record of the outcome of the Appeal of the Adverse Determination, explaining the resolution of the Appeal. Community First will provide written notification to the appealing party as soon as practical, but no later than thirty (30) days after we receive the oral or written Appeal.

5. An appropriate health care provider will make all Appeal decisions for adverse determination. If the Appeal is denied, and within ten (10) Working Days the health care provider sets forth, in writing, good cause for having a particular type of a specialty Provider review the case, the denial will be reviewed by a health care provider in the same or similar specialty as typically manages the medical, dental, or specialty condition, procedure, or treatment under discussion for review. Such specialty review will be completed within fifteen (15) Working Days of receipt of the request.

8. **Process for Requesting Independent Review of an Adverse Determination**

a. You, Your designated representative and Your provider of record will be notified at the time of the denial of the Appeal of an Adverse Determination of Your right to have Your Appeal reviewed by an Independent Review Organization (IRO). You may only seek independent review in the case of an Adverse Determination. The denial letter with the adverse determination will include an IRO form with instructions on how to file.

b. Community first will provide Your designated representative and Your provider of record with a medical release form. This form must be completed and returned to Community First in order to share confidential information with the person acting on behalf of the enrollee.

c. 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 the procedures for an Adverse Determination Appeal to Community First. In these circumstances, You, Your designated representative, or Your provider of record may

contact Community First by telephone to request the review and provide the required information.

d. The IRO must make its determination and notify You, Your designated representative, Your provider of record, Community First and the Texas Department of Insurance by the earlier of the 15th day after the date the IRO receives the information necessary to make the determination or by the 20th day after the date the IRO receives the request. In the event of a life-threatening condition, the determination must be made no later than the 3rd day after the date the IRO receives the information necessary to make the determination or the 3rd day after the date the IRO receives the request that the determination has been made.

e. There is no right of Appeal of the IRO determination by You, Your designated representative, Your provider of record or Community First. This Appeals 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 Appeal process places Your health in serious jeopardy.

B. IDENTIFICATION CARDS

Any identification cards (called ID Cards) issued by Community First, in connection with the Group Health Care Coverage, are for identification only and remain the property of Community First. Possession of an ID Card does not convey any rights to benefits under the Group Health Care Coverage. Any person who receives services, supplies, or other benefits to which the person is not entitled by the terms of the Group Health Care Coverage and of the Group Contract will be charged for the actual costs incurred by Community First for any such services or supplies or for the amount of any such benefits. If any Member permits another person to use the Member's ID Card, Community First may:

1. invalidate that Member's ID Card; and
2. terminate that Member's Coverage as provided in the "WHEN YOUR COVERAGE ENDS" section VIII.G.

C. CONFIDENTIAL NATURE OF MEDICAL RECORDS

Any information from a Member's medical records or received from Providers or Hospitals incident to the physician-patient or Hospital-patient relationships will be kept confidential as permitted by law. Such information may not be disclosed without the consent of the Member, except as is reasonably necessary in connection with the administration of

the Group Health Care Coverage, as permitted by law. Each Member agrees that Participating Providers or Consulting Physicians may release medical records to Community First, and any of its subsidiaries or affiliates, as is reasonably necessary for claim determination, litigation, or other normal business activities.

D. ASSIGNMENTS

Benefits provided to a Member under the Group Health Care Coverage are personal to the Member and are not assignable or otherwise transferable.

E. RELATION AMONG PARTIES AFFECTED BY THE CONTRACT

The relationship between Community First and any Hospital is that of an independent contractor. No Hospital is an agent or employee of Community First, nor is Community First, or any employee of Community First, an employee or agent of any Hospital. Each Hospital will maintain the Hospital-patient relationship with Members under the Group Contract and is solely responsible to Members for Hospital supplies and services.

The relationship between Community First and any Participating Physician or other Participating Provider is that of an independent contractor. No Participating Physician or other Participating Provider is an agent or employee of Community First, nor is Community First, or any employee of Community First, an employee or agent of a Participating Physician or other Participating Provider. Each Participating Physician or other Participating Provider will maintain the provider-patient relationship with Members under the Group Contract and is solely responsible to Members for supplies and services furnished to Members.

Neither the Contract Holder nor any Member under the Group Contract is the agent or representative of Community First. Any Member under the Group Contract will not be liable for any acts or omissions of Community First, its agents or employees, or of any Hospital, Physician, or other health care provider with which Community First, its agents or employees make arrangements for furnishing supplies and services to Members.

A Member may, for personal reasons, refuse to accept procedures or courses of treatment recommended by Participating Physicians. Participating Physicians will use their best efforts to render all needed, appropriate professional services in a manner compatible with the Member's wishes. Each Participating Physician will do this to the extent it is consistent with the Physician's judgment as to the needs of the person and proper medical practice. If a Member refuses to follow a recommended treatment or procedure and the Participating Physician

believes that there is no professionally acceptable alternative, the Member will be so advised.

If the Member then still refuses to follow the recommended treatment or procedure:

1. the Member will be given no further treatment for the condition being treated; and
2. neither Participating Providers, Hospitals, nor Community First, will have any further responsibility to provide care for that condition.

However, if the Member later accepts the recommended treatment, it will be provided. If the refusal of recommended treatment continues and such refusal results in an unsatisfactory relationship (as described in the "Termination of Members for Cause" part of the "WHEN YOUR COVERAGE ENDS" section of the Certificate of Group Health Care Coverage), Community First may give written notice to the Member that the person is no longer a Member for the Group Health Care Coverage. The procedures for receiving and resolving complaints described above are available to Members.

F. NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under the Group Contract may be sent by United States Mail, postage prepaid, addressed as follows:

If to Community First: At its address shown on the first page of this Certificate.

If to a Member: To the last address provided by the Member on an enrollment or change of address form actually delivered to Community First.

G. WHEN YOUR COVERAGE ENDS

1. **Employee and Dependent Coverage**.

a. <u>Your Employee Coverage or Your Dependent Coverage will end when the first of these occurs</u>:

(1) Your membership in the Covered Classes for the Coverage ends because Your employment ends (see "End of Employment" section below).
(2) The Group Contract ends.
(3) You fail to pay, when due, any contribution required for the Coverage. But failure to contribute for

Dependent Coverage will not cause Your Employee Coverage to end. However, there is a grace period of at least 30 days for the payment of any premium falling due after the first premium during which the coverage remains in effect. If payment is not received within the 30 days, coverage may be cancelled after the 30th day and the terminated member(s) may be held liable for the cost of services received during the grace period.

(4) You no longer reside, live or work within the Service Area. Cancellation is subject to 30 days written notice.

(5) You become eligible under Part A of Medicare by reason of reaching age 65 and You elect Medicare as Your primary benefit program (for active eligible Employees and their eligible Dependents).

(6) The coverage is Dependent Coverage and Your Employee Coverage ends.

b. Your Dependent Coverage for an Eligible Dependent will end when that person:

(1) moves his or her permanent residence outside the Service Area. Excluded from this requirement are dependent unmarried children whose eligibility for coverage is determined by a court-ordered child support or medical support document.

(2) ceases to be an eligible Dependent. (See the section entitled "Continued Coverage for an Incapacitated Child" below.)

c. End of Employment: For purposes of Coverage under the Group Contract, Your employment ends when You are no longer considered to be employed by the Employer. But, for Coverage purposes, the Contract Holder may consider You as still employed and in the Covered Classes during certain types of absences from work. The Contract Holder decides whether You are to be considered as still employed during those types of absences and for how long. In making such a determination, the Contract Holder must not discriminate among persons in like situations.

You may be considered as still employed up to any time limit on Your type of absence. When so considered, Your eligible Employee Coverage and Dependent Coverage will be continued only while You are paying contributions for such coverage at the time and in the amounts, if any, required by

the Contract Holder (whether or not those Coverages would otherwise be Non-contributory Coverages). But the Coverages will not be continued after they would end for a reason other than end of employment. The Contract Holder is liable for Your premiums from the time you are no longer part of the eligible group until the end of the month in which the Contract Holder notifies us that You are no longer part of the eligible group.

d. Cancellation and Non-Renewal of Coverage: ERS determines Your eligibility.

H. CONTINUATION PRIVILEGE

1. **Continued Coverage for an Incapacitated Child**: Your Dependent Coverage for a child will not end just because the child has reached a certain age if both a. and b. below are true:

a. The child is then mentally or physically incapable of earning a living. The Group Contract Holder must receive proof of this within the next thirty-one (31) days; and

b. The child otherwise meets the definition of eligible Dependent.

If these two conditions are met, the age limit will not cause the child to stop being an eligible Dependent under the Coverage. This will apply as long as the child remains incapacitated and dependent unless coverage is otherwise terminated with the terms of the Group Contract.

2. **Continued Coverage at You or Your Dependent's Option**: You or Your Dependent may be eligible for continued coverage upon the occurrence of certain events as described below.

a. Continued Coverage under COBRA. A Member may be eligible to continue coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) with the same benefits as provided under the Group Contract upon the occurrence of a qualifying event. Qualifying events are listed below, along with the length of time that COBRA coverage is available.

Qualifying Event	Length of Time COBRA Coverage is Available
Termination of Your Employment (unless due to gross misconduct)	18 months (29 months for a person who qualifies for Social Security disability benefits)
Reduction in Your work hours	18 months (29 months for a person who qualifies for Social Security disability benefits)
You become entitled to Medicare	36 months
Your death	36 months
Your divorce or legal separation	36 months
Dependent child loses eligibility	36 months

The continuation of coverage periods shown above include any periods that the Member was covered under any other continuation of coverage. The continuation of coverage may be terminated sooner than the indicated length of time when:

- the plan ends;

- the Member fails to timely pay the premium. However, there is a grace period of at least 30 days for the payment of any premium falling due after the first premium during which the coverage remains in effect. If payment is not received within the 30 days, coverage may be cancelled after the 30th day and the terminated member(s) may be held liable for the cost of services received during the grace period.

- the Member first becomes eligible for Medicare;

- in the case of a Member who is disabled when the continuation coverage begins, the Member becomes ineligible for disability benefits under the Social Security Act; provided, however, this will apply only if the Member becomes ineligible after such continuation coverage has been in effect for at least eighteen (18) months; or

- the Member becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any such pre-existing condition of the Member.

Election for continuation of coverage under COBRA must be made within sixty (60) days of the later of: (i) the occurrence of a qualifying event, or (ii) the date You or Your Dependent receives the appropriate COBRA election forms that must be provided by the Contract Holder.

b. Continued Coverage under State Law. A Member may be eligible for continued coverage under the requirements set forth below if their coverage under the Group Contract has been terminated for any reason, except involuntary termination for cause, or if they have completed continuation of coverage as provided under COBRA. The Member must have been continuously insured under the Group Contract for at least three (3) consecutive months immediately prior to termination.

(1) If the Member has completed continuation of coverage as provided under COBRA, such continuation, under State Law, must be offered to the Member not less than thirty (30) days prior to the expiration of COBRA;

(2) Such coverage continuation must be requested in writing by the member within sixty (60) days following the later of (a) the date the group coverage would otherwise terminate, or (b) the date the Member is given notice of the right of continuation by the Group Contract Holder;

(3) The Member must make the first payment no later than the 45th day after the initial election for coverage and on the due date of each payment thereafter. Following the first payment made after the initial election for coverage, the payment of any other premium shall be considered timely if made by the 30th day after the date on which payment is due. The Member will pay the Contract Holder the amount of contribution required by the Contract Holder plus two percent (2%) of the group rate for the coverage being continued on the due date of each payment;

(4) Maximum continuation period for a Member not eligible for continuation under COBRA is nine months after the date the election to continue coverage is made or for any Member eligible for continuation coverage under COBRA, six additional months following any period of continuation provided under statute unless (a) the date on which failure to make timely payments would terminate coverage; (b) the date on which the Member is covered for similar services and benefits by another health plan; or (c) the date on which group coverage terminates in its entirety;

The 180-day exclusion does not apply to a Member eligible for benefits under the continuation of coverage, who did not elect continuation during the election period, or whose elected continuation coverage lapsed or was canceled without reinstatement, following a period of continuation coverage under COBRA.

c. <u>Continued Coverage for Dependents</u>. A Dependent may be eligible for continued coverage if the Dependent's previous eligibility for coverage hereunder ceases because of the severance of the family relationship or the retirement or death of the employee; and the family member or the Dependent has been a member of the group for a period of at least one year or is an infant under one year of age. A Member electing such continued coverage must pay premiums for the coverage directly to the Contract Holder. The Member will have the option of paying the premiums in monthly installments. The premium for continuation of coverage shall be no more than the premium charged under the Group Contract for the Member had the family relationship not been severed.

An eligible Employee must give written notice to the Contract Holder within fifteen (15) days of any severance of the family relationship that might activate the continuation coverage option under this Section and, upon receiving this notice, the Contract Holder shall immediately give written notice to each affected Dependent of the continuation option; however, such written notice may be given by the eligible Employee's Dependent. On receipt of notice of the death or retirement of an eligible Employee, the Contract Holder will immediately

give written notice to the eligible Employee's Dependents of the coverage continuation option. Within sixty (60) days from the date of the severance of the family relationship or the retirement or death of the eligible Employee, the Dependent must give written notice to the Contract Holder of the desire to continue coverage.

Coverage under the policy will remain in effect during the sixty (60) day period if policy premiums are paid. Such continued coverage shall continue until: (1) the Member fails to make a premium payment in the time required to make that payment; (2) the Member becomes eligible for substantially similar coverage under another health benefit plan; or (3) a period of three years has elapsed since the severance of the family relationship or the retirement or death of the eligible Employee.

IX. DEFINITIONS

Act: Act means the Texas Employees Group Benefits Act (Chapter 1551 of the Texas Insurance Code).

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

1. Cognitive Communication Therapy: Services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.
2. Cognitive Rehabilitation Therapy: Services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual’s brain-behavioral deficits.
3. Community Reintegration Services: Services that facilitate the continuum of care as an affected individual transitions into the community.
4. Neurobehavioral Testing: An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.
5. Neurobehavioral Treatment: Interventions that focus on behavior and the variables that control behavior.
6. Neurocognitive Rehabilitation: Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

7. Neurocognitive Therapy: Services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.
8. Neurofeedback Therapy: Services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.
9. Neurophysiological testing: An evaluation of the functions of the nervous system.
10. Neurophysiological Treatment: Interventions that focus on the functions of the nervous system.
11. Neuropsychological Testing: The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.
12. Neuropsychological Treatment: Interventions designed to improve or minimize deficits in behavioral and cognitive processes.
13. Outpatient Day Treatment services: Structured services provided to address functional deficits in behavior and/or cognition. Such services may be delivered in settings that include transitional residential, community integration, or non-residential settings
14. Post-acute Care Treatment services provided after acute care confinement and/or treatment, which are based on an assessment of the individual's cognitive deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or re-establishing previously, learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.
15. Post-acute Transition services: Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.
16. Psychophysiological Testing: An evaluation of interrelationships between the nervous system and other bodily organs and behavior.
17. Psychophysiological Treatment: Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.
18. Remediation: The process (es) of restoring or improving a specific function.
19. Services: The work of testing, treatment, and providing therapies to an individual with an acquired brain injury.
20. Therapy: The scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an acquired brain injury.

Adverse Determination: The determination by Community First that the health care services furnished or proposed to be furnished to a Member are not Medically Necessary or are experimental or investigational or not appropriate.

After Hours Care: Health care services provided to a Member for an illness or an injury that occurs after normal provider office hours.

Annual Enrollment Period: A period of time each year set by the Contract Holder, during which an eligible Employee may:

1. Elect coverage under the Employer's Health Benefits Plan or the Group Health Care Coverage; or
2. Elect to change from the Group Health Care Coverage to coverage under the Employer's Health Benefit Plan; or
3. Elect to change from coverage under the Employer's Health Benefits Plan to the Group Health Care Coverage.

Appeal: A request, orally or in writing, for reconsideration of a decision reached under the Community First formal Complaint and Appeal process.

Appeal Panel or Panel: A Panel composed of equal numbers of Community First Staff, Physicians or other providers, and Members, which advises Community First on the resolution of a dispute.

Associated Company: Employers that are the Contract Holder's agencies or participating institutions of higher education and are reported in writing to Community First for inclusion under the Group Contract.

Autism Spectrum Disorder. A neurobiological disorder that includes Autism, Asperger's Syndrome, or Pervasive Developmental Disorder (Not otherwise specified).

Balance Billing: The practice of charging an enrollee that uses a provider network the balance of a non-network health care provider's fee for services received by the enrollee that is not fully reimbursed by the health benefit plan.

Chemical Dependency: The abuse of, or psychological or physical dependence on, or addiction to alcohol or a controlled substance.

Chemical Dependency Treatment Center: A facility that provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved and monitored by a Physician and meets one of these tests:

- it is affiliated with a Hospital under a contractual agreement with an established system of patient referral;
- it is licensed as a Chemical Dependency treatment program by the Texas Commission on Alcohol and Drug Abuse;
- it is licensed, certified, or approved as a Chemical Dependency treatment program or center by the appropriate agency of the state in which it is located.

Community First: Community First Health Plans, Inc., a health maintenance organization.

Complainant: A physician, provider, member, or other person designated to act on behalf of a Member, who files a complaint.

Complaint: Any dissatisfaction expressed by a Member or individual acting on behalf of a Member to Community First, orally or in writing, with any aspect of Community First's operation, including but not limited to, dissatisfaction with plan administration; Appeal of an Adverse Determination; the denial, reduction, or termination of a service; the way a service is provided; or disenrollment decisions. A Complaint is not 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.

Contract Year: The twelve (12) month period, commencing with the effective date of the Certificate of Group Health Care Coverage, during which coverage is in effect.

Contributory Coverage, Non-contributory Coverage: Contributory Coverage is coverage for which the Contract Holder requires Employee contributions. Non-contributory Coverage is coverage for which the Contract Holder does not require Employee contributions.

Controlled Substance: A toxic inhalant or substance designated as a controlled substance in Chapter 481, Health and Safety Code.

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Copayment: means the payment, as expressed in dollars, that must be made by or on behalf of a Participant for certain services at the time they are provided.

Counseling Services: Supportive services provided under a Hospice Care Program by members of the Hospice Team in counseling sessions with the Family Unit. These services are to assist the Family Unit in dealing with the death of a Terminally Ill Person.

Court-Ordered Dependent: Dependent unmarried children whose eligibility for coverage is determined by a court-ordered child support or medical support document.

Covered Services and Supplies: The services and supplies covered under the Group Health Care Coverage.

Covered Classes: All eligible Employees who live, work or reside in the Service Area. All eligible Retirees who live or reside in the Service Area. All eligibility is determined by The Employees Retirement System of Texas (ERS).

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

Custodial Care: Services which are not intended primarily to treat a specific Injury or Illness (including mental illness or Substance Abuse/chemical Dependency). These services may include:

1. services related to watching or protecting a Member;
2. services related to performing or assisting a Member in performing any activities of daily living, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can usually be self-administered; and
3. services not required to be performed by trained or skilled medical or paramedical personnel.

Creditable coverage: Is time spent covered under a prior health plan which is used to satisfy the pre-existing condition exclusion in a new policy or qualify an individual for a guaranteed issue HIPAA policy. Most health insurance plans are considered creditable coverage, including a group health plan (including COBRA or State continuation, individual health coverage, short-term major medical policies, Medicaid, Medicare, Tricare, Indian Health Service Plans, U.S. Government Employee Insurance, public health plans (US only), and Peace Corps). Creditable coverage does not include coverage that consists only of limited benefits, such as dental, vision or cancer policies.

Deductible: A specified dollar amount of Covered Expenses which must be incurred during the plan year before any other Covered Expenses can be considered for payment.

Dependent: Your dependent is someone who is:

1. The spouse of an Employee or Retiree, or
2. Any unmarried child who is either under 26 years of age or disabled; provided that in the case of a disabled child 26 years of age or older, such child is dependent upon the Employee or Retiree for care or support.

"Child" means:

(a) the natural child of the Employee or Retiree;
(i) includes a child who is related by blood or marriage and was claimed as a dependent on the Federal Income Tax return of an individual who is eligible to participate in the Group Benefits program.
(b) a legally adopted child (including a child living with the adopting parents during the period of probation);
(c) a child of an insured if the insured is a party in a suit in which the adoption of the child by the insured is sought;
(i) adoptees or children who have become the subject of a suit for adoption by the enrollee are not required to live with the adopting parents;
(d) a stepchild of the Employee or Retiree;
(e) a foster child;
(f) a child whose primary place of residence is the household of which the Employee or Retiree is the head and to whom the Employee or Retiree is legal

guardian of the person;

(g) a child who is in a parent-child relationship to the Employee or Retiree, provided that:
  (i) the child's primary place of residence is the Employee's or Retiree's household; and
  (ii) the Employee or Retiree provides the necessary care and support for the child; and
  (iii) if the natural parent of the child is 21 years of age or older, the natural parent of the child does not reside in the Employee's or Retiree's household;

(h) a child who is considered a dependent of the Employee or Retiree for federal income tax purposes and who is a child of the Employee or Retiree’s child; or

(i) an eligible child, as defined herein, for whom the Employee or Retiree must provide medical support pursuant to a valid order from a court of competent jurisdiction;

(j) any such child, regardless of age, who lives with or whose care is provided by any Employee or Retiree on a regular basis if such child is mentally retarded or physically incapacitated to such an extent as to be dependent upon the Employee or Retiree for care or support, as the trustee shall determine.

Mentally retarded or physically incapacitated means any medically determinable physical or mental condition which prevents the child from engaging in self-sustaining employment and satisfactory proof of such condition and dependency is submitted by the Employee or Retiree within 31 days following such child’s attainment of age 26 and at such intervals thereafter as may be required by the system but not more frequently than annually following the child's attainment of such limiting age.

Diabetic Equipment: Blood glucose monitors, including noninvasive glucose monitors and glucose monitors designed to be used by blind individuals; insulin pumps and associated appurtenances; insulin devices; and podiatric appliances for the prevention of complications associated with diabetes.

Diabetes Self Management Training: Instruction enabling a member to understand the care and management of diabetes, including nutritional counseling and proper use of diabetes equipment and supplies.

Diabetic Supplies: Test strips for blood glucose monitors; visual reading and urine test strips; lancets and lancet devices; insulin and insulin analogs; injection aids; syringes; prescriptive and nonprescriptive oral agents for controlling blood sugar levels; and glucon emergency kits.

Durable Medical Equipment: Equipment prescribed by the attending physician that meets each of the following:

- is medically necessary;
- is not primarily or customarily used for non-medical purposes;
- is designed to withstand repeated use; and

- serves a specific therapeutic purpose in the treatment of any injury or illness.

Eligible Employee: An Employee as defined under Section 1551.101 of the Texas Insurance Code.

Eligible Retiree: An eligible Employee or annuitant who has retired as defined in the Act and is eligible as defined by ERS for health coverage.

Emergency Care: Health care services provided in a Hospital emergency facility, free standing emergency medical care facility, or comparable emergency facility to evaluate and stabilize medical conditions, including a behavioral health condition, of a recent onset and severity including, but not limited to, severe pain that would lead a prudent lay person, possessing an average knowledge of medicine and health to believe that his or her condition, Illness, or Injury is of such a nature that failure to get immediate medical care could result in:

1. placing his or her health in serious jeopardy;
2. serious impairment to bodily functions;
3. serious dysfunction of any body organ or part;
4. serious disfigurement; or
5. in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Employee Coverage: Coverage that applies to an eligible Employee or eligible Retiree.

Employer: Collectively, all Associated Companies.

Employer's Other Health Benefits Plan: The health plan(s) of the Employer providing health care expense coverage, other than the Group Health Care Coverage. This does not include Medicare Part A or Part B.

ERS: Employees Retirement System of Texas, which is also referred to as the Group Contract Holder in this Certificate of Group Health Care Coverage.

Experimental or Investigational: Medical, surgical, diagnostic, psychiatric, Substance Abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time Community First makes a determination regarding coverage in a particular case, meet one of the following criteria:

1. Full and final approval has not been granted by the US Food and Drug Administration for the treatment of the patient's medical condition;
2. Specific evidence shows that the service, technology, supply, treatment, procedure, drug therapy or device is being provided subject to a) Phase I or Phase II clinical trial or the experimental arm of a Phase III and Phase IV clinical trial, b) a protocol to determine the safety, toxicity, maximum tolerated dose, efficacy, or efficacy in comparison to the standard means of treatment or

diagnosis, or c) protocol approved by and under the supervision of an institutional review board;

3. The published authoritative medical and scientific literature a) has not defined, or supports further research to define, the safety, toxicity, maximum tolerated dose, efficacy or efficacy in comparison to the standard means of treatment or diagnosis, and b) does not demonstrate statistically significant improvement in the efficacy or outcomes for the service, technology, supply, treatment, procedure, drug therapy or device compared to standard services, technologies, supplies, treatments, procedures, drug therapies or devices.

Eye Exam: Examinations to determine the need for corrective lenses.

Facility Based Physician: A radiologist, anesthesiologist, pathologist, emergency department physician or neonatologist to whom a facility has granted clinical privileges and provides services to patients of the facility.

Family Unit: Collectively, You and Your Dependents who are Members.

Freestanding Emergency Medical Care Facility means a facility, structurally separate and distinct from a hospital that receives an individual and provides emergency care.

Group: The Employees Retirement System of Texas.

Group Health Care Coverage: The services that are included in this Certificate of Group Health Care Coverage.

Health Care Facility: A hospital, emergency clinic, outpatient clinic, birthing center, ambulatory surgical center or other facility providing health care services.

Health Status Related Factor: Any of the following in relation to a Member: health status; medical condition (including both physical and mental Illnesses); claims experience; receipt of health care; medical history; genetic information; evidence of insurability (including conditions arising out of acts of domestic violence, including family violence) or disability.

Heritable Disease: An inherited disease that may result in mental or psychological retardation or death.

Home Health Care: A program, prescribed in writing by a Participating Physician and administered by a Home Health Care Agency, that provides for the care and treatment of a person's Illness or Injury in the person's home.

Home Health Care Agency: An organization that has been licensed or certified as a Home Health Care Agency in the state of Texas, or is a Home Health Care Agency as defined by Medicare.

Hospice: An organization that provides short periods of stay for a Terminally Ill Person in a home-like setting or facility for either direct care or respite. This organization may be either freestanding or affiliated with a Hospital. It must operate as an integral part of a Hospice Care Program. If such an organization is required by a state to be licensed, certified, or registered, it must also meet that requirement to be considered a Hospice.

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

Hospital Inpatient Stay: A Hospital stay for which a room and board charge is made by the Hospital.

Illness: Any disorder of the body or mind of a Member, but not an Injury.

Implant: An object or device that is surgically implanted, embedded, inserted, or otherwise applied and related equipment necessary to operate, program and recharge the implantable.(e.g. hip joints, heart pacemakers, penile implants, and implanted electrical stimulators).

Independent Review Organization (IRO): An organization that is certified by the Texas Department of Insurance to perform independent review of Adverse Determinations, as provided under Chapter 4202 of the Texas Insurance Code.

Injectable / Specialty Medications: All injectables including those that are considered specialty injectables which are those expensive biopharmaceuticals that are used to treat unique populations with diseases that need careful monitoring for compliance because of the high risk of side effects and cost.

Individual Conversion Plan: An individual health care coverage contract.

Individual Treatment Plan: A plan with specific attainable goals and objectives appropriate both to the patient and the treatment modality of the program.

Injury: Trauma or damage to some part of the body of a Member.

Life-Threatening Condition: A disease or other medical condition with respect to which death is probable unless the course of the disease is interrupted. A Member or the Member's provider of record shall determine the existence of a Life-Threatening Condition on the basis that a prudent lay person possessing an average knowledge of medicine and health would believe that his or her disease or condition is Life-Threatening.

Medicaid: Title XIX (Grants to States for Medical Assistance Programs) of the United States Social Security Act, as amended from time to time.

Medical Director: A Physician who is retained by Community First to coordinate and supervise the delivery of health care services for Members through Participating Physicians and Participating Providers.

Medical Emergency: A recent onset of a medical condition requiring Emergency Care.

Medical Necessity or Medically Necessary: Health care services which are determined by Community First to be medically appropriate, and prevent Illness or deterioration of medical conditions, or provide early screening, interventions and/or treatments for conditions that cause suffering or pain, physical deformity, limitations in function, or endanger life. Such services are consistent with the diagnosis; provided at appropriate facilities and at the appropriate levels of care; consistent with health care practice guidelines and standards that are issued by professionally recognized health care organizations or governmental agencies; and are no more intrusive or restrictive than necessary.

Medicare: Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act, as amended from time to time.

Member: An eligible Employee or eligible Retiree who is covered under the Group Health Care Coverage described in this Certificate or a Dependent with respect to whom an eligible Employee or eligible Retiree is covered for Dependent Coverage described in this Certificate.

Non-Participating Provider: A Physician, Hospital, or other provider of medical services or supplies that is not a contracting Provider.

Observation Period: A short-term hospital stay lasting less than 24 hours.

Ombudsman Program: Independent medical review program that provides case review for new and emerging technologies/therapies including, but not limited to, issues pertaining to the experimental/investigational status of an intervention, clinical trials and research studies, and other clinical information, for the purpose of assisting Community First in determining Medical Necessity and appropriateness.

Orthotics: A custom-fitted or custom-fabricated medical device that is applied to a part of the human body to correct a deformity, improves function, or relieves symptoms of a disease.

Out-of-Area: Outside the approved Service Area of Community First.

Out-of-Pocket: The Copayment/Percentage Copayment amounts that are the Member's responsibility each Contract Year. The specific Out-of-Pocket maximum Copayment/Percentage Copayment that applies under this Certificate of Group Health Care Coverage is listed in the attached Schedule of Copayments. Community First will assist the Member in determining when he or she has satisfied the Out-of-Pocket maximum Copayment/Percentage Copayment, so it is important to keep all receipts for Copayments/Percentage Copayments actually paid. The Copayment/Percentage Copayment amounts that are paid toward certain Covered Services are not applicable to a Member's Out-of-Pocket as set forth in the attached Schedule of Copayments.

Outpatient Surgery: Services provided by a hospital or facility for any procedure rendered that allows for operating room charges to be generated, but is not intended to be an inpatient stay.

Participating Physician: A Physician who is either a Primary Care Physician (PCP) or a Specialty Care Physician and who has contracted with Community First to provide services to Members.

Participating Provider: A Physician, Hospital, or other provider of medical services or supplies that is licensed or certified in the state in which it is located and which has contracted with Community First to arrange for or provide services and supplies for medical care and treatment of Members.

Percentage Copayment: The portion of eligible expenses that the member is required to pay for certain covered health services.

Phenylketonuria: An inherited condition that may cause severe mental retardation if not treated.

Physician: Any individual licensed to practice medicine by the Texas State Board of Medical Examiners.

Practitioner: A Physician, Hospital or other person or entity licensed to provide medical services under applicable law.

Pre-authorization: The verbal or written approval by Community First, or its designee, obtained prior to admitting a Member to a Facility or providing certain other Covered Services to a Member when approval is required for such services. Pre-authorization is not the same as a Referral, and a Member who has been referred to another Physician or Provider by the Member’s PCP may still need to obtain Pre-authorization prior to certain services being rendered by the Referral Physician.

Prescription Medication and/or Supplies: This means only:

1. a medicinal substance that, by law, can be dispensed only by prescription; or
2. other items that require a prescription order to be dispensed.

Primary Care Physician (PCP): A Participating Physician who is chosen by or for a Member to have the responsibility for:

1. providing initial and primary medical care to the Member; and
2. maintain the continuity of the Member's medical care and may initiate referrals to Participating or Non-Participating Physicians and/or other Providers if necessary.

Prosthesis: An external or removable artificial device that replaces a limb or body part (e.g. prosthetic arms, legs, and eyes). See Schedule of Copayments.

Provider: A person, other than a physician, who is licensed or otherwise authorized to provide a health care service in this state.

Psychiatric Day Treatment: A mental health facility that provides treatment for individuals suffering from acute, mental, and nervous disorders in a structured psychiatric program using Individual Treatment Plans and that is clinically supervised by a Physician of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology.

Reasonable Cash Value: The cash value assigned to a service or supply provided, ordered or authorized by a Participating Provider, as determined by Community First. Community First will base its determination on the range of Usual and Customary charges generally made by providers in the area for a like service or supply. Community First will also take into account any unusual circumstances and any medical complications that require additional time or special skill, experience, and/or facilities in connection with a particular service.

Referral: A recommendation by a Member's PCP or other treating provider for a patient to be evaluated or treated by another Physician or Provider.

Related Hospital Inpatient Stays: Separate hospital inpatient stays by a person that occur as a result of the same Illness or Injury. Hospital Inpatient Stays will be considered unrelated if:

1. there is a period of thirty (30) days or more between the stays; or
2. the stays result from wholly unrelated causes.

Residential Treatment Center for Children and Adolescents: A child-care institution that provides residential care and treatment for emotionally disturbed children and adolescents and that is licensed or operated by the appropriate state agency or board.

Retiree: An eligible Employee or annuitant who has retired as defined in the Act.

Serious Mental Illness: The following psychiatric Illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM): (A) bipolar disorders (hypomanic, manic, depressive, and mixed; (B) depression in childhood and

adolescence; (C) major depressive disorders (single episode or recurrent); (D) obsessive-compulsive disorders; (E) paranoid and other psychotic disorders; (F) schizo-affective disorders (bipolar or depressive); and (G) schizophrenia.

Service Area: Geographical areas within which Covered Services and Supplies for medical care and treatment are available and provided, by Participating Providers, under the Group Contract, to Members who live, reside or work within that geographic area. The Service Area applicable to Members is shown as Attachment A to Your Certificate of Group Health Care Coverage.

Skilled Nursing Facility: An institution that meets all of these tests:

1. Meets all Texas licensing requirements and is legally operated.
2. It mainly provides short-term nursing and rehabilitation services for persons recovering from Illness or Injury. The services are provided for a fee from its patients, and include both room and board and 24-hour-a-day skilled nursing service.
3. It provides the services under the full-time supervision of a Physician or registered nurse (R.N.); or, if full-time supervision by a Physician is not provided, it has the services of a Physician available under a contractual agreement.
4. Does not include an institution or part of one that is used mainly as a place for custodial care, rest or for the aged.

Specialty Care Physician: A Participating Physician who provides certain specialty medical care to Members upon referral by a PCP or other Participating Physician if necessary. Under special circumstances a Specialty Care Physician may function as a PCP if approved by the Medical Director. Members who are referred to Specialty Care Physicians may still need to obtain Pre-authorization to receive certain services from the Specialty Care Physician and should work with his/her PCP and Specialty Care Physician in order to obtain Pre-authorization if necessary.

Supplies: Medical supplies are non-reusable, disposable, and are not useful in the absence of illness or injury. Common household items are not considered medical supplies.

Surgical Procedure: Typically considered an invasive procedure, including, but not limited to: cutting, suturing, treatment of burns, correction of fracture, reduction of dislocation, manipulation of joint under general anesthesia, electrocauterization, tapping (paracentesis); application of plaster casts, administration of pneumothorax, endoscopy, or injection of sclerosing solution.

Telehealth Service: A health service, other than a telemedicine medical service, delivered by a Provider acting within the scope of his or her license, who does not perform a telemedicine medical service that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

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

Telemedicine Medical Service: A health care service initiated by a Physician, or another Provider authorized by law to act under Physician delegation and supervision, for purposes of patient assessment by a Provider, diagnosis or consultation by a Physician, treatment, or the transfer of medical data, that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

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

Terminally Ill Person: A person whose life expectancy is six (6) months or less, as certified by a Participating Physician.

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

Urgent Care: Health care services provided in a situation other than an emergency which are typically provided in settings such as a Physician or provider's office or Urgent Care Center, as a result of an acute Injury or Illness, including an urgent behavioral health situation, that is severe or painful enough to lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, Illness or Injury is of such a nature that failure to obtain treatment within a reasonable period of time would result in serious deterioration of the condition of his or her health.

Usual and Customary (U&C Fee or Rate): The claim payment amount established by Community First for a particular service, supply or medication, and type of provider based on Usual and Customary fee for the same service in the geographic area, standards in the industry or other relevant factors.

Utilization Review: A system for prospective, concurrent, or retrospective review of the Medical Necessity and appropriateness of health care services and a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services being provided or proposed to be provided to a Member. Utilization Review does not include elective requests for clarification of coverage.

Utilization Review Agent (URA): Community First, or an entity licensed by the Texas Department of Insurance as a Utilization Review Agent, that conducts Utilization Review for Community First.

You and Your: An Employee or a Member.

COMMUNITY FIRST HEALTH PLANS, INC.

ATTACHMENT A

Service Area

Community First Health Plans will provide services to State of Texas and Higher Education Employees, Retirees and Dependents in the following Texas counties: Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina, and Wilson. See service area map below. Please see Community First's Provider Directory for locations of providers and all health care delivery sites.

Please see Community First's Provider Directory on CFHP'S website at http://www.cfhp.com/ERS health links.

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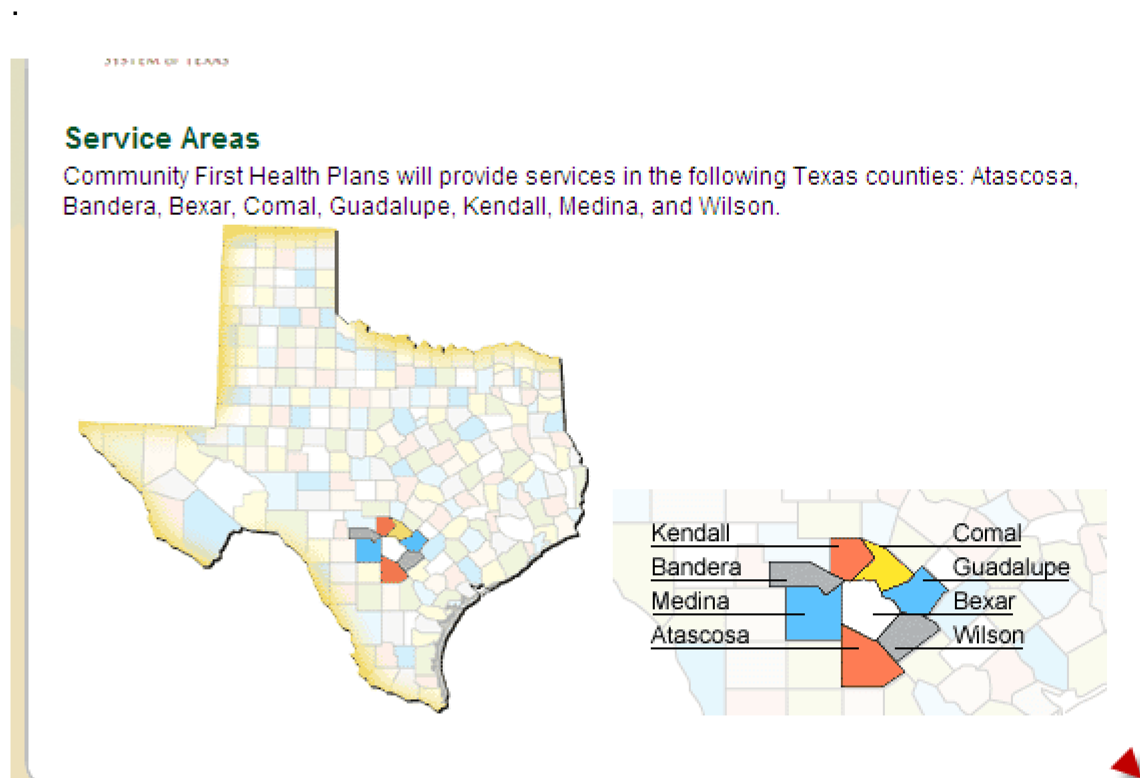

COMMUNITY FIRST HEALTH PLANS, INC.

MENTAL OR EMOTIONAL ILLNESS OR DISORDER AND ALTERNATIVE MENTAL HEALTH TREATMENT RIDER

ATTACHMENT B

These Provisions change the Certificate of Group Health Care Coverage to provide benefits for the care and treatment of mental or emotional Illnesses or disorders for You or Your eligible Dependent, subject to the applicable conditions, limitations, and exclusions stated in the Certificate of Group Health Care Coverage and this Rider.

1. **Covered Services**. Community First will cover the following mental health care services under this Rider:

   a. Treatment of mental or emotional Illness or disorder for a person when confined in a Hospital.

   b. Treatment under the direction and continued medical supervision of a doctor of medicine or doctor of osteopathy in a Psychiatric Day Treatment Facility that provides organizational structure and Individualized Treatment Plans separate from an inpatient program.

   c. Treatment at a Residential Treatment Center for Children and Adolescents or a Crisis Stabilization Unit for mental or emotional Illness which would otherwise necessitate confinement in a Hospital.

2. **Conditions for Coverage**.

   a. Treatment in a Psychiatric Day Treatment Facility must be obtained under the direction and supervision of a Participating Physician.

   b. Providers of services in a Residential Treatment Center for Children and Adolescents and a Crisis Stabilization Unit must be licensed or operated by the appropriate state agency or board.

   c. Treatment rendered in a Psychiatric Day Treatment Facility must be delivered not more than eight (8) hours in any 24-hour period and the attending Physician must certify that the treatment is in lieu of Hospitalization.

   d. Treatment in a Psychiatric Day Treatment Facility, Residential Treatment Center for Children and Adolescents, or Crisis Stabilization Unit must be based on an Individual Treatment Plan for the Member.

e. Coverage for Psychiatric Day Treatment Facility, Residential Treatment Center for Children and Adolescents, and Crisis Stabilization Unit.

f. Each two days of treatment in a Psychiatric Day Treatment Facility, Residential Treatment Center for Children and Adolescents, or Crisis Stabilization Unit will be considered equal to one day of treatment of mental or emotional illness or disorder in a hospital or inpatient program for the purpose of determining policy benefits and benefit maximums.

3. **Copayment/Percentage Copayment**

Subject to the same amount limits, deductibles, Percentage Copayments and Copayments that apply to physical illness generally.

COMMUNITY FIRST HEALTH PLANS, INC.

OUTPATIENT PRESCRIPTION MEDICATION RIDER
ATTACHMENT C

Upon presentation of a valid Community First Identification Card that indicates coverage for outpatient Prescription Medications at a Participating Pharmacy, Members shall be entitled to have a Prescription Order filled for any of the outpatient Prescription Medications described below and Community First will cover same, subject to the conditions, limitations and exclusions stated below and in the Certificate of Group Health Care Coverage ("Certificate") and the underlying Group Contract. Definitions used in this Rider have the same meanings as defined in the Group Contract/Certificate of Group Health Care Coverage and Section 1 below.

A $50 deductible per member per plan year must be met before the benefits are available.

1. **Definitions**. All defined terms are capitalized in this Rider.

   a. **Brand Name Medication**. A Prescription Medication that has been given a brand or trade name by its manufacturer and is advertised and sold under this name.

   b. **Generic Medication**. A pharmaceutical equivalent of one or more Brand Name Medications that is approved by the United States Food and Drug Administration as meeting the same standards of safety, purity, strength, and effectiveness as the Brand Name Medication.

   c. **Heritable Disease**. An inherited disease that may result in mental or physical retardation or death.

   d. **Maintenance Medication**. A Prescription Medication, in certain therapeutic categories, that Community First's Pharmacy and Therapeutics Committee (P&T) determines can be used for chronic medical conditions.

   e. **Non-preferred Medications.** All Brand Name or Generic Medications not selected as Preferred Medications by the Community First P&T Committee.

   f. **Participating Pharmacy**. A pharmacy duly licensed in the state of Texas contracting with Community First to dispense Prescription Medications to Members who are entitled to coverage for Prescription Medications. Members are able to obtain a list of Participating Pharmacies by accessing the CFHP website at http://www.cfhp.com/ERS health links.

g. **Pharmacist**. A person duly licensed to prepare, compound, and dispense medication and practicing within the scope of his/her license.

h. **Pharmacy**. A licensed establishment where Prescription Medications are dispensed by a Pharmacist.

i. **Pharmacy and Therapeutics Committee (P&T Committee)**. A committee of physicians, pharmacists and Community First staff responsible for ensuring that the quality and cost-effectiveness of Community First's pharmacy benefit is maintained.

j. **Phenylketonuria**. An inherited condition that may cause severe mental retardation, if not treated.

k. **Preferred Medications.** A limited listing of Prescription Medications that have been evaluated by Community First's Pharmacy and Therapeutics Committee (P&T Committee), and have been determined to be safe, appropriate and cost-effective. This listing is provided to all Community First Members and Participating Providers, and is periodically reviewed and updated by the P&T Committee. This listing may change during the Contract Period.

l. **Prescription Medication**. A medication which, according to federal law, can be obtained only by a Prescription Order and is required to bear a label which reads, "Caution: Federal Law Prohibits Dispensing Without a Prescription", or is restricted to prescription dispensing by laws of the state of Texas.

m**.** **Prescription Order**. A written or oral order for the preparation and use of a Prescription Medication or Supplies directly relating to the treatment of an Illness or Injury and which is issued by the treating Participating Provider or Dentist within the scope of his or her professional license.

n. **Three-tier Prescription Medication Plan.** This Outpatient Prescription Drug Rider has three tiers of Copayments that apply to both Retail Non-Maintenance and Maintenance medications, as well as Mail Order medications. You will pay the lowest Copayment for Tier 1 medications and the highest for Tier 3 medications.

Tier 1 medications are primarily Preferred Generic Medications.

Tier 2 medications are mostly Preferred Brand Name Medications and some higher cost Generic Medications.

Tier 3 consists of all Non-Preferred Medications. The P&T Committee determines which medications (Brand Name and/or Generic) are considered Non-Preferred.

2. **Covered Medications and Supplies:**

a. Medically Necessary Prescription Medications and Supplies including those prescribed for off-label drug use. These Prescription Medications may be dispensed only with a Prescription Order from a Participating Provider or Dentist, and may only be obtained at a Participating Pharmacy, except in the case of those Prescription Medications or Supplies required as a result of a Medical Emergency, or approved by Community First.

b. Contraceptive Medications and Supplies prescribed by a Participating Provider.

c. Covered Prescription Medications and Supplies dispensed by Non-Participating Pharmacies located in or outside of Community First's Service Area are covered only when dispensed in conjunction with, and immediately following, an event requiring Emergency or Urgent Care where the Member is unable to obtain same from a Participating Pharmacy. The quantity of Prescription Medications dispensed by a Non-Participating Pharmacy shall be limited to a three (3) day supply. In such circumstances, the Member must pay for Prescription Medications and Supplies at the time of dispensing and submit a claim for reimbursement to Community First.

d. Dietary formulas necessary for the treatment of PKU and other heritable diseases, including amino-acid based formulas.

e. Orally administered anticancer medication.

f. Off Label Drugs – Any drug prescribed to treat a Member for a covered chronic, disabling, or life-threatening illness is covered if the drug: (1) has been approved by the Food and Drug Administration (FDA) for at least one indication; and (2) is recognized for treatment of the indication for which the drug is prescribed in a prescription drug compendium approved by the Commissioner of Insurance; or substantially accepted peer-reviewed medical literature.

3. **Limitations.** The Prescription Medications described above are subject to the following limitations.

a. Covered Prescription Medications and/or Supplies must be ordered by an appropriate Participating Provider and obtained at a Participating Pharmacy, except when dispensed in conjunction with and immediately following an event requiring Emergency or Urgent Care where the Member is unable to obtain same from a Participating Pharmacy.

b. This benefit requires the use of generic equivalent medications when available. If a Brand Name medication is dispensed when a Generic is available, member will be responsible for the Generic Copayment plus the cost difference between the Generic and the Brand Name medication, even if a Prescription Order is written “Dispense as Written.” This will require the Member to pay a higher cost for the Prescription Medication. See the Schedule of Copayments.

c. Covered Prescription Medications will be limited to the quantity prescribed by a Community First Participating Provider, not to exceed a thirty (30) day supply. Some Prescription Medications will have further quantity limit restrictions for the 30 days supply. Maintenance Medications will be limited to the quantity prescribed by a Community First Participating Provider, not to exceed a ninety (90) day supply.

d. The preceeding limitations apply to all Prescription Medications prescribed for daily administration. Prescription Medications prescribed “as needed” will be dispensed in a quantity prescribed by a Participating Provider, not to exceed a thirty (30) day supply, based on current, clinically-accepted treatment protocols and the limitations related to restricted quantities for certain medications set forth in the previous subsection. The quantity dispensed may vary based on the medication and diagnosis.

e. Except for inhalers, “prepackaged” medications that are packaged in standardized containers from a Prescription Medication manufacturer shall not be dispensed in more than one standardized container per Prescription Order. A maximum of two (2) inhalers per Prescription Order may be obtained at one time during a thirty (30) day period, either through retail or mail order.

f. Certain Prescription Medications are subject to Pre-authorization.

g. Coverage for smoking cessation products is provided in accordance with current or medically accepted treatment protocols.

h. Certain Prescription Medications are subject to age restrictions.

4. **Exclusions.** The Prescription Medications described above are subject to the following exclusions.

a. Over-the-counter medicines and Supplies or items that may be purchased without a Physician's recommendation or written Prescription Order, unless covered under the Certificate of Group Health Care Coverage or included in this rider as an exception.

b. Non-prescriptive family planning supplies, except as covered under 2.b. above.

c. Prescription Medications or Supplies required solely because a non-Covered Service or Supply is provided. This provision does not include Prescription Medications or Supplies dispensed in connection with a medical condition resulting from a non-Covered Service or Supply.

d. Prescription Medications or Supplies that are Experimental, and non-Experimental Prescription Medications that are prescribed for Experimental purposes or indications not approved by the United States Food and Drug Administration are subject to appeal under Community First's Adverse Determinations guidelines, and is eligible for the IRO process as outlined in Section VIII of the Certificate of Group Health Care Coverage.

e. Prescription Medications or Supplies that are not Medically Necessary for the treatment of the medical condition for which it is administered.

f. Cosmetics, health or beauty aids, dietary supplements, anorectics (i.e., appetite suppressants) or any other diet medications. Also excluded is retinoic acid for cosmetic purposes, medication prescribed to remove or lessen wrinkles in the skin, and topical minoxidil and other medications to treat baldness.

g. Placebo injections and medications.

h. Aphrodisiacs.

i. The following Prescription Medications and items are excluded under this Outpatient Prescription Medication Rider because they are covered under the Certificate of Group Health Care Coverage. Please review Section II.B. of the Certificate, Covered Services and Supplies, for specific details about coverage for each of the items below.

   (1) Implantable medications and devices (e.g. pain control, Norplant and other contraceptive devices), drug infusion pumps and release devices.
   (2) Biological sera, blood, blood derivations and blood plasma.

(3) Allergy desensitization products.
(4) Medications to be taken by or administered to a Member while the Member is a patient in a nursing home, Hospital, sanitarium, Skilled Nursing Facility, rest home, convalescent Hospital, or facility of similar character, except when the facility becomes the Member's place of residence, the cost of which is not covered by Community First. In such cases, Prescription Medications must be obtained through a Participating Pharmacy.
(5) Immunizing agents.
(6) Durable Medical Equipment.
(7) Oxygen and oxygen supplies.

j. Hormonal medications required before and after sex change surgery.

k. Growth Hormones unless medically necessary due to a medical condition and not idiopathic short statue or familial short statue based on heredity.

l. Medical Foods which are formulated to be consumed or administered internally under the supervision of a physician and do not have approval by the FDA. Individual medical food products do not have to be registered with FDA.

m. Compounded medications.

5. **Important Information**.

a. Community First's outpatient Prescription Medication benefit includes the use of a Preferred Drug Listing. If You have any questions regarding Community First's Preferred Drug Listing, or if You want to know whether a specific Prescription Medication is included, You may contact Member Services at 210-358-6262 or 1-877-698-7032.

b. The inclusion of a specific Prescription Medication on Community First's Preferred Drug Listing does not guarantee that a Participating Provider will prescribe that medication for a particular medical or behavioral health condition.

c. Community First will make a Prescription Medication that was approved or covered for a medical condition or mental illness available to You at the contracted benefit level until Your plan renewal date, regardless of whether the Prescription Medication has been removed from Community First's Preferred Drug List.

This requirement will not preclude a Participating Provider from prescribing another Prescription Medication from the Preferred Drug Listing that is medically appropriate.

D. The formulary is reviewed annually by the **Pharmacy and Therapeutics Committee (P&T)** of the health plan. The P&T Committee of physicians, pharmacists and Community First staff responsible for ensuring that the quality and cost-effectiveness of Community First's pharmacy benefit is maintained.

6. **Identification Card Requirement**. If a Member must have a Prescription Order filled and has not received a Community First Identification Card, or it has been lost or is not in the Member's possession, or, if newly-enrolled, does not have the Member's copy of ERS' Enrollment Form and/or the ERS Online Enrollment Form, the Member must pay for Prescription Medications and/or Covered Supplies at the time they are dispensed and submit a claim for reimbursement to Community First, subject to a deduction for Copayment.

7. **Claims Submission**. If You have to pay for Prescription Medications or Supplies, submit the original of the paid bill along with a completed claim form. (claim forms may be obtained from the Member Services Department or on the website through www.cfhp.com/ERS). Your claim will be processed according to the procedure outlined in Section VI. of the Certificate of Group Health Care Coverage, Claim Rules.

8. **Refills**. Please ask Your Participating Provider to call Prescription Orders to Your desired Participating Pharmacy 24 to 48 hours in advance. If You are going to travel out of the service area, please contact Member Services should You need assistance in obtaining refills, if appropriate.

9. **General Provisions**.

   a. Participating Pharmacies dispensing Prescription Medications or Supplies to Members pursuant to the Group Contract and this Rider do so as an independent contractor. Community First shall not be liable for any claim or demand on account of damages arising out of or in any manner connected with any injuries suffered by Members.

   b. Community First shall not be liable for any claim or demand on account of damages arising out of or in any manner connected with the manufacturing, compounding, dispensing or use of any Prescription Medication.

COPAYMENTS

This benefit requires the use of generic equivalent medications when available. If a Brand Name medication is dispensed when a Generic is available, member will be responsible for the Generic Copayment plus the cost difference between the Generic and the Brand Name medication, even if a Prescription Order is written "Dispense as Written." This will require the Member to pay a higher cost for the Prescription Medication including oral contraceptives, insulin, and syringes. See the Schedule of Copayments.

1. A **$10** Copayment is required, per Prescription Order, for a **Tier 1 Non-maintenance** Medication. Prescription Medications will be limited to the quantity prescribed by a Community First Participating Provider, up to a thirty (30) day supply.

   A **$35** Copayment is required, per prescription, for a **Tier 2 Non-maintenance Medication**. Prescription Medications will be limited to the quantity prescribed by a Community First Participating Provider, up to a thirty (30) day supply.

   A **$60** Copayment is required per Prescription Order for a **Tier 3 Non-maintenance Medication**.

   Prescription medications will be limited to the quantity prescribed by a Community First Participating Provider, up to a thirty (30) day supply.

   If a Brand Name medication is dispensed when a Generic is available, member will be responsible for the Generic Copayment plus the cost difference between the Generic and the Brand Name medication.

2. A **$10** Copayment is required, per Prescription Order, for a **Tier 1 Maintenance Medication**. Prescription Medications will be limited to the quantity prescribed by a Community First Participating Provider, up to a thirty (30) day supply.

   A **$45** Copayment is required, per prescription, for a **Tier 2 Maintenance Medication**. Prescription Medications will be limited to the quantity prescribed by a Community First Participating Provider, up to a thirty (30) day supply.

   A **$75** Copayment is required per Prescription Order for a **Tier 3 Maintenance Medication**.

   Prescription medications will be limited to the quantity prescribed by a Community First Participating Provider, up to a thirty (30) day supply.

   If a Brand Name medication is dispensed when a Generic is available, member will be responsible for the Generic Copayment plus the cost difference between the Generic and the Brand Name medication.

3. **Mail Order** - One **$30** Copayment for up to a 90-day supply, per Prescription Order or refill for a **Tier 1** medication.

   One **$105** Copayment for up to a 90-day supply, per Prescription Order or refill for a **Tier 2** medication, including oral contraceptives, insulin, and syringes.

   One **$180** Copayment for up to a 90-day supply, per Prescription Order or refill for a **Tier 3** medication, including oral contraceptives, insulin, and syringes.

   If a Brand Name medication is dispensed when a Generic is available, member will be responsible for the Generic Copayment plus the cost difference between the Generic and the Brand Name medication, including nsulin, and syringes.

4. Maintenance Medications will be limited to the quantity prescribed by a Community First Participating Provider, up to a ninety (90) day supply. If the Member receives a Preferred Brand Name or a Non-Preferred Maintenance Medication when a Generic equivalent is available, the member will be responsible for the Generic Copayment plus the cost difference between the Generic and the Brand Name medication. In all cases, the Member will pay the lower of the actual cost of the Maintenance Medication or the Copayment.

5. Copayments for Covered Diabetic Supplies are 20% of the negotiated rate.

6. Copayments for infertility drugs are 50% of the negotiated rate.

7. Maximum Dollar Benefit Limitation: None.

8. Out-of-Pocket Limitation:

   Copayments paid toward Prescription Medications under this Outpatient Prescription Medication Rider are applicable to any annual Out-of-Pocket maximum under the Certificate of Group Health Care Coverage.

9. In all cases, the Member will pay the lower of the Usual and Customary cost of the Medication or the Copayment.

The following chart shows eligible services and supplies for Your Coverage. This Schedule is intended to be a summary. Some of these benefits are subject to limitations and exclusions described in the Certificate of Group Health Care Coverage. Please review the Covered Services and Supplies, Member Financial Responsibility section in the Certificate of Group Health Care Coverage regarding balance billing by Non-Participating Providers. Members are responsible for the payment of Copayments upon receipt of some of the Covered Services described below. Percentage Copayments will apply to certain Covered Benefits.

Summary of HMO Carrier Benefits for Fiscal Year 2016[1]

Benefit Description	Member's Cost Share PY 2016
Plan year out-of-pocket percentage copayment maximum per person (Not mutually exclusive from other out of pocket ("OOP") limits[11])	$2,000
Overall plan year out-of-pocket maximum per person, including percentage copayments and copayments (Not mutually exclusive from other out of pocket limits[11]) (OOP includes both medical and pharmacy)	$6,450
Overall plan year out-of-pocket maximum per family, including percentage copayments and copayments (Not mutually exclusive from other out of pocket limits[11]) (OOP includes both medical and pharmacy)	$12,900
Lifetime maximum	None
Physicians and Lab Services	
*Physician office visit Primary Care Physician (if applicable)	$25
*Specialist office visit	$40

*Under the Affordable Care Act, certain preventive health services are paid at 100% (i.e., at no cost to the member) dependent upon physician billing and diagnosis. In some cases, you will be responsible for payment of some services.

<table>
<tr><td>*Routine preventive care – One per calendar year or as directed by the primary care physician (if applicable)
• Children and Well Baby periodic exams
• Well Woman exam (to include Cervical Cancer Screening)
• Men's Health Exam</td><td>No charge</td></tr>
<tr><td>*Diagnostic x-rays, mammography, and lab tests</td><td>20%</td></tr>
<tr><td>High Tech Radiology (CT Scan, MRI, and Nuclear Medicine) Outpatient testing only</td><td>$100 copayment plus 20%</td></tr>
<tr><td>*Immunizations - For children and adults</td><td>No charge</td></tr>
<tr><td>*Vision, speech, and hearing screenings - For all enrolled Participants</td><td>20% without office visit,
$40 plus 20% with office visit</td></tr>
<tr><td>*Colorectal Cancer Screening - (zero cost sharing for certain preventive services under the Affordable Care Act)</td><td>No charge</td></tr>
<tr><td>*Exam for Detection and Prevention of Osteoporosis - (zero cost sharing for certain preventive services under the Affordable Care Act)</td><td>No charge</td></tr>
<tr><td>*Cervical Cancer Screening - (zero cost sharing for certain preventive services under the Affordable Care Act)</td><td>No charge</td></tr>
<tr><td>*Tubal Ligation – (zero cost sharing for certain preventive services under the Affordable Care Act)</td><td>No charge</td></tr>
<tr><td>Speech and hearing testing - For all enrolled Participants</td><td>20% without office visit,
$40 plus 20% with office visit</td></tr>
<tr><td>Speech therapy and rehabilitative therapy, including physical and occupational therapy - Covered as any other illness and not subject to any maximum</td><td>20% without office visit,
$40 plus 20% with office visit</td></tr>
<tr><td>Allergy testing</td><td>20%</td></tr>
<tr><td>Allergy serum</td><td>20%</td></tr>
<tr><td>Allergy serum administration - When allergy shot is administered without an office visit</td><td>20%</td></tr>
<tr><td>*Routine eye exam - One per plan year[2]</td><td>$40</td></tr>
<tr><td>Office surgery and procedures (all office surgeries, excluding vasectomies and tubal ligations)</td><td>20%</td></tr>
<tr><td>Benefit Description</td><td>Member's Cost Share</td></tr>
</table>

*Under the Affordable Care Act, certain preventive health services are paid at 100% (i.e., at no cost to the member) dependent upon physician billing and diagnosis. In some cases, you will be responsible for payment of some services.

	PY 2016
*Maternity care (physician services only)- Pre- and post-natal care, and network obstetrician delivery charges (including delivery by C-section)- – ***see "Hospital Services" for Inpatient charges*** (Does not include complications of pregnancy.)	Pre-natal office visit and obstetrician delivery: No charge Post-natal office visit: $25 copayment primary care physician, $40 copayment specialist
*Family planning	No charge
Vasectomy	20%
Infertility benefits[3]	50%
Hospital Services[9]	
Inpatient hospital - Semi-private room and board or intensive care units; other inpatient charges, including medically necessary surgical procedures. Includes orthognathic surgery. Personal items not covered are as follows: Guest trays, cots, telephone, maternity kits, and paternity kits.	$150 per day copayment per admission, up to $750 copayment max. per admission, $2250 copayment max. per person per year plus 20%
Outpatient day surgery	$100 copayment plus 20%
Blood and blood products - Inpatient and outpatient	20%
Outpatient facilities, including pre-admission testing and/or treatment room	20%
Emergency care - In-area and out-of-area covered at listed copayment. If hospitalized, copayment is applied to hospital confinement.	$150 copayment plus 20%
Urgent care- Includes physician's after-hours care or at an urgent care facility	$50 copayment plus 20%
Extended Care Services (Based on medical necessity)	
Skilled nursing facility (based on medical necessity)	20%
Hospice care - Inpatient and outpatient (based on medical necessity)	20%
Home health	20%
Private duty nursing	20%

*Under the Affordable Care Act, certain preventive health services are paid at 100% (i.e., at no cost to the member) dependent upon physician billing and diagnosis. In some cases, you will be responsible for payment of some services.

Other Medical Services	
Hearing aids (repairs not covered)	Plan pays $1,000 per ear every 3 years
Hearing aid batteries - Not subject to any maximum amounts	20%
Accidental Dental[4] - Restoration or replacement of dental work that was in place at the time of the injury, including, but not limited to, crowns, veneers, bridges, and implants, occurring while covered under the plan for services provided within 24 months of the date of the accident. Certain oral surgeries are covered.	20%
Durable Medical Equipment[5, 6] - Includes medically necessary purchase and/or rental. Benefits for rental are limited to, and will not exceed, the purchase price of the equipment. (Repairs are covered if not due to neglect or abuse.) This benefit also includes diabetic supplies other than insulin, diabetic oral agent(s), and syringes as specified in Section 1358.051(2), Tex. Ins. Code.	20%
Benefit Description	**Member's Cost Share PY 2016**
Prostheses - Artificial devices, surgical or non-surgical, which replace body parts, including arms, legs, eyes and cochlear implants are covered. Replacements and repairs are covered as required by medical necessity. Prosthetic devices, orthotic devices, and professional services related to the fitting and use of these devices are included, if services are pre-authorized and provided by a contracted provider.	20%
Organ Transplants - Covered as any other illness for kidney, cornea, liver, heart, heart-lung, lung, pancreatic-kidney, bone marrow, and other organ transplants that the HMO Carrier determines to be not experimental and/or not investigational according to current medical plan guidelines. Donor expenses are covered. Artificial organs (e.g. heart) not covered.	$150 per day copayment per admission, up to $750 copayment max. per admission, $2250 copayment max. per person per year plus 20%
Ambulance - Professional local ground or air ambulance transportation services to the nearest hospital, appropriately equipped and staffed for the treatment of the participant's condition	20%
Behavioral Health Care Benefits	
Inpatient mental health	$150 per day copayment per admission, up to $750 copayment max. per admission, $2250 copayment max. per person per year plus 20%

*Under the Affordable Care Act, certain preventive health services are paid at 100% (i.e., at no cost to the member) dependent upon physician billing and diagnosis. In some cases, you will be responsible for payment of some services.

Inpatient serious mental illness - Covered as any other illness[7]	$150 per day copayment per admission, up to $750 copayment max. per admission, $2250 copayment max. per person per year plus 20%
Inpatient chemical dependency - Covered as any other illness (based on medical necessity)	$150 per day copayment per admission, up to $750 copayment max. per admission, $2250 copayment max. per person per year plus 20%
Outpatient mental health therapy	$25
Outpatient serious mental illness therapy - Covered as any other illness[7]	$25
Outpatient chemical dependency therapy - Same as any other illness and not subject to any maximums	$25

Benefit Description	**Member's Cost Share** **PY 2016**
Prescription Drugs[8]	
Plan Year Deductible	$50
If a brand-name medication is dispensed when a generic is available, member will be responsible for the generic copayment plus the cost difference between the generic and the brand-name medication.	
Participating Retail Pharmacy - Tier 1, Tier 2, & Tier 3	
Up to 30-day supply per prescription or refill of **Non-Maintenance** medication	$10/$35/$60
Up to a 30-day supply per prescription or refill of **Maintenance** medication	$10/$45/$75
Infertility drugs	50%
Up to a 30-day supply of insulin for one copayment	$10/$35/$60
Up to a 30-day supply of each diabetic oral agent for one copayment	$10/$35/$60
The supply of necessary disposable syringes for the insulin supply for	$35

*Under the Affordable Care Act, certain preventive health services are paid at 100% (i.e., at no cost to the member) dependent upon physician billing and diagnosis. In some cases, you will be responsible for payment of some services.

one copayment	
Diabetic supplies other than insulin, diabetic oral agent(s), and syringes as specified in Section 1358.051(2), Tex. Ins. Code up to a 30-day supply.	20%
Mail Order Pharmacy - Tier 1, Tier 2, & Tier 3	
Up to a 90-day supply per prescription or refill for one mail order copayment	$30/$105/$180
Infertility drugs	50%
Up to a 90-day supply of insulin for one mail order copayment	$30/$105/$180
Up to a 90-day supply of each diabetic oral agent for one mail order copayment	$30/$105/$180
The supply of necessary disposable syringes for the insulin supply for one mail order copayment	$105
Diabetic supplies other than insulin, diabetic oral agent(s), and syringes as specified in Section 1358.051(2), Tex. Ins. Code up to a 90-day supply.	20%

*Under the Affordable Care Act, certain preventive health services are paid at 100% (i.e., at no cost to the member) dependent upon physician billing and diagnosis. In some cases, you will be responsible for payment of some services.

Footnotes:

1. This Summary of HMO Carrier Benefits reflects the current benefit plan structure and is subject to change as required by state and federal laws, rules and regulations or if ERS deems it to be in the best interest of ERS, the GBP, its Participants, and the state of Texas. All state mandated services shall be provided for in the HMO Carrier's Evidence of Coverage whether included in or omitted from this Summary of Benefits. The Summary of the HMO Carrier Benefits itemizes the services required by Chapter 1551, TIC, generally, by the TIC and by the rules of the TDI. The Summary of the HMO Carrier Benefits is not intended to identify all services required by the TIC, TDI; however, the following benefits should be listed:

   a. Well-child care from birth per TIC section 1271.154;
   b. Screening test for hearing loss for newborns per TIC section 1367.103;
   c. Tests for detection of prostate cancer per TIC section 1362.003;
   d. Tests for detection of colorectal cancer per TIC section 1363.003;
   e. Coverage for hospital stays following performance of a mastectomy and certain related procedures per TIC section 1357.054;
   f. Coverage for reconstructive surgery after mastectomy per TIC section 1357.004;
   g. Benefits for detection and prevention of osteoporosis per TIC section 1361.003;
   h. Coverage for craniofacial abnormalities per TIC section 1367.151-153;
   i. Telemedicine per TIC section 1455.004;
   j. Anesthesia for dental procedures in a hospital setting per TIC Chapter 1360;
   k. Coverage for certain benefits related to brain injury per TIC Chapter 1352;
   l. Coverage for prescription contraceptive drugs and devices and related services per TIC section 1369.104;
   m. Coverage for inpatient stay following childbirth per TIC section 1366.055;

*Under the Affordable Care Act, certain preventive health services are paid at 100% (i.e., at no cost to the member) dependent upon physician billing and diagnosis. In some cases, you will be responsible for payment of some services.

n. Coverage for special dietary formulas for individuals with Phenylketonuria (PKU) or other heritable diseases per TIC section 1359.003;
o. Coverage for certain amino acid-based elemental formulas per TIC section 1377.051;
p. Coverage for off-label drug use per TIC Chapter 1369;
q. Coverage for fibrocystic breast conditions per TIC section 544.201-204;
r. Eligibility for benefits for Alzheimer's disease per TIC Chapter 1354;
s. Coverage for cervical cancer per TIC Chapter 1370;
t. Coverage for certain tests for early detection of cardiovascular disease per TIC section 1376.003;
u. Coverage for routine patient care costs for enrollees participating in certain clinical trials per TIC section 1379.051; and
v. Coverage for autism spectrum disorder from date of diagnosis until the enrollee completes nine years of age per TIC section 1355.015. Coverage for autism must be provided from the date of diagnosis of the diagnosis was in place prior to the enrollee's 10th birthday.

2. Routine eye exam means an eye exam by a Doctor of Ophthalmology or a Doctor of Optometry which, when within the scope of their license, includes such services as:
   - External examination of the eye and its structure;
   - Determination of refractive status; and
   - Glaucoma screening test.

   It does not include a contact lens exam, prescriptions or fittings of contact lenses or eyeglasses, and the cost of the contact lenses or eyeglasses.

3. Infertility Benefits do not include sterilization reversal, transsexual surgery, gender reassignment, intra-fallopian transfer and related services, artificial insemination, or *in-vitro* fertilization. Also excluded from coverage are any services or supplies used in any procedures performed in preparation for or immediately after any of the above-referenced excluded procedures. Pharmaceuticals are covered at 50% copayment.

4. Certain oral surgeries mean maxillofacial surgical procedures limited to:
   - Excision of neoplasm, including benign, malignant and premalignant lesions, tumors, and nonodontogenic cysts.
   - Incision and drainage of cellulitis.
   - Surgical procedures involving accessory sinuses, salivary glands and ducts.
   - Coverage for temporomandibular joint ("TMJ") shall be in compliance with Chapter 1360, TIC. Excludes oral appliances and devices used to treat TMJ pain disorders or dysfunction of the joint and related structures, such as the jaw, jaw muscles, and nerves.

5. The diabetes benefit is as listed in Section 1358.051 of the TIC and includes benefits for diabetic equipment, diabetes supplies, and diabetes self-management training programs as follows:

   Diabetic equipment: (20% copayment)
   a. Blood glucose monitors, including monitors designed to be used by blind individuals.
   b. Insulin pumps and associated appurtenances.
   c. Insulin infusion devices.
   d. Podiatric appliances for the prevention of complications associated with diabetes.

   Diabetic supplies:
   a. Insulin and insulin analogs (covered under pharmacy benefit).
   b. Syringes (covered under pharmacy benefit at the Tier 2 copayment).
   c. Prescriptive and nonprescriptive oral agents for controlling blood sugar levels (covered under pharmacy benefit).
   d. Glucagon emergency kits (covered under pharmacy benefit).
   e. Test strips for blood glucose monitors (20% copayment).
   f. Visual reading and urine test strips (20% copayment).
   g. Lancets and lancet devices (20% copayment).
   h. Injection aids (20% copayment).
   i. Alcohol wipes (20% copayment).

   Diabetic self-management training programs: (same as office visit copayment)

*Under the Affordable Care Act, certain preventive health services are paid at 100% (i.e., at no cost to the member) dependent upon physician billing and diagnosis. In some cases, you will be responsible for payment of some services.

a. Training provided after the initial diagnosis of diabetes in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies.
b. Additional training is provided after a diagnosed significant change in the member's symptoms or condition that requires changes in the self-management regime.
c. The Food and Drug Administration approves periodic or episodic continuing education training as warranted by the development of new techniques and treatments for the treatment of diabetes.

6. ERS defines orthotics as pertaining to the feet; therefore, services or supplies for routine foot care, insoles, or shoe inserts of any type are not covered, except when prescribed for a diagnosis of or related to the treatment of diabetes or circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency. Orthotic devices, and the professional services relating to the fitting and use of those devices, are covered if the services are pre-authorized and provided by a contracted provider.

7. Restrictions on mental health benefits are not applicable to expenses incurred for the treatment of "serious mental illness" as defined in Section 1355.001, TIC. At a minimum, coverage for autism spectrum disorder must be provided from the date of diagnosis until the enrollee completes nine years of age as described in Section 1355.015, TIC.

8. Pharmacy Benefits: ERS allows the use of a formulary provided it offers a broad spectrum of high quality drug therapies. Vitamins are not covered except those that require a prescription by law and have no non-prescription equivalent.

9. Weight reduction programs, services, supplies, surgeries, or gym memberships are not covered, even if the Participant has medical conditions that might be helped by weight loss, or even if prescribed by a physician.

10. **All Applicable Copayment and Deductible Resets**

10.a. **Break in Coverage.** The prescription drug deductible and the inpatient out-of-pocket maximum per person per plan year should be reset for a Participant designated as a new hire. This would include an employee who left state or higher education employment and experienced a break in health insurance coverage. This Participant would be considered a new employee and the prescription deductible and the inpatient out-of-pocket maximum should be calculated the same as for a new employee.

10.b. **COBRA/Dependent Coverage.** Participants under COBRA and dependents who were previously covered but are now directly insured under the GBP shall not be requested to satisfy a new prescription deductible and inpatient out-of-pocket maximums as soon as their coverage becomes effective as a directly insured GBP Participant.

11. Not mutually exclusive for out-of-pocket maximums means that a Participant's total out-of-pocket maximum could contain a combination of percentage copayments and/or copayments. (For example, a Participant could pay up to $6,450 in copayments alone if there was no percentage copayment paid throughout the year. If a Participant met the $2,000 percentage copayment out-of-pocket maximum, he/she would pay $4,450 in copayments, totaling $6,450 in overall out-of-pocket expense.)

*Under the Affordable Care Act, certain preventive health services are paid at 100% (i.e., at no cost to the member) dependent upon physician billing and diagnosis. In some cases, you will be responsible for payment of some services.