SOUTHWEST LIFE & HEALTH INSURANCE COMPANY
(Herein Called We, Our, or Us)

PREFERRED PROVIDER OPTION
LARGE GROUP ACCIDENT AND HEALTH MAJOR MEDICAL PLAN
CERTIFICATE OF INSURANCE

This Certificate of Insurance certifies that the Insured becomes insured for the benefits stated in the Schedule of Benefits on the Effective Date.

THE INSURANCE POLICY 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.

Southwest Life & Health Insurance Company

SOUTHWEST LIFE & HEALTH INSURANCE COMPANY
FirstCare PPO

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Southwest Life & Health Insurance Company's toll free telephone number for information or to make a complaint at:

(800) 240-3270

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

(800) 252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
FAX: (512) 475-1771
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 Southwest Life & Health Insurance Company 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 informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de Southwest Life & Health Insurance Company's para informacion o para someter una queja al:

(800) 240-3270

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

(800) 252-3439

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104
FAX: (512) 475-1771
Web: http://www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con Southwest Life & Health Insurance Company primero. Si no se resuelva la disputa, puede entoneces comunicarse con al Departmento de Seguros de Texas.

UNA ESTE AVISO A SU POLIZA:

Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

SOUTHWEST LIFE & HEALTH INSURANCE COMPANY
FirstCare PPO

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INFORMATION IMPORTANT TO UNDERSTANDING THE BENEFITS IN THE GROUP INSURANCE POLICY

This is a Preferred Provider Option Policy or PPO. Your Employer has selected this PPO plan for You and Your Dependents (if any). As a PPO Insured, You and Your Insured Dependents will be provided a list of "Preferred" or "In-Network Providers" from whom You or Your Dependents may receive Covered Health Care Services. You may however, choose to receive Covered Health Services from any other licensed Non-Preferred Provider at a reduced benefit and subject to Our determination of Non-Preferred Provider Reimbursement (NPPR) amount. If You use any Non-Preferred Provider, You will pay higher Coinsurance and Deductible amounts as shown in Your Schedule of Benefits and You will be responsible for any amounts over Our determination of NPPR. See the definition of NPPR in *Section 1, Definitions.*

A Preferred Provider is a Hospital, Facility, Home Health Agency, or other Health Care Provider that is located within Our Service Area and has contracted with Southwest Life & Health Insurance Company (SWL&H) to provide services and treatment under this Policy. See *Section 1, Definitions*, for additional details.

A Non-Preferred Provider is any Hospital, Facility, Home Health Agency, or other Health Care Provider that has not contracted with SWL&H. When an Insured receives covered Emergency Care services from a Non-Preferred Provider, those services will be paid as if they were received from a Preferred Provider. However, once the Insured can be safely transferred to a Preferred Provider, the Insured will be required to transfer to a Preferred Provider in order to continue receiving the Preferred Provider level of benefits. If the Insured chooses not to transfer, benefits will be payable at the Non-Preferred Provider level of benefits. See *Section 1, Definitions*, for additional details.

PPO Service Area is the geographical area in which Southwest Life & Health Insurance Company's contracted Preferred Providers are located.

SECTION 1 DEFINITIONS

Some words and phrases used in this Policy are defined below. Other words and phrases are defined where they appear.

Throughout this document, "You" and "Your" refer to a Southwest Life & Health Insurance Company Insured, including any Dependents (such as spouses and children) that are also enrolled in the Plan. "We," "Our," or "Us" refers to Southwest Life & Health Insurance Company. "Your Plan" and "this Plan" refers to the Southwest Life & Health Insurance Company Policy, which is described in this document, together with Your Schedule of Benefits and any applicable Riders.

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

Adverse Determination - A determination by a utilization review agent that health care services provided or proposed to be provided to a patient are not medically necessary or are experimental or investigational.

Allowable Amount - the amount We determine to be eligible for consideration of payment for a particular Covered Health Service, supply, or procedure.

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

Application - all forms required to be completed by the Policyholder or the employee.

Assignment of Benefits - a written transfer of benefits payable for Covered Health Services made by the Insured and obtained by or delivered to Us with the Claim for benefits. We will pay the benefit payment directly to the Hospital, Facility, Home Agency, or other Health Care Provider. This written Assignment of Benefits does not relieve the Insured of any contractual responsibility to pay the Deductible or the Coinsurance.

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

Calendar Year - the calendar year starting on January 1st and continuing through December 31st.

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

Certificate of Insurance - this document along with any attachments, Riders, and Your Application. The Certificate of Insurance, also referred to as the Policy, is issued to the Insured.

Chemotherapy Associated Agents - any medication used as supportive therapy for Cancer Chemotherapy administered at the time of chemotherapy administration. Medications used as supportive therapy not administrated at the time of chemotherapy infusion will be covered on a Pharmacy Rider benefit only.

Claim - notification that a service has been rendered or supplies have been furnished to an Insured. This notification must set forth in full, the details of the service or supplies, as required by Us.

Coinsurance - the percentage of charges for Covered Health Services that You pay. The Coinsurance percentage is 100% minus the benefits payable shown in the Schedule of Benefits.

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

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

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

Complaint - any dissatisfaction expressed by You, or anyone acting on Your behalf, orally or in writing to Us with any aspect of Our operation, including but not limited to, dissatisfaction with plan administration, procedures related to review or appeal of an Adverse Determination, the denial, reduction or termination of a service for reasons not related to Medical Necessity, the way a service is provided, or disenrollment decisions. The term does not include a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the Insured and does not include a Plan Provider's or the Insured's oral or written dissatisfaction or disagreement with an Adverse Determination.

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

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

The following conditions are not considered Complications of Pregnancy:

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

Complications of pregnancy are treated as any other Illness.

Contract Year - a 12 month period beginning with the effective date of coverage for a Policy, and each succeeding 12 month period thereafter that the Policy is effective.

Copayment - the amount You are required to pay to a Plan Provider or other authorized provider in connection with the provision of Covered Health Services. Copayments that are not subject to the Deductible must continue to be paid even when an Insured has reached their Deductible. The Copayment amounts are indicated in the Schedule of Benefits.

Covered Health Services - those Medically Necessary services, supplies, or benefits described in *Section 4, What is Covered,* of this Certificate of Insurance, as well as in any applicable Riders provided under the terms and conditions of this Certificate of Insurance.

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

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

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

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

Deductible - the amount of Covered Health Services You are responsible for paying each Policy Year before benefits become payable under this Policy. The *Deductible* is the amount of Covered Expenses You must pay for each Insured before any benefits are available regardless of provider type. The *Out-of-Network Deductible* is the additional amount of Covered Expenses You must pay for each Insured when using Non-Preferred Providers. Refer to Your Schedule of Benefits for details.

Dependent - a member of an employee's Family who meets the eligibility requirements specified in *Section 2, Eligibility,* and who is enrolled in this plan.

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

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

Diabetic Supplies and Equipment - equipment and supplies for the treatment of diabetes for which a physician or practitioner has written an order, including blood glucose monitors, including non-invasive blood glucose monitors, including those designed to be used by or adapted for the legally blind; test strips specified for use with a corresponding glucose monitor; lancets and lancet devices; visual reading strips and urine testing strips and tablets which test for glucose, ketones and protein; insulin and insulin analog preparations; injection aids, including devices used to assist with insulin injection and needleless systems; insulin syringes; biohazard disposal containers; insulin pumps, both external and implantable, and associated appurtenances, which include insulin infusion devices; batteries; skin preparation items; adhesive supplies; infusion sets; insulin cartridges; durable and disposable devices to assist in the injection of insulin; and other required disposable supplies; 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; prescription medications and medications available without a prescription for controlling the blood sugar level; podiatric appliances, including up to two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes; glucagon emergency kits.

As new or improved treatment and monitoring equipment or supplies become available and are approved by the United States Food and Drug Administration, such equipment or supplies shall be covered if determined to be medically necessary and appropriate by a treating physician or other practitioner through a written order. All supplies, including medications, and equipment for the control of diabetes

shall be dispensed as written, including brand name products, unless substitution is approved by the physician or practitioner who issues the written order for the supplies or equipment.

Drug Coverage List - a listing of prescription drugs that are approved by the FirstCare Pharmacy and Therapeutics Committee to be dispensed through participating pharmacies and which will be a covered benefit pending any utilization management approvals.

Durable Medical Equipment (DME) - medical equipment that in the absence of Illness or Injury is of no medical or other value to You. DME is able to withstand repeated use by more than one person and is not disposable. Examples of such equipment include crutches, hospital beds, wheelchairs, canes, walkers, and traction devices.

Effective Date - with respect to this Policy, the coverage date of the Policy begins and, with respect to any Insured, the date the Insured is first covered under this Certificate of Insurance.

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

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

Medical screening evaluations, which are necessary to determine whether an emergency medical condition exists, shall be provided to the Insured in the Hospital emergency department, Freestanding Emergency Medical Care Facility, or comparable emergency Facility, and all necessary Emergency Care services will be provided to the Insured regardless of whether services are received within the Service Area or outside the Service Area. Some Covered Health Services originating in a Hospital emergency department following stabilization of an emergency condition are subject to Preauthorization by Us in order to receive the maximum benefit.

Eligible Person - an employee of the Enrolling Group who works on a full-time (usually at least 30 hours a week) or full time equivalent basis, or other person whose connection with the Enrolling Group meets the eligibility requirements specified by the Application, Policy, Employer Group and Us. The term also includes a sole proprietor, a partner, and an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of an Employer. The term does not include:

1. An employee who works on a temporary, seasonal, or substitute basis; or
2. An employee who is covered under:
    - Another health benefit plan;
    - A self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the employee retirement income security act of 1974;
    - The Medicaid program if the employee elects not to be covered;
    - Another federal program, including the CHAMPUS program or Medicare program, if the employee elects not to be covered; or
    - A benefit plan established in another country if the employee elects not to be covered.

Employer - the entity shown on the face page of this Certificate of Insurance who has purchased for its Eligible Persons, this Policy from Southwest Life & Health Insurance Company. If the Employer is a partnership or a sole proprietorship, each of its partners, or the sole proprietor, is considered an employee for Policy purposes.

Essential Health Benefits – are comprised of general categories and covered items/services within those categories, as defined by Section 1302(b) of the Patient Protection & Affordable Care Act (PPACA), such as:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity & newborn care;
- Mental health & substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services/devices;
- Laboratory services;
- Preventive/wellness services & chronic disease management; and
- Pediatric services, including oral and vision care.

Facility - a health care or residential treatment center licensed by the state in which it operates to provide medical inpatient, residential, day treatment, partial hospitalization, or outpatient care. Facility also means a treatment center for the diagnosis and/or treatment of chemical dependency or mental illness.

Family - You and Your Dependents who are covered under this Certificate of Insurance who are not otherwise covered by this Policy.

Freestanding Emergency Medical Care Facility - means a facility, structurally separate and distinct from a hospital that receives an individual and provides emergency care, as defined under Chapter 254 of the Health and Safety Code.

Health Care Facility - a Facility which is licensed, certified, or otherwise authorized, according to the laws of the state where located to provide Covered Health Services.

Health Care Provider - with respect to any Medical Care and service, a person or organization that is:

- Certified or licensed under the laws of the state where treatment is provided;
- Qualified for the medical or surgical service for which the Claim is made;
- Practicing within the scope of certification or licensure; or
- Any other Health Care Provider or allied practitioner as recognized or mandated by state law. The term does not include an intern, a resident, or a person in training.

Home Health Agency - an organization licensed by the state where this Policy is issued to render home health services.

Hospital - an institution, which is licensed as a Hospital under the laws of the jurisdiction where it is located, and meets the following conditions:

- Is engaged in providing for pay and on its own premises, inpatient care and treatment of Ill and Injured persons through medical and diagnostic Facilities;
- Provides 24-hour nursing service by or supervised by a registered nurse;
- Has major surgery Facilities on its premises, or a written contractual agreement with an accredited Hospital for the performance of surgery;

- Is accredited under a program of the Joint Commission on Accreditation of Health Care Organizations; and
- Is under the supervision of a staff of one or more duly licensed physicians.

Hospital Confinement - being registered as a bed patient in a Hospital on the recommendation of a Health Care Provider.

Hybrid Injectables - any injectables defined as a Pharmacy Injectable required to be administered at the time of dialysis or cancer chemotherapy infusion. If these medications are not administered at the point of service, and they are Pharmacy Injectables, they are covered on a Pharmacy Rider only. These drugs will be defined by the Pharmacy and Therapeutics Committee.

Illness - a bodily disorder or infirmity, including Complications of Pregnancy that results in expenses covered under this Policy. Illness does not include any Illness or Injury for which benefits are provided under any Workers' Compensation, occupational disease, employer's liability, or similar statute.

Injury - physical damage to the Insured's body, including all related conditions and recurrent symptoms caused by accidental means and independent of all other causes.

Independent Review Organization (IRO) - an organization selected as provided under Chapter 4202 of the Texas Insurance Code.

Insured(s) - an employee and/or his Dependent who is covered and entitled to benefits under this Policy.

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

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

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

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

Maternity - ante/postpartum care, childbirth, or early involuntary termination of pregnancy.

Medical Care - furnishing those services defined as the practice of medicine.

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

Medically Necessary or Medical Necessity - treatments, service, supply, drug, or Hospital Confinement (or part of a Hospital Confinement):

- Is appropriate to diagnose or treat the patient's Illness or Injury;
- Does not exceed in scope, duration, or intensity, the level of care which is needed to provide safe, adequate, and appropriate diagnosis and/or treatment;
- Is prescribed by a Physician;
- Is consistent with widely accepted professional standards of medical practice in the United States;
- Is not primarily for the personal comfort of the patient, the Family, Physician, or other provider of care;

- Is not a part of, or associated with, the scholastic, educational, or vocational training of the patient;
- Is neither investigative nor experimental in nature; or
- For inpatient care, cannot be supplied safely on an outpatient basis.

The fact that a Physician has prescribed, recommended, or supplied a treatment, service, or supply does not make it Medically Necessary. Our Utilization Review Agent evaluates all conditions listed above. The Utilization Review Agent will decide whether a service or supply is Medically Necessary, considering the views of the medical community, guidelines and practices of Medicare and Medicaid, and peer review literature.

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

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

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

Neurobehavioral treatment - Interventions that focus on behavior and the variables that control behavior.

Neurobiological disorder - means an illness of the nervous system caused by genetic, metabolic or other biological factors.

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

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

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

Neurophysiological testing - An evaluation of the functions of the nervous system.

Neurophysiological treatment - Interventions that focus on the functions of the nervous system.

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

Neuropsychological treatment - Interventions designed to improve or minimize deficits in behavioral and cognitive processes.

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

Non-Preferred Provider - any Hospital, Facility, Home Health Agency, or Health Care Provider who is not contracted with Us at the time services are rendered. The Allowable Amount for Covered Health Services provided by Non-Preferred Providers will be considered based upon Non-Preferred Provider

Reimbursement (NPPR) amounts. See this Section for the definition of NPPR amounts. When an Insured receives covered Emergency Care services from a Non-Preferred Provider, those services will be paid as if they were received from a Preferred Provider. However, once the Insured can be safely transferred to a Preferred Provider, the Insured will be required to transfer to a Preferred Provider in order to continue receiving the Preferred Provider level of benefits. If the Insured chooses not to transfer, benefits will be payable at the Non-Preferred Provider level of benefits.

Non-Preferred Provider Reimbursement (NPPR) - also referred to as the Usual, Customary and Reasonable (UCR) amount. NPPR is the amount we will consider for medical care from Non-Preferred Providers. We determine this amount based on the payment methodology established by Medicare. Non-Preferred Providers may bill Insureds for charges over Our determination of the NPPR amount. The Insured is responsible for these charges, in addition to all applicable Coinsurance and Deductibles.

Non-Specialist Physician - A Physician who practices general medicine, family medicine, internal medicine or pediatrics who provides basic health care services to You. Please see Your Schedule of Benefits for further details.

Open Enrollment Period - a 31-day period occurring at least once a year, as specified in the Policyholder's Application and decided periodically by Southwest Life & Health Insurance Company and the Policyholder, during which Eligible Persons may enroll.

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

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

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

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

Physician - any Physician who is licensed and qualified to practice within the scope of a medical practice license issued under the laws of the state in which treatment is received. This term does not include an intern or a person in training.

Plan, Your Plan, The Plan - the coverage of health care services available to You under the terms of this Certificate of Insurance.

Policy - this Certificate of Insurance, the Application, and any subsequent amendment, Rider, or endorsement that We issue to the Policyholder.

Policyholder - the entity shown on the face page of this Certificate of Insurance who has purchased for its Eligible Persons, this Policy from Southwest Life & Health Insurance Company. If the Employer is a partnership or a sole proprietorship, each of its partners, or the sole proprietor, is considered an employee for Policy purposes.

Policy Year - the annual period that begins on the anniversary of this Policy's Effective Date. See the Schedule of Benefits for details as to if Your Policy is administered on a Contract Year or Calendar Year basis.

Post-acute transition services - services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

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

Preauthorization - the medical review process examining the Medical Necessity of a procedure or service which You must obtain from Us prior to receiving such procedure or service from a Health Care Provider. Preauthorization must be obtained to receive the maximum benefits under this Policy. You or Your Health Care Provider must contact Us at least five days prior to any scheduled outpatient tests or any other treatments that require Preauthorization.

Preauthorization Penalty - a monetary penalty, which is levied upon You when You or Your Health Care Provider fails to Preauthorize, as required by this Policy. We will charge a Failure to Preauthorize Penalty if You or Your healthcare provider do not obtain Preauthorization for the services, tests, or other treatments listed in *Section 6, Utilization Review (U.R.) Program.* The Failure to Preauthorize Penalty applies each time the service or treatment is provided without the proper Preauthorization.

Preferred Provider - any Hospital, Facility, Home Health Agency, Physician, Health Care Provider, practitioner, Institutional Provider, or organization of Health Care Providers who has contracted with Us to provide services and treatments to You under this Certificate of Insurance. These Preferred Providers have signed an agreement with Us and have agreed to file Claims on Your behalf. If services are not available through Preferred Providers, Non-Preferred Providers shall be reimbursed at the same rate the Preferred Providers would have been reimbursed, had You been treated by contracted Preferred Providers up to Our determination of NPPR amounts.

Premium or Premiums - money paid monthly to Us by the Policyholder in order for You to receive services and benefits under this Certificate of Insurance.

Premium Due Date- the first day of each calendar month during a Policy Year.

Prior Plan - the group health plan provided by the Policyholder immediately prior to this Policy provided by Southwest Life & Health Insurance Company.

Prosthetics - artificial devices designed to replace, wholly or partially, an arm or leg.

Psychiatric Day Treatment Facility - a facility that provides treatment for individuals suffering from acute mental and nervous disorders in a structured psychiatric program using individualized treatment plans with specific attainable goals and objects that are appropriate to the patient and the program's treatment modality. This type of facility is clinically supervised by a doctor of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology, and is similar to a Residential Treatment Center for adults.

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

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

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

Residential Treatment Center for Children and Adolescents - a child-care institution that provides residential care and treatment for emotionally disturbed children and adolescents and that is accredited as

a residential treatment center by the Council on Accreditation, the Joint Commission on Accreditation of Healthcare Organizations or the American Association of Psychiatric Services for Children.

Rider(s) - benefit options, which are made available to a Policyholder, pursuant to applicable underwriting requirements and Premium rates. Such Riders, when purchased, will be attached to or incorporated into the applicable Policy.

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

Service Area - a geographic area where or within which Preferred Providers that have contracted with Us are located. Refer to the Provider Directory to determine if You live in Our Service Area or visit Our website at www.FirstCare.com.

Skilled Nursing Facility or Extended Care Facility - an institution which:

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

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

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

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

Utilization Review - a system for prospective and/or concurrent review of the Medical Necessity and appropriateness of Covered Health Services Your provider is currently providing or proposes to provide to You. Utilization Review does not include elective requests by You for clarification of coverage.

Utilization Review Agent (URA) - an entity designated by Us to perform Utilization Review of Medically Necessary treatment. The URA also determines Totally Disabled and Total Disability.

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

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

We, Our, or Us - Southwest Life & Health Insurance Company.

You or Your - an Insured.

SECTION 2 ELIGIBILITY, ENROLLMENT & EFFECTIVE DATE OF COVERAGE

ELIGIBILITY

Employee Coverage

You are an Eligible Person and eligible to enroll in This plan if You:

- Work on a full time or full time equivalent basis;
- Usually work at least 30 hours a week, or
- Are another person whose connection with the Enrolling Group meets the eligibility requirements specified by the Application, Policy, Employer Group and Us; and
- Satisfy any probationary or waiting period requirements required by Your Group.

The term does not include:

1. An employee who works on a temporary, seasonal, or substitute basis; or
2. An employee who is covered under:
   - Another health benefit plan;
   - A self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974;
   - The Medicaid program if the employee elects not to be covered by this health plan;
   - Another federal program, including the CHAMPUS program or Medicare program, if the employee elects not to be covered by this health plan; and
   - A benefit plan established in another country if the employee elects not to be covered by this health plan.

Dependent Coverage

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

1. Be an eligible Dependent of an employee/retiree who is enrolled in the program;
2. Meet all Dependent eligibility criteria established by the applicable Policyholder; and
   - Be the employee's lawful spouse;
   - Be Your or Your spouse's child (including a step-child, a legally adopted child, or a child for whom You or Your spouse is party in suit for adoption) who is under age 26; or
   - Be a child for whom You or Your spouse is a court appointed legal guardian, and provided proof of such guardianship is submitted with the Application;
   - Be a child who is and continues to be both:
     a. Incapable of self-sustaining employment by reason of mental or physical handicap; and
     b. Is chiefly dependent upon You or Your spouse for economic support and maintenance. You must provide proof of such incapacity and dependency to Us within 31 days of the child's attainment of the applicable limiting age.

        Subsequently, We may require that You continue to provide proof of Your child's incapacity and dependency to Us, but not more frequently than once per year, after the two-year period following the child's attainment of the limiting age;

- Be a newborn child of You or Your spouse. If You wish to add Your newborn to Your current coverage (even if You already have dependent coverage) You or Your employer must notify the plan verbally or in writing to enroll Your newborn as a Dependent within 31 days following Your child's birth, and pay any necessary Premium charges, if applicable. If We do not receive verbal or written notification from You or Your employer, Your newborn will not be added, and cannot be added until the next group open enrollment period (even if You already have dependent coverage);
- Be an unmarried grandchild who is dependent upon You for federal income tax purposes at the time Application for coverage of the child is made, and who otherwise meets the requirements for an unmarried child specified above. Coverage may not be terminated solely because the covered child is no longer a Dependent of the Policyholder for federal income tax purposes;
- Be a child for whom You or Your spouse must provide medical support by order issued under Section 14.061, Texas Family Code or similar state law; or
- Be a child of any age who is medically certified as disabled and dependent on the parent.

Effects of Medicare Eligibility

Medicare eligibility *does not* alter eligibility under this Certificate of Insurance. Medicare eligibility *does* affect the way benefits are coordinated. Refer to *Section 7, Determination of Order of Benefits* for information on primary and secondary coverage.

ENROLLMENT

No person meeting employee or Dependent eligibility requirements will be refused enrollment or re-enrollment because of health status, age, requirements for health services, or the existence on the Effective Date of coverage of a pre-existing physical or mental condition, including pregnancy. No Insured's coverage shall be terminated due to health status or health care needs.

1. Initial Enrollment

Each Eligible Person shall be entitled to apply for coverage for himself or herself and eligible Dependents during the initial Open Enrollment Period. All persons included for coverage must be listed on the Application. No proof of insurability shall be required.

2. Open Enrollment

Open Enrollment Period means a 31-day period provided annually, in which an Eligible Person and eligible Dependents may enroll for coverage, and is held at least annually. It must be a 31-day period consisting of the entire calendar month beginning on the first day of the month and ending no earlier than 31 days later. For example, if the month is February, the period should last through March 2nd. No proof of insurability shall be required.

3. Newly Eligible Person

Each new Eligible Person of the Employer who becomes eligible for coverage at other than the initial enrollment or Open Enrollment Period shall be permitted to enroll himself or herself and eligible Dependents within 31 days of becoming eligible.

4. Newly Eligible Dependents

Any person attaining eligibility to become a Dependent may be enrolled by the Eligible Person within 31 days of attaining eligibility. No proof of Insurability shall be required. If a newly eligible Dependent is not added within the first 31 days of eligibility, that Dependent cannot be added to coverage until the next Open Enrollment Period.

5. Limitation

Persons initially or newly eligible for enrollment who do not enroll within 31 days of eligibility may be enrolled only during a subsequent Open Enrollment Period.

6. Notice of Ineligibility

It is your responsibility to notify FirstCare and Your employer of any changes that will affect You or Your Dependent's eligibility for services or benefits under this Policy within 31 days of the event. You and Your employer may be responsible for premiums through the end of the month of notification to FirstCare as outlined in the Texas Insurance Code.

7. Late Enrollee

A late enrollee is an Eligible Person or Dependent who applies for coverage after the expiration of the Initial Enrollment Period established through the Employer or after the expiration of the annual Open Enrollment. An Eligible Person or Dependent requesting enrollment as a Late Enrollee shall be excluded until the next annual Open Enrollment Period.

8. Who is Not a Late Enrollee

An Eligible Person or Dependent is not a late enrollee if:

1. The employee or Dependent:
   - Was covered under another health benefit plan or self-funded employer health benefit plan during the time the person was eligible to enroll; and declined coverage under this Policy during the time the person was eligible to enroll in writing on the basis of the coverage under another health benefit plan or self-funded employer health benefit plan; and
   - Had coverage under the other health benefit plan or self-funded employer health benefit plan, and that coverage is ending due to termination of the plan, reduction in the number of hours of employment, termination of employment, termination of contributions toward the Premium made by the employer, death of a spouse, or divorce; and requests enrollment within 31 days after the date coverage ends under the other health benefit plan or self-funded employer health benefit plan.
2. Is employed by an employer who offers multiple health benefit plans and the employee elects a different health benefit plan during an Open Enrollment Period;
3. Is under a court order to provide coverage for an employee's child and the request for enrollment is made within 31 days from the date the employer receives notification of the court order;
4. Is under a court order to provide coverage for an employee's spouse and the request for enrollment is made within 31 days after issuance of the court order;
5. An Eligible Person has a change in Family composition due to marriage, birth of a child, adoption of a child or because an Eligible Person becomes a party in a suit for the adoption of a child and requests enrollment within 31 days of marriage, birth, adoption, or within 31 days of the date the Insured becomes a party in a suit for the adoption of a child; and
6. A person becomes a Dependent due to marriage, birth of a child, adoption of a child or because an Insured becomes a party in a suit for the adoption of a child and requests enrollment within 31 days of marriage, birth, adoption, or within 31 days of the date the Insured becomes a party in a suit for the adoption of a child.

7. Is an individual who is a child of a covered employee who has lost coverage under Title XIX of the Social Security Act (42 U.S.C. Section 1936 et seq.), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1936s), or under Chapter 62, Health and Safety Code, and the request for enrollment is made not later than the 31st day after the date on which the child loses coverage.

EFFECTIVE DATE OF COVERAGE

Subject to Our receipt of a completed Application and the payment of applicable Premiums, coverage under this Certificate of Insurance shall become effective on the earliest of the following dates:

1. **Initial Enrollment and Open Enrollment**

   Coverage shall be effective as of such date agreed upon by the Policyholder and Us, commonly the first day of the month following the enrollment period.

2. **Newly Eligible Persons**

   Coverage will be effective as of the first day of the month following the enrollment, provided We receive the appropriate Application and applicable Premiums within 31 days of initial eligibility.

3. **Newly Eligible Dependents**

   Coverage will be effective as of the date of the event establishing eligibility (for example, marriage, adoption, guardianship, or birth), provided We receive the appropriate notification and applicable Premiums within 31 days of the event. Newborn children of the employee or employee's spouse and newborn children of enrolled Dependents are covered for the first 31 days from the date of birth. Continued coverage for these newborn children is dependent upon enrollment as explained above. Newly eligible Dependents, including newborn children, not added to coverage within 31 days of the event may not continue coverage and may not be added until the next Open Enrollment Period.

ADOPTED CHILDREN

If an Insured adopts a child while insured by the Policy, the child may be enrolled at the option of the Insured, within either:

- Thirty-one days after the Insured is a party in a suit for adoption; or
- Thirty-one days of the date the adoption is final.

If an Insured decides not to continue coverage for the newly adopted child beyond either of the 31-day periods, a Premium will be charged for the 31 days coverage was in force.

SECTION 3 HOW BENEFITS ARE PAID

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

DEDUCTIBLE

The Deductible shown in the Schedule of Benefits means the amount of Covered Health Services which You must incur each Policy Year before benefits are paid under this Policy. The Deductible applies to all Covered Health Services. The Deductible *does* apply toward the Out-of-Pocket Maximum.

Family Deductible

When the Family Deductible, as noted in the Schedule of Benefits, has been met by combining the per Insured Deductibles that have been satisfied, then no further Deductible will apply for the remainder of that Policy Year.

Common Accident

If two or more of Your covered Family members are injured in the same accident, only one individual Deductible will apply. This covers all of the combined Family expenses due to that accident during that Policy Year.

COINSURANCE

The Coinsurance rate is Your and/or Your Dependent's share of covered medical benefits that each of You must pay. The Coinsurance percentage is 100% minus the benefits payable percentage shown in the Schedule of Benefits. The Coinsurance amount applies toward the Out-of-Pocket Maximum.

OUT-OF-POCKET MAXIMUM

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

ANNUAL MAXIUMUM BENEFIT

The annual maximum is the maximum amount for Non-Essential Health Benefits that We will pay for any Insured under all policies issued by Us providing Covered Health Services for the Policy Year span of any Insured. When this maximum is reached, coverage for such Insured will end..

LIFETIME MAXIMUM BENEFIT

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

SUBROGATION, REIMBURSEMENT and/or THIRD PARTY RESPONSBILITY

A. Subrogation

1. Covered Persons, Plan Beneficiaries, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns collectively referred to hereinafter in this section as "Covered Person(s)." The Covered Person(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage (which includes, but is not limited to no-fault,

uninsured motorist, underinsured motorist, medical payment provisions, third party asses, third party insurance, and/or grantor(s) of a third party (collectively "Coverage")) to which the Covered Person(s) is entitled, not to exceed the benefits advanced by the Plan, at the Plan's discretion, to seek payment of funds advanced by the Plan for losses which are the responsibility of that other Coverage.

2. The Plan may, at its discretion, in its own name or in the name of the Covered Person(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits paid by the Plan.

3. If the Covered Person(s) fails to file a claim or pursue damages against:

   - the responsible party, its insurer, or any other source on behalf of that party;
   - any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
   - any policy of insurance from any insurance company or guarantor of a third party;
   - any other liability insurance company;
   - worker's compensation, subject to the relevant statute and rules regarding workers compensation or,
   - any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;the Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

   the Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person(s)' and/or the Plan's name and agrees to fully cooperate with reasonable requests with the Plan in the prosecution of any such claims. The Covered Person(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

B. Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid up to the amount of money recovered by the Covered Person, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Covered Person(s) is fully compensated by his/her recovery from all sources. The obligation to reimburse the Plan exists regardless of how the judgment or settlement classifies funds paid to the Covered Person and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Person(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved, not to exceed the amount of recovery achieved, in accordance with applicable law.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

3. The Plan may recover up to the amount of money recovered and the Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

4. All of the Plan's subrogation and reimbursement rights are set forth in these provisions, within this certificate. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person(s).

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

C. Excess Insurance

If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to:

- the responsible party, its insurer, or any other source on behalf of that party;
- any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- any policy of insurance from any insurance company or guarantor of a third party;
- any other liability insurance company;
- worker's compensation, subject to the relevant statute and rules regarding workers compensation; or
- any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

D. Wrongful Death

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

E. Obligations

1. It is the Covered Person(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan, to a reasonable extent:
    - to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
    - to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
    - to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
    - to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
    - to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
    - to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Beneficiary may have against any responsible party or Coverage.
2. If the Covered Person(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person(s).

3. The Plan's rights to reimbursement and/or subrogation are in no way dependant upon the Covered Person(s)' cooperation or adherence to these terms.

F. Minor Status

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

G. Severability

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

NON-DUPLICATION

Workers' Compensation

The benefits under this Policy are not designed to duplicate any benefit to which You are entitled under Workers' Compensation Insurance or laws. Charges for health services arising out of job related Illness or Injury is not covered under this Policy, regardless of whether such Illness or Injury is covered by Workers' Compensation Insurance. In the event benefits are provided, all sums payable under Workers' Compensation Insurance or other laws shall be payable to, and retained by Us, not to exceed the amount We have paid. You must complete and submit to Us such consents, releases, assignments, and other documents reasonably requested by Us in order to obtain or assure such reimbursement. When We determine, after investigation and verification, that an Injury or Illness is not work related, We will assume responsibility for Covered Health Services.

Other Plans

If any benefits to which You are entitled under this Policy are also covered by any other plan(s), the payable benefits shall be coordinated with the benefits that are available to You under such other plans, whether or not a Claim has been made for the other benefits.

PAYMENTS TO THE TEXAS DEPARTMENT OF HUMAN SERVICES

If notified in writing, Southwest Life & Health Insurance Company must pay any benefits for Your Dependent child to the Texas Department of Human Services if the Agency is paying benefits on behalf of Your Dependent child under Chapter 31 or Chapter 32, Human Resources Code.

If notified in writing, Southwest Life & Health Insurance Company must pay the Texas Department of Human Services for the actual cost of medical expenses the Department pays through medical assistance for an Insured under this Policy, if the Insured is entitled to payment for the Covered Health Services.

PAYMENT TO A POSSESSORY OR MANAGING CONSERVATOR

If notified in writing, We must pay any benefits for the Eligible Person's Dependent child to the possessory or managing conservator of the child. A certified copy of a court order establishing the person as possessory or managing conservator must be submitted with the Claim or other evidence designated by rule of the Texas Department of Insurance that the person qualifies to be paid the benefits as provided by §1204.251 of the Texas Insurance Code.

SECTION 4 - WHAT IS COVERED

Southwest Life & Health Insurance Company will pay benefits upon receipt of proper proof that any Insured incurs Covered Health Services for treatment of an Illness or Injury covered under this Certificate of Insurance.

Some services outlined in the section below may require pre-approval. Refer to the pre-authorization list posted at www.firstcare.com or contact Customer Service at 1-800-240-3270 to determine if a specific service requires pre-approval.

COVERED HEALTH SERVICES

Benefits are paid for the following Medically Necessary treatments, services, and supplies for Covered Health Services:

PLEASE REFER TO THE SCHEDULE OF BENEFITS FOR APPLICABLE COINSURANCE AND DEDUCTIBLE AMOUNTS, AND ANY BENEFIT LIMITATIONS THAT MAY APPLY FOR CERTAIN SERVICES.

A. Inpatient Services

1. *Semi-Private Room and Board Charges*

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

2. *Hospital Delivery Rooms and Related Facilities*

   We cover Hospital delivery rooms, newborn nursery and related Facilities, and any special procedures, as may be Medically Necessary. Inpatient care is provided for the mother and her newborn child in a Health Care Facility for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarean section, unless the mother requests and the attending Physician agrees to discharge prior to the expiration of the minimum length of stay. If a decision is made to discharge the mother or newborn child from inpatient care before the expiration of the minimum hours of inpatient care, post-delivery care will be provided by a Physician, registered nurse, or other appropriate licensed Health Care Provider in either the mother's home, a provider's office, or a Health Care Facility.

   Note: *If your Newborn requires confinement in NICU, then any applicable deductible / coinsurance will be applied separately to Your newborn, for any covered charges associated with that confinement. This is in addition to any applicable Mother deductible / coinsurance.*

3. *Inpatient Services for the Treatment of Breast Cancer*

   Inpatient services required to diagnose and treat breast cancer are provided for a minimum 48-hour inpatient stay following a mastectomy and a 24-hour inpatient stay following a lymph node dissection. The inpatient stay may be less than the minimum hours of inpatient care, if the Insured and the Insured's treating Physician determine that a shorter period of inpatient care is appropriate.

4. *Other Hospital Services and Supplies*

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

B. Outpatient Services

PLEASE REFER TO THE SCHEDULE OF BENEFITS FOR APPLICABLE COINSURANCE AND DEDUCTIBLE AMOUNTS, AND ANY BENEFIT LIMITATIONS THAT MAY APPLY FOR CERTAIN SERVICES.

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

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

Other covered outpatient care services include:

1. Health Care Provider Services

Covered Health Care Services include the following:

- Inpatient and outpatient surgery;
- Physician Hospital visits;
- Physician office and home care;
- Maternity care, including Physician services for pre and post-natal care; and
- Allergy testing, serum, services, and treatment of allergy symptoms.

2. Outpatient Surgery

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

3. Laboratory and Radiology Services

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

C. Preventive Health Care Services

PLEASE REFER TO THE SCHEDULE OF BENEFITS FOR APPLICABLE COINSURANCE AND DEDUCTIBLE AMOUNTS, AND ANY BENEFIT LIMITATIONS THAT MAY APPLY FOR CERTAIN SERVICES.

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

2. *Well-baby and well-child preventive care* for children.

3. *Immunizations* for all Insureds according to generally accepted medical practice standards, including "preventive health" immunizations & vaccines (e.g. flu, pneumonia, tetanus, etc.), and for those immunizations approved by the Center for Disease Control for travel outside the United States.

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

5. *Routine sight, speech, and hearing screenings*. Speech and hearing services include care or treatment of a speech or hearing impairment or loss; services necessary to restore speech loss; services provided to correct a congenital malformation for which corrective surgery has been performed.

6. *Screening Test for Hearing Impairment* in newborns.

7. *Screening mammograms* for women to detect breast cancer. In addition to routine screening, mammograms are covered when prescribed by a Physician as Medically Necessary to diagnose or treat Illness.

8. *Screening for Detection of Colorectal Cancer* includes screening examinations and procedures for Insureds at a normal risk for developing colon cancer. These exams include fecal occult blood tests, a flexible sigmoidoscopy, or a colonoscopy.

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

10. *Prostate cancer testing* to detect prostate cancer, including a physical examination and a prostate-specific antigen (PSA) test.

11. *Pap Smear Screen* for women who are insured under this plan awe cover a screening test performed in accordance with the guidelines adopted by the American College of Obstetricians and Gynecologists or another similar national organization of medical professionals recognized by the State of Texas.

12. *Cardiovascular Disease Screenings (noninvasive)*, for men (over age 45) and women (over age 55) who are insured under this plan, are diabetic or have a risk of developing coronary heart disease, based on a score derived from the Framingham Heart Study coronary prediction algorithm, that is intermediate or higher. We cover up to $200 for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five (5) years. These tests include CT scanning measuring coronary artery calcification, or ultrasonography measuring carotid intima-media thickness and plaque.

14. *All Other Preventive Services*, that are mandated as covered by the federal government, can be viewed in Section 2713 of the Patient Protection and Affordable Care Act (PPACA). Please note that this list is maintained by the United States Preventive Services Task Force, and it is subject to change at any time, and without notice.

    For further information on Preventive Services, visit www.firstcare.com or contact FirstCare at (800) 240-3270.

D. Family Planning

PLEASE REFER TO THE SCHEDULE OF BENEFITS FOR APPLICABLE COINSURANCE AND DEDUCTIBLE AMOUNTS, AND ANY BENEFIT LIMITATIONS THAT MAY APPLY FOR CERTAIN SERVICES.

Family Planning Services

We cover these Family planning services:

- Physical exams, related laboratory tests, and medical supervision;
- Information and counseling on contraception;
- Materials and services to insert or remove an intrauterine device (IUD);
- Materials and services to fit a diaphragm contraceptive;
- Materials and services to insert or remove a birth control device implanted under the skin (such as Norplant); and
- Vasectomy and tubal ligation (voluntary sterilization).
- Depo-Provera™ Injections

E. Other Health Care Services

PLEASE REFER TO THE SCHEDULE OF BENEFITS FOR APPLICABLE COINSURANCE AND DEDUCTIBLE AMOUNTS, AND ANY BENEFIT LIMITATIONS THAT MAY APPLY FOR CERTAIN SERVICES.

Spinal Manipulation Services

Your plan may include coverage for Spinal Manipulation Services. Services may be rendered by a participating In-Plan Provider.

Rehabilitative Services

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

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

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

Reconstructive Surgery

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

- Correct a defect resulting from a congenital anomaly that is present at birth in a child who is younger than 18 years of age;
- Restore normal physiological functioning following an accident, injury, or disease;

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

Prosthetics and Orthotics

We cover standard external, non-cosmetic prosthetic or orthotic devices, as well as professional services related to the fitting of prosthetic and orthotic devices. Examples of covered devices include artificial arms, legs, hands, feet and eyes, breast prostheses and surgical brassieres after mastectomy for breast cancer.

We do cover repair or replacement of any external prosthetic or orthotic devices, except in cases of loss or misuse of the device(s).

We do not cover corrective orthopedic shoes, shoe inserts, orthotic inserts, arch supports, splints or other foot care items, except for the treatment of diabetes. We do not cover ankle braces with the exception of braces required for recovery after surgery, for the treatment of diabetes, and for certain illness and injury.

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

Internal Implantable Devices

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

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

Dorsal Column Stimulators

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

Pain Management Services

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

- Services must be ordered by Physician Services and can be expected to meet or exceed treatment goals established for You by Your Physician;
- Services are scientifically proven and evidenced-based to improve Your medical condition.

Acquired Brain Injury

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

- Cognitive rehabilitation therapy;
- Cognitive communication therapy;
- Neurocognitive therapy and rehabilitation;
- Neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing and treatment;
- Neurofeedback therapy;
- Remediation required for and related to treatment of an acquired brain injury
- Post-acute transition services;
- Community reintegration services, including outpatient day treatment services, or other post-acute care treatment services necessary as a result of and related to an acquired brain injury.

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

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

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

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

We will not refuse required covered services for and related to treatment of an acquired brain injury solely because they are provided by an assisted living facility.

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

Second Surgical Opinion

We cover services for second surgical opinions.

Dialysis Services

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

Organ Transplant Services

Physician and hospital services for medically necessary organ transplants are covered, including costs associated with organ procurement and the reasonable medical and hospital expenses of the organ donor. The following conditions must be met:

- A contracted and/or nationally recognized medical facility designated and approved by Southwest Life & Health Insurance Company is authorized to evaluate the Insured's case, has determined that the proposed transplant is appropriate for treatment of the Insured's condition and has agreed to perform the transplant.
- The proposed transplant is not experimental or investigational for treatment of the Insured's condition, and is not to be performed in connection with a drug, device or medical treatment or procedure that is experimental or investigational; and

  Note: Denials for experimental/investigational treatments or procedures are eligible for review by an Independent Review Organization (IRO). See Section 9 for information on complaints and appeal procedures.
- In order to receive the maximum benefit, all services relating to organ transplantation must be pre-approved by the Southwest Life & Health Insurance Company Medical Director and performed in a facility approved by Southwest Life & Health Insurance Company.

The following organ transplants that meet the criteria defined above are covered:

- Heart transplants;
- Lung transplants;
- Heart/Lung transplants;
- Bone marrow transplants;
- Pancreas transplants;
- Liver transplants;
- Corneal transplants; and
- Kidney transplants.

See Your Schedule of Benefits for specific information regarding Deductibles, Coinsurance percentages, Out-of-Pocket Maximums, Maximum Benefit limits.

Limitations & Non-covered Services
Coverage of each type of solid organ transplant listed above is limited to one (1) initial transplant and one (1) subsequent re-transplant due to rejection.

The following transplant services are ***not*** covered:

- Artificial organs;
- Experimental/investigational medical and surgical procedures;
- Services when the Insured acts as a donor, unless the recipient is a Covered Person under this Policy.

If the donor is a Covered Person under this SWL&H Policy, coverage is subject to all procedures, limitations, exclusions, copayments, and deductibles that apply under the donor-Insured's policy. We do not cover any other donor expenses, including any transportation costs.

Chemical Dependency Services

Inpatient and outpatient treatment for chemical dependency and detoxification are covered as any other medical Illness or Injury. Chemical dependency is subject to Medically Necessary requirements. A series of treatments is a planned, structured, and organized program to promote chemical free status. The series may include different Facilities or modalities and is complete when:

- The Insured is discharged on medical advice from inpatient detoxification, inpatient rehabilitation/treatment, partial hospitalization, or intensive outpatient;

- The Insured completes a series of these levels of treatment without a lapse in treatment; or
- The Insured fails to materially comply with the treatment program for 30 days.

The contracted behavioral health provider must pre-approve all chemical dependency services.

Acute/Non-Chronic Mental Health Services

We cover evaluations and treatment for mental health conditions, which are not chronic or organic in nature, and which are responsive to short-term treatment for Crisis Intervention.

Services are provided for acute/non-chronic mental health care, including group and individual treatments. Coverage for these services, including for the purpose of medication management, is covered the same as treatment of any physical illness.

The contracted behavioral health provider must pre-approve the services.

Serious Mental Illness Services

Treatment of serious mental illness is covered if the mental illness or disorder being treated is one of the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

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

The contracted behavioral health provider must pre-approve all serious mental illness services.

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

Autism Spectrum Disorder

We provide coverage for screening a child for autism spectrum disorder at the ages of 18 and 24 months.

We provide coverage to enrollees who are diagnosed with autism spectrum disorder from the date of diagnosis , only if the diagnosis was in place prior to the child's 10^{th} birthday.

All generally recognized services prescribed in relation to Autism Spectrum Disorder by the enrollee's provider in the treatment prescribed by the provider will be covered as stated in the Schedule of Benefits by a provider, or an individual acting under the supervision of a health care provider:

- Who is licensed, certified, or registered by an appropriate agency of the State of Texas;
- Whose professional credential is recognized and accepted by an appropriate agency of the United States; or
- Who is certified as a provider under the Tricare military system.

Generally recognized services may include services such as:

- Evaluation and assessment services;
- Applied behavior analysis;
- Behavior training and behavior management;
- Speech therapy;
- Occupational therapy;
- Physical therapy; or
- Medications or nutritional supplements used to address symptoms of autism spectrum disorder

Note: For Plan Members 10 years of age or older, who were diagnosed with Austism Spectrum Disorder before their 10th birthday, We will provide coverage as required by State Regulation.

Durable Medical Equipment

The following Durable Medical Equipment are covered:

Durable Medical Equipment (DME) is medical equipment that in the absence of Illness or Injury is of no medical or other value to You, which is able to withstand repeated use by more than one person, and is not disposable. Examples of such equipment include but are not limited to: crutches, Hospital beds, wheelchairs, walkers, lymphedema pumps, traction devices, canes, Continuous Passive Motion (CPM) devices, infusion pumps, phototherapy light, alternating pressure pads and pumps.

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

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

- DME must be ordered or prescribed by a Health Care Provider;
- DME must be Medically Necessary as determined by Us;
- DME may be purchased or rented, whichever is most cost effective, as determined by Us;
- Coverage is provided for the initial equipment only; and
- Only the standard equipment is covered. Special features which are not part of the basic equipment are not covered, such as electric beds and motorized or customized wheelchairs.
- In the event it is determined to be more cost effective to purchase or when the rental payments equal the purchase price of any DME, then that DME becomes Our property. You are responsible for any replacement, repair, adjustment, or routine maintenance of Your equipment.

The following items *are not included* in the DME limitation:

- Oxygen and mechanical equipment necessary for treatment of chronic or acute respiratory failure;
- DME used for the treatment of diabetes; and
- Monitoring devices, such as apnea, glucose and uterine monitors, for use in the home when prescribed and directed by a Health Care Provider.

Medical Supplies

The following Medical Supplies are covered:

- Medical supplies used for the treatment of diabetes are covered. Examples of these supplies include test strips, lancets, and lancet devices. For a more complete listing of these supplies, see the definition of Diabetes Supplies in Section 1, Definitions.
- Standard ostomy supplies, sterile dressing kits, such as tracheostomy and central line dressing kits, as well as those medical supplies requiring a Physician's order to purchase. Supplies, which can be purchased over-the-counter without a Physician order, are not covered. See Section 5, What is Not Covered.
- Allergy syringes.

Limited Accidental Dental – Related Services

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

- Removal of broken teeth as necessary to reduce a fractured jaw
- Reconstruction of a dental ridge resulting from removal of a malignant tumor
- Extraction of teeth prior to radiation therapy of the head or neck

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

- The fracture, dislocation or damage results from an accidental injury;
- Both the injury and treatment occur while Your coverage under this Plan is in effect;
- You seek treatment within **48 hours** of the time of the accident;
- Restoration or replacement is completed within 6 months of the date of the injury;

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

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

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

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

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

Temporomandibular Joint Disorder

We cover the diagnosis and surgical treatment of disorders of, and conditions affecting the temporomandibular joint, which includes the jaw and the craniomandibular joint resulting from an accident, a trauma, a congenital defect, a developmental defect, or a pathology.

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

Blood and Blood Products

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

Home Health Care Services

Covered Health Services include:

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

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

Skilled Nursing Facility Services

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

Hospice Care

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

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

- Inpatient care - room and board, not to exceed the Semi-Private Room rate, and other necessary services and supplies;
- Outpatient care - part-time nursing care by or under the supervision of a registered nurse (R.N.); home health aide services; nutrition services; and medical supplies, drugs, and medicines that are prescribed by a Health Care Provider and that can be administered only by a licensed health professional, but only to the extent that such items or services would have been covered under this Certificate of Insurance if the Insured had been confined in a Hospital or Skilled Nursing Facility; and
- Bereavement counseling for the patient's immediate Family. "Immediate Family" means the patient's spouse and children who are insured under this Certificate of Insurance. If the patient is a child, it includes the parents and siblings who are insured under this Certificate of Insurance. Such services are only covered during the six-month period following the patient's death.

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

We cover medically injectable drugs, defined hybrid injectables, radiation therapy, specified transplant anti-rejection therapy, specified cancer chemotherapy and defined associated agents, and orally administered anticancer medications. Refer to the Schedule of Benefits for details.

Home Infusion Therapy

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

- Medical Injectable Drugs and IV solutions;
- Pharmacy charges;
- Equipment and supplies needed to administer the therapy;
- Delivery services;
- Related nursing services; and
- Patient and Family education.

Injectable Medications recognized by the FDA as appropriate for self-administration (referred to as "self-injectable" drugs), regardless of the enrollee's ability to self-administer, are not covered, unless Your group has purchased the prescription drug Rider or coverage is otherwise specified in this document. Refer to Your prescription drug Rider for details.

Treatment of Diabetes

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

1. Diabetic Medications

We cover the following medications:

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

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

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

2. Diabetic supplies, equipment and self-management education

We cover Diabetic Supplies and Equipment as defined in *Section 1, Definitions.* Diabetes Self-Management Training programs are covered as Basic Plan Benefits under the following circumstances:

- After the initial diagnosis, including nutritional counseling and proper use of Diabetes Equipment and supplies;

- When Your Physician diagnoses a significant change in Your condition which requires a change in Your self-management regimen; or
- When Your Physician prescribes, orders, or recommends such additional training in order to teach You about new techniques and treatments for diabetes.

Insulin Pump Supplies can be obtained in 30-day amounts through this Durable Medical Supply benefit or in a 90-day amount through a Participating Mail Service Pharmacy. Call the SWL&H Customer Service Department at (800) 240-3270 for more information.

Amino Acid-Based Elemental Formulas

We provide coverage for amino acid-based elemental formulas, as well as any medically necessary services associated with the administration of the formulas, regardless of the formula delivery method, that are used for the diagnosis/treatment of the following:

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

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

Clinical Trials – Routine Patient Care

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

Routine patient care costs DO NOT include:

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

This benefit is provided for routine patient care for a Member in connection with a Phase I, II, III, or IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of a life threatening disease or condition.

F. Emergency and Urgent Care Services

PLEASE REFER TO THE SCHEDULE OF BENEFITS FOR APPLICABLE COINSURANCE AND DEDUCTIBLE AMOUNTS, AND ANY BENEFIT LIMITATIONS THAT MAY APPLY FOR CERTAIN SERVICES.

Emergency Care

Emergency Care includes the following services:

- An initial medical screening examination by the Facility providing the Emergency Care or other evaluation required by state or federal law that is necessary to determine whether an emergency medical condition exists;
- Services for the treatment and stabilization of an emergency condition; and
- Post-stabilization care originating in a Hospital emergency room, Freestanding Emergency Medical Care Facility, or comparable emergency Facility. You, Your Physician, or Family member must notify Us if You are admitted to the Hospital.

See the definition of Emergency Care in *Section 1, Definitions.*

Ambulance Services

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

Urgent Care Services

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

If You are not able to go to a Preferred Provider, You may seek Medically Necessary urgent care services from a Non-Preferred Provider, however, You will be responsible for the higher Non-Preferred Provider Deductible, Out-of-Pocket Maximum, and Coinsurance amounts listed on Your Schedule of Benefits.

Urgent care means medical services that:

- Do not meet the requirements necessary to be considered "Emergency Care" described above in *Section 1, Definitions;*
- You or Your Dependent urgently need such services, and if You are outside Our Service Area, You could not reasonably have anticipated needing such services before You left the SWL&H Service Area; and
- If treatment is delayed, the urgent medical condition could become worse or result in a more serious condition.

Preferred Providers:

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

Non-Preferred Providers:

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

- We will pay the Non-Preferred Provider Reimbursement (NPPR) amount (see *Section 1, Definitions)* for care received from Non-Preferred Providers; or
- We will arrange to pay those providers at rates negotiated with the provider by Us.

SOUTHWEST LIFE & HEALTH INSURANCE COMPANY

FirstCare PPO

PLEASE REFER TO THE SCHEDULE OF BENEFITS FOR APPLICABLE COINSURANCE AND DEDUCTIBLE AMOUNTS, AND ANY BENEFIT LIMITATIONS THAT MAY APPLY FOR CERTAIN SERVICES.

SECTION 5 WHAT IS NOT COVERED

Exclusions are named medical conditions or health services that are not covered under this Certificate of Insurance. In addition to any specific limitations or exclusions listed elsewhere, no benefits are paid under this Certificate of Insurance for:

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

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

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

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

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

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

7. The following **cosmetic,** plastic, medical, or surgical procedures, and cosmetic therapy and related services or supplies, including, but not limited to Hospital confinements, prescription drugs, diagnostic laboratory tests, and x-rays or other reconstructive procedures (including any relates prosthesis, except breast prosthesis following mastectomy and craniofacial reconstruction for children), unless specifically provided in Section 4, *What is Covered*. Among the procedures that We do not cover are:

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

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

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

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

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

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

- Cleaning the teeth
- Any services related to crowns, bridges, filings, or periodontics;
- Rapid palatal expanders;
- X-rays or exams;
- Dentures or dental implants;
- Dental prostheses, or shortening or lengthening of the mandible or maxillae for Insureds over age 18, correction of malocclusion, and any non-surgical dental care involved in the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome, such as oral appliances and devices;
- Treatment of dental abscess or granuloma;
- Treatment of gingival tissues (other than for tumors);
- Surgery or treatment for overbite or underbite and any malocclusion associated thereto, including those deemed congenital or developmental anomalies; and
- Orthodontics, such as splints, positioners, extracting teeth, or repairing damaged teeth.

The only dental-related coverage We provide is described in *Section 4, What Is Covered.*

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

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

- Corrective shoes, shoe inserts, arch supports, orthotic inserts and devices except for those described in Section 4, Prosthetics and Orthotics, What is Covered, or for the treatment of diabetes.
- Comfort or convenience items, such as bathtub chairs, whirlpool tubs, safety grab bars, stair gliders or elevators, over-the-bed tables, bed boards, saunas, exercise equipment, and institutional equipment, such as air fluidized beds and diathermy machines.
- Environmental control equipment such as air purifiers, air conditioners, humidifiers, dehumidifiers, electrostatic machines, and heat lamps.
- Foam cervical collars;
- Stethoscopes, sphygmomanometes, and recording or hand-held oximeters;
- Hygienic or self help items or equipment;
- Electric, deluxe and custom wheelchairs or auto tilt chairs;
- Sequential lymphedema compression devices, except for treatment after a mastectomy.

13. The following **drugs, equipment, and supplies**, except immunizations and prescribed treatment of Phenylketonuria (PKU), diabetes and Autism Spectrum Disorder *(as covered under this Policy)*:

- Outpatient prescription drugs, except as covered by a Rider;
- Medications for use outside of the Hospital or other inpatient facility, including take-home and over-the-counter drugs, except those used in the treatment of diabetes or as covered by a Rider.
- Experimental drugs and agents; or
- Drugs used to treat cosmetic conditions.
- DESI Drugs

14. **Educational testing** and therapy, motor or language skills, or services that are educational in nature or are for vocational testing or training except in cases of Autism Spectrum Disorder and Acquired Brain Injuries as described in *Section 4 - What Is Covered*.

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

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

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

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

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

20. **Equine** or Hippo therapy, except for Autism Spectrum Disorder *(as covered under this Policy)*.

21. The following **equipment and supplies,** except as provided for the treatment of diabetes, and Autism Spectrum Disorder *(as covered under this Policy)*:

    - All Durable Medical Equipment, except as provided herein; and
    - Disposable or consumable outpatient supplies, such as needles, blood or urine testing supplies (except supplies used in the treatment of diabetes and allergy syringes) and sheaths, bags, elastic garments and bandages, home testing kits, vitamins, dietary supplements, and replacements, special food items and formulas (except for formulas necessary to treat phenylketonuria or other heritable diseases).

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

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

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

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

23. Routine **foot care,** including treatment of weak, strained or flat feet, corns, calluses, or medications such as Lamisil or Sporanox for the treatment of uncomplicated nail fungus. We also do not cover corrective orthopedic shoes, arch supports, splints or other foot care items, except for the treatment of diabetes. This will not apply to the removal of nail roots. We do not cover ankle braces, with the exception of those listed under Section 4.

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

25. **Growth hormone** drugs for persons 18 years of age or older. However, growth hormone therapy for the treatment of documented growth hormone deficiency in children for which epiphyseal closure has not occurred, are covered if Your group has purchased the Prescription Drug Rider.

26. **Hearing Devices** such as hearing aids, hearing aid batteries, and temporary or disposable hearing aids, unless an additional rider has been purchased.

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

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

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

30. **Illegal Acts:** Charges for services received as a result of Injury or Sickness caused by or contributed to by the covered person engaging in an illegal act or occupation or by committing or attempting to commit a crime, criminal act, assault or other felonious behavior. For purposes of this exclusion, an act is "illegal" if it is contrary to or in violation of law, and includes, but is not limited to, operating a motor vehicle, recreational vehicle or watercraft while intoxicated. Intoxication includes situations in which the covered person has a blood alcohol content or concentration (BAC) which exceeds the applicable legal limit. This exclusion does not apply if the Injury resulted from an act of domestic violence or medical condition (including both physical and mental health), or in case of emergency, the initial medical screening examination, treatment and stabilization of an emergency condition.

31. **Illness or Injury** incurred as a result of war or any act of war, whether declared or undeclared, and whether or not the Insured served in the military.

32. **Infertility** testing and treatment, infertility drugs, reversal of voluntary sterilization; gamete intra-fallopian transfer (GIFT); zygote intra-fallopian transfer (ZIFT); in vitro fertilization (IVF); any costs related to surrogate parenting; infertility services required because of a sex change by the Member or the Member's partner; medical services for artificial insemination; or any assisted reproductive technology or related treatment, unless an additional rider has been purchased.

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

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

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

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

37. **Medications** prescribed for non-FDA approved indications, referred to as off-labeled drug use, and are not covered. This includes experimental, investigational, any disease or condition that is excluded from coverage; or that the FDA has determined to be contraindicated for treatment of the current indication. Off-labeled drug use may be covered if the drug is approved by the FDA for at least one indication; and is recognized for treatment of the indication for which the drug is prescribed in substantially accepted peer-reviewed national medical professional journals. Denials for Experimental/Investigational drugs, devices, treatments or procedures are eligible for review by an IRO. See Section 9 for information on complaints and appeal procedures.

38. **Medications** for use outside of the Hospital or other inpatient facility, including take-home and over-the-counter drugs, except those used in the treatment of diabetes or as covered by a Rider. Any denials for Experimental/Investigational drugs, devices, treatments or procedures are eligible for review by an IRO. See Section 9 for information on complaints and appeal procedures.

39. Inpatient and outpatient treatment, surgery, service, procedures, or supplies that are not **Medically Necessary**; even if they are prescribed or recommended by a Health Care Provider, dentist, or ordered by a court of law, except when prescribed for the treatment of diabetes. Any denials for Experimental/Investigational drugs, devices, treatments or procedures are eligible for review by an IRO. See Section 9 for information on complaints and appeal procedures.

40. **Mental health services** for the following conditions: mental retardation; gender identity disorder; senile deterioration, such as progressive dementia of Alzheimer's and Alzheimer's like diseases; sleep disorders and factitious disorders. Marriage counseling is not a covered health service. Court ordered evaluation; diagnosis and treatment for mental conditions are excluded unless this Policy would otherwise cover such services. Court ordered testimony is not a covered health service.

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

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

43. Charges that exceed **Non-Preferred Provider Reimbursement** amounts.

44. If a service is **not covered** under this Policy, We will not cover any services that are related to it. Related services are:

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

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

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

46. Services intended primarily to treat **obesity**, such as gastric bypasses and balloons, vertical banding, stomach stapling and jaw-wiring, weight reduction programs, gym memberships, gym equipment, prescription drugs or other treatments for obesity (except preventive services related to obesity including screening for obesity in adults, counseling and behavioral interventions to promote sustained weight loss, diet and behavioral counseling in primary care to promote healthy maintenance of hyperlipidemia and cardio risk factors along with other diet-related chronic disease factors) even if prescribed by a Physician or the Insured has medical conditions that might be helped by weight loss, regardless of medical necessity. Any complications/services related to the treatment of obesity will not be covered under this Policy.

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

48. **Orthotripsy** and related procedures.

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

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

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

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

53. Elective, non-therapeutic termination of **pregnancy** (abortions), including any abortion-inducing medications, except where the life of the mother would be endangered if the fetus were to be carried to term.

54. All internal and external **prosthetic items and devices,** except for those specified in Section 4, *What is Covered*. WE do not cover splints unless they are needed for urgent or emergency treatment and/or in lieu of castings or surgery.

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

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

57. **Self Injectable Medications** recognized by the FDA as appropriate for self-administration, regardless of the enrollee's ability to self-administer, are not covered, except as covered in the Prescription Drug Rider or coverage is otherwise specified in this document. Refer to Your Prescription Drug Rider for details.

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

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

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

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

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

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

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

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

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

67. **Services** required as a result of Experimental/Investigational drug testing done voluntarily by the Insured without Our authorization**.** Any denials for Experimental/Investigational drugs, devices, treatments or procedures are eligible for review by an IRO. See Section 9 for information on complaints and appeal procedures.

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

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

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

70. Procedures, services, or supplies for or related to **sex change**, transformation or reassignment; modification surgery and services, any treatment of gender identity disorders, or any treatment or surgery related to sexual dysfunction or inadequacies including, but not limited to, hormone therapy, impotency, regardless of Medical Necessity.

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

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

73. Infertility drugs, reversal of voluntary **sterilization**; gamete intra-fallopian transfer (GIFT); zygote intra-fallopian transfer (ZIFT); in vitro fertilization (IVF) unless the Insured has subscribed to the In-Vitro Fertilization Rider; any costs related to surrogate parenting; infertility services required because of a sex change by the Insured or the Insured's partner; or any assisted reproductive technology or related treatment that is not specified in *Section 4, What is Covered.*

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

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

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

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

78. **Vision** exams, eye exercises, training, orthoptics, or multiphase testing, eyeglasses (including eyeglasses and contact lenses prescribed following vision surgery) contact lenses, except for

treatment of Keratoconus, and any other items or services for the correction of Your eyesight, including but not limited to: orthoptics, vision training, vision therapy, radial keratotomy (RK), automated lamellar keratoplasty (ALK or LK), astigmatic keratotomy (AK) and photo refractive keratectomy (PRK-laser) unless specifically provided in *Section 4, What Is Covered,* or as provided by a Rider.

Limitations Due to Certain Conditions

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

SOUTHWEST LIFE & HEALTH INSURANCE COMPANY

FirstCare PPO

SECTION 6 UTILIZATION REVIEW (U.R.) PROGRAM

The following provisions apply to Your coverage under the Southwest Life & Health Insurance Company Certificate of Insurance. If You do not comply with these provisions, We will reduce Your benefits under this Certificate of Insurance, as stated below and in the Schedule of Benefits.

DEFINITIONS

Preauthorization, Authorization, and Authorize - the review and confirmation of the Medical Necessity of an admission or Covered Health Service that is subject to the U.R. Program Requirements.

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

EFFECT ON BENEFITS

We will pay for Covered Health Services described in the Schedule of Benefits and subject to all provisions of this Certificate of Insurance, when the Utilization Review requirements are properly followed and the applicable Medical Care is Preauthorized. You are responsible for obtaining Preauthorization. We will reduce payment for Covered Health Services by the amount of the failure to Preauthorize penalty if You do not properly follow the Utilization Review Program. The additional amounts that You are charged as a result of the benefit reduction, will not count toward the Deductibles or the Out-of-Pocket Maximums in this Certificate of Insurance.

In the event of an Adverse Determination, the URA will provide a written notification to You and Your Health Care Provider. The URA will provide notification within 24 hours by telephone or electronic transmission if You are an inpatient or within three calendar days if You are not an inpatient. In the event of an Adverse Determination denying post-stabilization care for emergency treatment, as requested by a treating physician or provider, notification will be provided within one (1) hour of the determination having been made by Our Utilization Review Agent. You can request an appeal if Your Health Care Provider does not agree with an Adverse Determination made by Our Utilization Review Agent.

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

UTILIZATION REVIEW PROGRAM REQUIREMENTS

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

PREAUTHORIZATION REQUIREMENTS

We require that certain medical services, care, or treatments be Preauthorized before We will pay for all related Covered Health Services. Preauthorization means that We review and confirm that proposed services, care, or treatments are Medically Necessary. You are responsible for ensuring that Your Physician obtains preauthorization for any proposed services at least five (5) days before You receive them. For a listing of the services requiring preauthorization, please go to www.firstcare.com or contact Customer Service at **(800) 240-3270**. This listing is subject to change.

If You fail to get proper authorization on the services, care, or treatment that require preauthorization, We will reduce payment for those covered services, as outlined in the Schedule of Benefits.

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

Catastrophic Case Management

Any case that is expected to exceed $25,000 or any case in the following categories is considered a catastrophic case:

- AIDS;
- Amputations;
- Cancer;
- Coronary disease;
- Head injuries;
- Lung & respiratory disease;
- Multiple fractures;
- Multiple Sclerosis;
- Multiple trauma;
- Neonatal high risk infants;
- Severe burns;
- Spinal cord injuries; and
- Stroke.

We will automatically review the case and confer with the Insured's attending Physician. Once a Catastrophic Case is identified, Medical Care coordinators will work with Your Family and medical professionals to develop an effective long-term treatment plan tailored to the Insured's unique needs.
The treatment plan includes a comprehensive medical evaluation, an outline of specific treatment goals, and a concise plan of action around which You, Your Family, Physician, Employer, and Providers can focus their efforts. Once the treatment plan is implemented, We will continue to monitor the case and provide You and Your Family with an ongoing source of information about additional treatment alternatives.

SECTION 7 DETERMINATION OF ORDER OF BENEFITS

APPLICABILITY

The Coordination of Benefits (COB) provision applies under This Plan when the Insured has health care coverage under more than one health Plan. This Policy provision will only apply for the duration of Your employment.

If this COB provision applies, the order of benefit determination rules apply and should be considered first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

- Will not be reduced when This Plan determines its benefits before another Plan; but
- May be reduced when another Plan determines its benefits first.

DEFINITIONS

Allowable Expense - an amount allowed for covered health care when the service is covered at least in part by one or more Plans insuring the Insured for whom the Claim is made.

The difference between the cost of a private Hospital room and the cost of a Semi-Private Hospital Room is not considered an Allowable Expense under the above definition, unless the insured's stay in a private room is Medically Necessary, either in terms of generally accepted medical practice, or as specifically defined in the Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

When benefits are reduced under a primary Plan because an Insured does not comply with the Plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to Preauthorization of admissions or services.

Claim Determination Period - a Policy Year. However, it does not include any part of a year during which an Insured has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

Plan - any of these, which provides benefits or services for or because of, medical or dental care or treatment:

- Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, or individual practice coverage. It also includes coverage other than school accident-type coverage.
- Coverage under a government plan or coverage required or provided by law. This does not include a state Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

Each Policy or other arrangement for coverage is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

This Plan - the part of this Policy that provides benefits for health care expenses.

Primary Plan/Secondary Plan - the order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan covering the person.

- When This Plan is a primary Plan, its benefits are determined before those of the other Plan and without consideration of the other Plan's benefits.

- When This Plan is a secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, This Plan may be a primary Plan as to one or more other Plans, and may be a secondary Plan as to a different Plan or Plans.

ORDER OF BENEFIT DETERMINATION RULES

General

When there is a basis for a Claim under This Plan and another plan, This Plan is the secondary Plan that has its benefits determined after those of the other plan, unless:

- The other plan has rules coordinating its benefits with those of This Plan; and
- Both those rules and This Plan's rules require that This Plan's benefits be determined before those of the other plan.

Rules

This Plan determines its order of benefits using the first of the following rules which applies:

1. Non-Dependent/Dependent

The benefits of the Plan which insures the covered person as an employee, are determined before those of the Plan, which insures the covered person as a Dependent. Except that, if the Insured is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

- Secondary to the plan insuring the Insured as a Dependent; and
- Primary to the plan insuring the Insured as other than a Dependent (e.g. a retired employee).

Then the benefits of the plan insuring the Insured as a Dependent are determined before those of the plan, insuring that Insured as other than a Dependent.

2. Dependent Child/Parents Not Separated or Divorced

Except as stated below, when This Plan and another plan cover the same child as a Dependent of different persons, called parents:

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

However, if the other plan does not have the rule described immediately above, but instead has a rule based on gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

3. Dependent Child/Separated or Divorced

If two or more plans insure an Insured as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

- First, the plan of the parent with custody of the child; then
- The plan of the spouse of the parent with custody; and

- Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first.

The plan of the other parent will be the secondary plan. This paragraph does not apply with respect to any Claim, Determination Period, or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. Joint Custody

If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in Dependent Child/Parents Not Separated or Divorced.

5. Active/Inactive Employee

The benefits of a plan, which insures You as an employee who is neither laid off nor retired are determined before those of a plan which insures the Insured as a laid off or retired employee. The same would hold true if an Insured were a Dependent of a person, insured as a retiree, and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

6. Continuation Coverage

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

- First, the benefits of a plan insuring the Insured as an employee, (or as the Insured 's Dependent);
- Second, the benefits under the continuation coverage.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

7. Longer/Shorter Length of Coverage

If none of the above rules determine the order of benefits, the benefits of the plan that covered an employee longer are determined before those of the plan that covered the Insured for the shorter term.

EFFECT ON THE BENEFITS OF THIS PLAN

When This Section Applies

This section applies when This Plan is the secondary Plan in accordance with the order of benefits determination outlined above. In that event, the benefits of This Plan may be reduced under this section.

Reduction In This Plan's Benefits

The benefits of this Plan will be reduced when the sum of the benefits that would be payable for the Allowable Expense under this Plan, in the absence of this COB provision, and the benefits that would be payable for the Allowable Expense under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not a Claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of this Plan will be reduced so that they and the benefits

payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Rules of Coordination for Medicare

Medicare Part A – (Hospital Insurance)

- If you have been diagnosed with end stage-renal disease, benefits will be determined in accordance with Medicare guidelines for Insureds with end-stage renal disease.
- When Medicare benefits are primary, claims must be filed with Medicare first. You are responsible for sending the Medicare explanation of benefits form to us for determination of SWL&H benefits.
- In general, if you are an active, working employee, SWL&H is the primary payer for you and your dependents; however, if your Employer has less than 20 employees, Medicare will be the primary payer for you and your dependents.
- If you are a retiree enrolled in Medicare Part A, Medicare is the primary payer, SWL&H will pay the Medicare Part A deductible, and you will be responsible for any copayments.
- If you are a retiree not enrolled in Medicare Part A, SWL&H will be the primary payer.

Medicare Part B – (Supplemental Medical Insurance)

- In general, if you are an active, working employee, SWL&H is the primary payer for you and your dependents; however, if your Employer has less than 20 employees, Medicare will be the primary payer for you and your dependents.
- If you are Medicare-eligible due to retirement, disability or other reason(s), regardless of your Medicare Part B status, SWL&H will provide benefits secondary to Medicare Part B.
    - *If you choose not to enroll in Medicare Part B, you may have greater out-of-pocket expenses after SWL&H pays secondary benefits than an individual who is enrolled in Medicare Part B.*

OPTIONS UNDER MEDICARE COVERAGE

If You are 65 or older, You may reject coverage under this Policy. This rejection must be in writing and sent to Us. Benefits end when We receive the notice for You and Your Dependents. If only Your covered spouse rejects coverage under this Policy, then this Policy will end for Your covered spouse but not for You.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. We have the right to decide which facts are needed. We may give or obtain needed information to any other organization or person. We do not need to tell or get the consent of, any Insured to do this. Each Insured claiming benefits under This Plan must give Us any facts needed to pay the Claim.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount, which should have been paid under This Plan. If it does, We may pay that amount to the other plan that made that payment. That amount will then be treated as though it was a benefit paid under This Plan. We 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 reasonable cash value of the benefits provided in the form of services.

RIGHT TO RECOVERY

If the amount of the payments We make is more than We should have paid under this COB provision, We may recover the excess from one or more of the following:

- The person We have paid or for whom We have paid;

- Insurance companies; or
- Other organizations.

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

SECTION 8 CLAIM REQUIREMENTS

CLAIM REQUIREMENTS

You or Your Dependents do not need to file a Claim form when a Preferred Provider renders services or supplies. When You receive services or supplies from a Non-Preferred Provider, You may obtain a Claim form from either Your Employer or Us. If the Claim Forms are not sent to You within 15 days after We receive the Notice of Claim, You may file a Claim by submitting written proof of loss within 180 days.

Written proof of loss should be given to Us within 180 days after the date of loss. Proof of loss must include the nature and extent of the loss. You must provide any information pertaining to the Claim, such as original bills or explanation of benefits.

We will not reduce or deny a Claim because You or Your Dependent did not furnish a proof of loss within 180 days, if proof is furnished as soon as reasonably possible. We will not accept any proof of loss, unless You do not have the legal capacity to furnish one, after one year from the time it was incurred.

PAYMENT OF CLAIMS

We will pay all benefits to You, Your designated Beneficiary or Beneficiaries, or to Your estate, unless You assign benefits to another person. You must provide the written Assignment of Benefits to Us by the time proof of loss is filed. We will pay the party We determine is entitled to the payment, if You or Your Dependent does not have the legal capacity to give a valid receipt for payment of benefits, or there is no legal guardian. Payment made in good faith under this provision will release Us from their obligation.

Payment of Claims to You will be handled as follows:

- No later than the 15th day after receipt of a Claim from You, We will:
  - Acknowledge receipt of the Claim;
  - Commence any investigation of the Claim; and
  - Request information, statements, and forms from You as deemed necessary. Additional requests may be made during the course of the investigation.
- No later than the 15th day after receipt of all requested items and information, We will:
  - Notify You of the acceptance or denial of the Claim and the reason if denied; or
  - Notify You that additional time is needed and state the reason. No later than the 45th day after the date of notification of the additional time requirement, We shall accept or deny the Claim.

Claims will be paid no later than the 5th day after notification of acceptance of the Claim.

LEGAL ACTION

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

SOUTHWEST LIFE & HEALTH INSURANCE COMPANY

FirstCare PPO

SECTION 9 MEMBER COMPLAINT & APPEAL PROCEDURES

A *Complaint* means any dissatisfaction expressed by You, or anyone acting on Your behalf, orally or in writing to Us with any aspect of Our operation, including but not limited to, dissatisfaction with plan administration, procedures related to review or appeal of an Adverse Determination, the denial, reduction or termination of a service for reasons not related to medical necessity, the way a service is provided, or disenrollment decisions. The term does not include a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the Insured and does not include a Provider's or Insured's oral or written dissatisfaction or disagreement with an Adverse Determination. A Complaint filed concerning dissatisfaction or disagreement with an Adverse Determination constitutes an appeal of that Adverse Determination. The Member will have 180 days from the original paid date of the claim to appeal.

A. Complaint Procedure

If You notify Us orally or in writing of a Complaint, We will no later than the fifth business day after the date of the receipt of the Complaint, send to You a letter acknowledging the date We received Your Complaint. If the Complaint was received orally, We will enclose a one-page Complaint form clearly stating that the Complaint form must be returned to Us for prompt resolution.

Complaints should be directed to the Customer Service Department at (800) 240-3270 or in writing to:

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

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

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

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

B. Complaint Appeal Procedure

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

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

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

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

- Any documentation to be presented to the panel by Our staff;
- The specialization of any Physicians or providers consulted during the investigation; and
- The name and affiliation of each of Our representatives on the panel.

You or a designated representative is entitled to:

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

In all other cases, written notification of Our final decision on the appeal will be provided no later than the 30th calendar day after the date We received the appeal. The notice of final decision will address the specific medical determination, clinical basis, and contractual criteria used to reach the final decision. The notice will also include the toll-free telephone number and address of the Texas Department of Insurance.

C. Adverse Determination Appeal Procedure

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

- The principal reasons for the Adverse Determination.
- The clinical basis for the Adverse Determination.
- A description or source of the screening criteria that were utilized as guidelines in making the determination.
- Notification of the right to appeal an Adverse Determination to an Independent Review Organization (IRO).
- Notification of the procedures for appealing an Adverse Determination to an IRO.
- Notification to the Insured who has a Life-Threatening condition of the Insured's right to an immediate review by an Independent Review Organization and the procedure to obtain that review.

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

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

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

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

The Physician or provider reviewing the appeal may interview You or Your designated representative and shall render a decision on the appeal. Initial notice of the decision may be delivered orally if followed by written notice of the determination within three (3) days.

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

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

D. Filing Complaints with the Texas Department of Insurance

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

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104

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

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

E. Appeals to an Independent Review Organization (IRO)

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

Per §4201.402, Texas Insurance Code, the utilization review agent will provide the following to the IRO, no later than the third business day after receipt of the request for review:

- A copy of any medical records of the enrollee that are relevant to the review;
- A copy of any documents used by the plan in making the determination to be reviewed;
- A copy of the written Notice of Appeal;
- A copy of any documents and other written information submitted to the agent in support of the appeal; and
- A list of each physician or other health care provider:
    - Who has provided care to the enrollee; and
    - May have medical records relevant to the appeal.

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

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

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

Southwest Life & Health (SWL&H) will not take any retaliatory action, such as refusing to renew or cancelling coverage, against You or Your Group because You, the Group, or any person acting on You or Your Group's behalf, has filed a Complaint against SWL&H or appealed a decision made by SWL&H.

F. RELEASE OF MEDICAL RECORDS

Any Insured who files a Complaint, appeal, or request for arbitration thereby authorizes Us or anyone designated by Us, as permitted by law, to review or disseminate, as necessary to the resolution of the Complaint, Your individual medical records, without notice to You or any other person.

G. RETALIATION

We will not take any retaliatory action against (a) an Insured because an Insured, or other person on behalf of an Insured, appeals a decision made by Us or files a Complaint against Us or a Preferred Provider; (b) a Preferred Provider who, on behalf of an Insured, reasonably files a Complaint against Us or appeals a decision made by Us.

SECTION 10 TERMINATION OF COVERAGE

TERMINATION OF EMPLOYEE COVERAGE

Except as provided under the provision *"Continuation of Coverage Under COBRA" in Section 11,* Your coverage will end on the first of the following:

- The date this Policy ends;
- The date the Annual and/or Lifetime Maximum Benefit amount under this Policy has been paid to You or on Your behalf;
- The end of the month in which You are no longer employed by Your Employer after your Employer has notified us;
- The date You are no longer an Eligible Person;
- The last day of the period for which Premium payments have been paid to Us on Your behalf;
- The date of Your death.

TERMINATION OF DEPENDENT COVERAGE

Except as provided below or under section 11, Your Dependent's coverage will end on the first of the following:

- The date this Policy ends;
- The date the Annual and/or Lifetime Maximum Benefit amount under this Policy has been paid to or on Your Dependent's behalf;
- The date Your coverage under this Policy ends;
- The date Your spouse or child no longer satisfies this Policy's definition of an eligible Dependent;
- The last day of the period for which Premium payments have been paid to Us, on Your or Your Dependent's behalf;
- The date of Your Dependent's death.

TERMINATION OR NON-RENEWAL OF THIS POLICY BY US

We reserve the right to end this Policy in the following cases:

- Your Employer fails to pay the required Premium to Us;
- Your Employer commits fraud or intentional misrepresentation of a material fact, except as indicated in the *Time Limit on Certain Defenses* in Section 13; or
- No Insured with the plan lives or works in the Service Area.

This Policy will terminate on the last day of the month in which Premiums were paid.

If Your Employer fails to meet the qualifying participation requirement for a period of at least six consecutive months, We may terminate coverage upon the first renewal date following the end of the six-month consecutive period.

RESCISSIONS

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

> A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or

coverage may not be cancelled except with prior notice to the enrollee, and only as permitted under section 2702(c) or 2742(b).

SECTION 11 CONTINUATION OF COVERAGE UNDER COBRA

You and Your Dependents may continue coverage under the Southwest Life & Health Insurance Company Policy if insurance would otherwise end due to a qualifying event. Coverage will be the same as the major medical coverage under this Policy, had this Policy remained in force. Continuation of coverage for You and Your Dependents under the Consolidated Omnibus Budget Reconciliation Act (COBRA) is available if Your Employer has 20 or more employees on a typical business day in the previous Policy Year. Your Employer is required to notify You and Your Dependents of COBRA continuation privileges under this Policy. You and Your Dependents have 60 days after the notification to accept coverage or lose all rights to benefits.

QUALIFYING EVENT

A qualifying event means one of the following circumstances, which would otherwise end Your or Your Dependent's insurance in the absence of this provision:

- Your employment ends, other than for gross misconduct;
- Your work hours are reduced;
- Your death;
- Your entitlement to Medicare;
- Your divorce; or
- Your child is no longer an eligible Dependent under this Policy's definition.

NOTIFICATION

It is Your Employer's responsibility to inform You or Your Dependents of Your rights under the continuation of coverage provision under COBRA. It is Your responsibility to notify Your Employer in writing, within 60 days of any of the Qualifying Events stated above.

ELECTION PERIOD

You or Your Dependent may continue coverage within 60 days after the later of the date You or Your dependent would lose coverage due to a Qualifying event or the date You or Your Dependent receives notice of Your rights under the continuation provision.

You or Your Dependent must request continuation of coverage on the form supplied by Us. Benefits will continue provided:

- You or Your Dependent properly completes the form and returns it to Us within 60 days after We notify You or Your Dependent; and
- You or Your Dependent pays the required Premium to the Policyholder within 45 days, returns the form to Us, and the Premium is paid to Us.

The Premium is the total amount of Premium paid by both You and Your Employer for coverage under this Policy, plus any applicable administrative fee. If either You or Your Dependent is disabled, and the term of coverage will be increased from 18 months to 29 months, the Premium may be increased for the last 11 months of coverage to 150% of the total Premium.

DISABILITY UNDER THE SOCIAL SECURITY ACT

If You or Your Dependent is determined to be disabled according to the Social Security Act, COBRA coverage is extended to 29 months. Under a clarification made by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the 29-month period also applies to non-disabled Family members.

The disability must take place within the first 60 days of COBRA coverage. The determination of disability can be made any time before the end of the 18-month period by Social Security Administration. Typically,

a Social Security disability determination will be made several months after the actual disability. In any case, if an individual becomes disabled after the first 60 days of COBRA coverage, the 29-month rule does not apply. A copy of the Social Security disability determination must be provided within 60 days to the Policyholder.

Notification must also be provided to the Policyholder if a final determination is made that the individual is no longer disabled. When recovery occurs from the disability before the end of the 29-month period, COBRA coverage can be terminated.

DURATION OF CONTINUATION OF COVERAGE

Normally, We provide continuation of coverage under COBRA up to 18 months for any individual covered under this Policy the day before a Qualifying Event. We will provide continuation of coverage up to 29 months if You or Your Dependent is determined under Title II or XVI of the Social Security Act to be disabled within the first 60 days of COBRA coverage. You or Your Dependent's continuation of coverage under COBRA begins on the date that coverage under this Policy would otherwise end because of a qualifying event.

We provide continuation of coverage under COBRA up to 36 months for:

- Your surviving spouse and Your Dependent children after Your death;
- Your separated or divorced spouse including Your spouse's Dependent children;
- Your spouse and Your Dependent children if You elect Medicare as primary coverage; and
- Your Dependent child whose coverage would otherwise end because the child has ceased to be an eligible Dependent as defined in this Policy.

We may end the continuation of coverage prior to expiration of the mentioned time periods if:

- Your Employer ends its employee health benefit plan;
- You or Your Dependent fails to make timely payments of any charges or Premiums required;
- The aggregate Annual and/or Lifetime Maximum Benefit under this Policy is reached.

If You or Your Dependent becomes covered under another group health policy, coverage provided under the continuation Policy is secondary to coverage under the other group health policy. The coverage provided under the continuation Policy is primary for any Pre-Existing Conditions that are not covered under the new policy. If You or Your Dependents are Hospitalized when coverage under this Policy ends, We will pay expenses for that confinement.

SECTION 12 CONTINUATION OF COVERAGE UNDER STATE LAW

An Insured whose health coverage ends has the right to continuation of group health coverage as outlined below. In order to be eligible the Insured must:

- Have been continuously covered under this Policy for at least three consecutive months prior to the coverage ending; and
- Not have been terminated from coverage under this Policy for cause.

There is no right to continuation if:

- The termination of coverage occurred because the Insured failed to pay the required Premium;
- The Insured is or could be covered by Medicare;
- The Insured has similar benefits under another group or individual health plan, whether fully insured or self-funded;
- The Insured is eligible for similar benefits under another group plan, whether fully insured or self-funded; or
- Similar benefits are provided for or available to the Insured under any state or federal law.

The Insured must complete a written Application within 60 days, following the later of:

- The effective date of termination of Group coverage;
- The effective date of termination of COBRA coverage; or
- The date You are given notice of the right of continuation by the employer.

You must submit the premium payments applicable for such continuation membership within 45 days after the date of the initial election for coverage. 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 31st day after the date which the payment is due. If You fail to meet any of these conditions for continuation, then You shall not be eligible to elect continuation anytime after the election period.

Continuation is permitted for a maximum of six (6) months. The Premium rate will be 102% of the group Premium charged to the Policyholder. The Premium will be paid in advance to the Employer or Policyholder on a monthly basis. Continuation of this Policy may not terminate until the earliest of:

- Six (6) months after the date Continuation is chosen, if you were previously covered by COBRA;
- Nine (9) months after the date Continuation is chosen, if you were not previously covered by COBRA;
- The date the Insured fails to make timely Premium payments;
- The date on which this Policy terminates in its entirety;
- The date on which the Insured is or could be covered under Medicare;
- The date on which the Insured is covered for similar benefits under another group or individual health plan;
- The date on which the Insured is eligible for similar benefits under another group health plan; or
- The date on which similar benefits are provided for or available to the Insured under any state or federal law.

An Insured whose health coverage ends has the right to apply for coverage through the Health Insurance Risk Pool. Thirty days prior to the end of COBRA or the State Continuation coverage, You will be provided information necessary to pursue coverage through the Health Insurance Risk Pool as provided under Texas Insurance Code.

CONTINUATION FOR CERTAIN DEPENDENTS

If coverage under this Policy ends as the result of an employee's death, retirement, or divorce, a Dependent's coverage can continue. The Dependent must have been covered under the Plan for at least

one year, unless the Dependent is an infant under one year of age. Continuation is not available when coverage terminates due to any of these circumstances:

- This Policy is canceled; or
- The Dependent fails to make timely Premium payments.

Continuation ends at the earliest of:

- Three years after the date that the coverage would have ended;
- The Dependent fails to make timely Premium payments;
- The Dependent becomes eligible for coverage under any other group health plan providing similar benefits; or
- This Policy is canceled.

Notification Requirements

The Dependent must notify the Policyholder within 15 days of the employee's death, retirement, or divorce. The Policyholder will immediately, within five working days, provide written notice to the Dependent of the right to continue coverage and will send the election form, and instructions for Premium payment.

Within 60 days of the employee's death, retirement, or divorce, the Dependent must give written notice to the Policyholder of the desire to exercise the right of continuation or the option expires. Coverage remains in effect during the 60-day period provided Premium is paid.

SECTION 13 GENERAL PROVISIONS

WAIVER OF RIGHTS

If We fail to enforce a provision of this Policy earlier, we do not lose the right to enforce that provision later. Our failure to enforce one provision does not affect Our ability to enforce any other Policy provision.

ENTIRE POLICY

A copy of any Applications, amendments, Riders, or endorsements attached to this Policy constitutes the entire contract of insurance. All statements made by the Employer or by the employee, are considered representations and not warranties.

This Policy cannot be amended or changed without the permission of both the Employer and Us. No change is valid unless it is made through an endorsement to this Policy, or by an amendment or Rider, signed by an officer of Southwest Life & Health Insurance Company, and agreed to by the Employer. Each employee and any other individuals referred to in this Policy are bound by any change that is made.

INCONTESTABILITY

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

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

TIME LIMIT ON CERTAIN DEFENSES

This provision limits Our use of statements made by the Policyholder and You in contesting coverage under this Policy. All statements made by the Policyholder and You shall be considered representations and not warranties. We issue this coverage based upon statements made by the Policyholder and You. The statements are considered to be truthful and are made to the best of the Policyholder's and Your knowledge and belief.

MISSTATEMENTS ON THE APPLICATION AT ISSUANCE OF THIS POLICY

The following rules apply to each statement:

The statement will not be used in a contest to void, cancel, or non-renew the coverage unless:

- It is in written Application signed by the Policyholder or You;
- A copy of the Application is or has been furnished to the Policyholder or to You or Your personal representative; and
- Within the first two years from the issue date, an intentional misrepresentation is material to Our agreement to issue this Policy, or after two years, the Application contains a fraudulent misstatement.

In lieu of voiding, canceling, or non-renewing the coverage, We may increase the Premium for this Policy to the appropriate level if We determine that You made a misstatement on the Application/enrollment form. We must give the Policyholder written notice of any Premium rate change at least 31 days prior to the change.

CONFIDENTIALITY OF MEDICAL RECORDS

The Insured must authorize the release of all medical information requested by Us. We agree to maintain

and preserve the confidentiality of all medical information. We may supply medical information to its Utilization Review Agent, a peer review committee, or a governmental agency. We can deny the Claim if the Insured refuses to authorize a release of the medical information requested by Us.

CONTINUITY OF TREATMENT

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

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

EXTENSION OF BENEFITS

Any person covered under this Policy who is totally disabled at the date of discontinuance of this Policy will continue coverage under this Policy for a period of 90 days or the period of total disability, whichever is less. If coverage continues under this provision, benefits will only be paid for expenses of treatment of the condition causing the disability. Benefits payable will be subject to the stated benefit levels in Your Schedule of Benefits.

This provision will not apply if the totally disabled person's coverage under the group Policy being discontinued is replaced by coverage with a succeeding carrier providing substantially equivalent or greater benefits than those provided under this Policy.

CHANGE IN PREMIUM UPON NOTICE:

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

MISSTATEMENT OF AGE

If the age of an Insured has been misstated, all amounts payable under this Policy shall be adjusted by the ratio of the Premium for the correct age to the Premium for the age in the application of such.

PHYSICAL EXAMINATION

We reserve the right to choose a Health Care Provider to examine any Insured whose condition, Illness, or Injury is the basis of a Claim. All examinations are at Our expense. Our rights may be exercised when

and as often as it may require during the investigation of a Claim. We will deny the Claim if the Insured refuses to be examined.

AUTOPSY

We can request that an autopsy be performed on any deceased Insured whose condition, Illness, or Injury is the basis of a Claim. Our rights exist only where not prohibited by law.

CONFORMITY WITH STATE STATUTES

Any provision of this Policy which, on its Effective Date, conflicts with the state laws where this Policy was issued or delivered, is amended to meet the minimum requirements of the law.

CLERICAL ERRORS

Clerical errors or delays in record keeping:

- Will not deny coverage that otherwise would have been issued;
- Will not continue coverage that otherwise would have been issued; and
- May require a change in Premium.

RECOVERY OF PAYMENTS

We will deduct from any benefits payable under this Policy the amount of any payment, which has been made:

- In error;
- Based on a misstatement contained in a Claim;
- Based on a misstatement made to obtain coverage under this Policy within two years after the date the Insured's coverage begins; or
- On behalf of an ineligible person.

AGENCY RELATIONSHIP

Nothing in this Policy establishes that the Employer is an agent of Southwest Life & Health Insurance Company.

POLICIES ISSUED UNDER A COLLECTIVE BARGAINING AGREEMENT

If the Premium for this Policy is paid in whole or in part by an Employer according to the terms of a collective bargaining agreement, this Policy may remain in effect for the Employees covered by this Policy who are involved in a labor dispute. This Policy will continue through the end of the 6th month from when the strike began, or when the policy is eligible to terminate based on the provisions in Section 10, Termination or Non-renewal of this Policy by Us. The Employer will provide COBRA notification by certified mail for continuation of medical coverage.