HEALTH BENEFIT PLAN

EVIDENCE OF COVERAGE

GOLD HSA

2021

CommunityHealthChoice.org
713.295.6704 | 1.855.315.5386

COMMUNITY HEALTH CHOICE

CONSUMER CHOICE HEALTH BENEFIT PLAN

EVIDENCE OF COVERAGE

Community Health Choice, Inc.
2636 South Loop W est, Suite 125
Houston, Texas 77054
713.295.6704 and 1.855.315.5386
TDD: 7-1-1
www.communityhealthchoice.org

PLEASE READ THIS CONTRACT CAREFULLY

This Evidence of Coverage (Contract) is a contract issued to You as our member (You) and states the coverage to which You are entitled and describes the healthcare plan terms including restrictions and limitations.

We agree to pay benefits for services rendered to You, subject to all the terms of this Contract.

This Contract is issued in consideration of the Contract Holder's application, incorporated herein, and in consideration of the Contract Holder's payment of premium as provided under this Contract.

Omissions or misstatements of material facts in the application may cause Your Contract to be voided and claims to be denied. Please check Your application for errors and write to Us if any information is not correct or is incomplete.

This Contract and the coverage it provides become effective 12:00 a.m. (Your time) of the Effective Date stated on Your Member Identification Card. This Contract and the coverage it provides terminates at 12:00 midnight (Your time) on the date of termination. The provisions stated above and on the following pages are part of this Contract.

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

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Eligibility

A Contract Holder who resides, lives or works in the Service Area and their Dependents. A Dependent may reside anywhere in the United States.

Renewability

This Contract remains in effect at the option of the Contract Holder except as provided in the Renewability and Termination section of this Contract.

Right to Return Contract

You have the right to return this Contract within 10 calendar days of receiving it and to have the portion of premium You paid refunded if, after examination of the Contract, You are not satisfied with it for any reason. If You choose to return this Contract within the 10-day period, it is considered void from the beginning and the parties will be in the same position as if no contract had been issued. If services are rendered or We pay claims during the 10 days, You are responsible for such services or claims.

_____
[Signature of Officer]

Lisa Wright
President and Chief Executive Officer

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Community Health Choice
To get information or file a complaint with your insurance company or HMO:

Call: 713.295.2294
Toll-free: 1.855.315.5386
Email: ServiceImprovement@CommunityHealthChoice.org
Mail: Community Health Choice
Service Improvement
2636 South Loop West, Suite 125
Houston, Texas 77054

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:

Call: 1.800.252.3439
Online: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Community Health Choice
Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: 713.295.2294
Teléfono gratuito: 1.855.315.5386
Correo electrónico: Service Improvement@CommunityHealthChoice.org
Dirección postal: Community Health Choice

Service Improvement
2636 South Loop West, Suite 125
Houston, Texas 77054

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame: 1.800.252.3439
En línea: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714

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Welcome to Community Health Choice, Inc.

Thank You for choosing Community Health Choice, Inc. (Community) as Your health benefits plan. Community is committed to arranging to provide You with excellent care when You are sick or injured, and benefits to keep You healthy. We encourage You to read this Evidence of Coverage and learn about the ways this plan can help You.

Service Area

The Service Area is also listed at www.communityhealthchoice.org. You may also call Member Services at the telephone number on Your Member Identification Card.

1. Access to Care

a. How to Find a Participating Provider

An online directory of Participating Providers is accessible via www.communityhealthchoice.org. Please check the online directory of Participating Providers and verify with the provider that they participate in Community's plan before obtaining services. If You do not have access to the online directory, please call the Member Services telephone number on Your Member Identification Card to assist You in finding a Participating Provider or to request a provider listing of your preference.

b. Use of Participating Providers

In most instances, there are Participating Providers available to provide Medically Necessary services. Participating Providers have agreed to accept discounted or negotiated fees. You are responsible for paying the Participating Provider for any applicable Deductible and/or Copayment for services received. We offer different managed care plans, and a provider who participates in one plan may not necessarily be a Participating Provider for other plans offered by Community.

When receiving services, You must make sure the provider participates as a Participating Provider to avoid additional out-of-pocket expenses.

Community provides no benefit for services You receive from Non-Participating Providers, with specific exception as described in this Evidence of Coverage.

You have a right to an adequate network of Participating Providers. If You believe that the network is inadequate, You may file a complaint with the Texas Department of Insurance at: www.tdi.texas.gov/consumer/ complfrm.html.

If Community approves a referral for Non-Participating Provider services because no Participating Provider is available (as described under Section M under Access to Care of this EOC) or if You have received Emergency Care Services provided by a Non-Participating Provider, Community must, in most cases, resolve the Non-Participating Provider's bill so that You only have to pay any applicable copayment, coinsurance or deductible amounts.

You may obtain an online directory of Participating Providers at the following Web site: www.communityhealthchoice.org or by calling 1-855-315-5386 for assistance in finding available Participating Providers. If You relied on materially inaccurate directory information, You may be entitled to have a claim by a Non-Participating Provider paid as if it were a Participating Provider, if You present a copy of the inaccurate directory information to Community, dated not more than 30 days before You received the service

c. Selecting a Primary Care Physician or Provider (PCP)

You must select a Primary Care Physician or Provider (PCP) for Yourself and for each covered Dependent. Selecting a PCP will provide You with a Medical Home and is so important to Your overall health, We give You a number of choices to select for PCP services.

You can choose any PCP You like as long as he or she is in our network and is accepting new patients. You can choose a pediatrician as a PCP for Your children.

If You do not choose a PCP, We will choose one close to Your home for You. You can change Your PCP at any time. The change will be effective at the beginning of the following month. For helpful tips on how to choose a PCP, and for a list of doctors in Our network, please visit Our Web site or access the member portal at www.communityhealthchoice.org.

The following Participating Provider types may serve as PCPs:

- Physicians from any of the following practice areas: General Practice, Family Practice, Internal Medicine, or Pediatrics.

- Obstetrical/Gynecology Physicians who notify the Health Plan that they are willing to serve as PCP for selected Members.
- Other Specialty Care Physicians who notify the Health Plan that they are willing serve as PCP for selected Members with chronic, disabling, or Life-Threatening Illness.
- Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and similar community clinics.
- Advanced Practice Nurses (APNs) and Physician Assistants (PAs) when practicing under the supervision of a Physician designated as a PCP.

If You have a chronic, disabling, or Life-Threatening Illness, You may apply to Our Medical Director to use a Specialty Care Physician as Your PCP. You may make this request by calling Our Member Services telephone number on Your Member Identification Card. If Your request is denied, You have the right to seek review of the denial through Our Complaints process. Refer to the Appeals, Complaints and External Review Rights provision in the General Provisions section in this Contract for more information.

You may change Your PCP by calling Our Member Services Department. In the meantime, Your current PCP will continue to coordinate Your care. For members selecting a PCP for the first time, the change is effective on the first of the following month. You must arrange to have You/Your Dependent's medical files transferred to the new PCP.

Seeing an Obstetrician or Gynecologist

You don't need authorization from Community or a referral from Your PCP to see an obstetrician or gynecologist (OB/GYN). You can choose one from Our network. Just be sure that the one You choose specializes in OB/GYN.

During the course of Your treatment, Your OB/GYN may have to obtain prior authorization for certain services, follow a pre-approved treatment plan or follow certain procedures when referring You to someone else for treatment. For a list of Participating Providers who specialize in OB/GYN care, please visit Our Web site or access Your member portal at www.communityhealthchoice.org.

Enrollees may select, in addition to a PCP, an OB/GYN Physician to provide Medically Necessary services that are within the scope of the Physician's practice without first receiving a referral from Your PCP.

d. Role of the PCP

Your PCP is responsible for providing primary medical care and helping to guide and initiate referrals for any care You receive from other medical care providers, including Specialty Care Physicians.

e. When a PCP is Not Available

When Your PCP is unavailable, You may need to obtain services from the back-up Participating Provider designated by Your PCP. You must make sure the provider is a Participating Physician or Participating Provider in your specific plan's network to avoid additional out-of-pocket expenses. Please be sure to discuss these back-up arrangements with Your PCP.

f. Seeing a Specialist

All medical needs should be discussed with Your PCP. A wide range of Specialty Care Physicians are included in the Community network. We allow open access to Specialty Care Physicians without a referral from a PCP or authorization from Us so long as it is within Your plans' specific network. If a Covered Person and his or her

PCP determine that there is a need to see a Specialty Care Physician the PCP should refer You to Participating Providers.

We do require Prior Authorization for certain services. Visit our Web site at www.communityhealthchoice.org or call the Member Services' telephone number on Your Member Identification Card for a list of services that require Prior Authorization.

g. Seeking Emergency Care Services

If You need Emergency Care:

1. Go to the nearest Participating Hospital emergency room; or
2. Find the nearest Hospital emergency room if Your condition does not allow You to go to a Participating Hospital.

You, or someone on Your behalf, must call Us within 48 hours after Your admission to a Non-Participating Hospital for Emergency Care. If Your condition does not allow You to call Us within 48 hours after Your admission, please contact Us as soon as Your condition allows. We may transfer You to a Participating Hospital in the Service Area when Your condition is stable. You must see a Participating Provider for any follow-up care. If emergency services are provided at a Non-Participating Hospital, We will pay for those services at the Usual and Customary rate or an agreed rate.

h. Seeking Urgent Care Services

The steps for seeking Urgent Care services are as follows:

1. Contact Your PCP or his/her back-up.
2. If the Primary Care Physician is unavailable, You may go to an Urgent Care Center that is a Participating Provider. You can obtain the names of Participating Provider Urgent Care Centers by calling Us or accessing the Provider Directory on Our Web site at www.communityhealthchoice.org.
3. You must receive any services in follow-up to an Urgent Care Center visit from Your PCP or a Participating Provider.
4. You must pay any Deductible and/or Copayment required for Urgent Care.

j. Use of Non-Participating Providers

If Covered Services are not available through Participating Physicians or Participating Providers, upon Your Participating Physician's or Participating Provider's request and within the time appropriate to the circumstances, but not to exceed five (5) business days, We will allow a referral to a Non-Participating Physician or Provider and fully reimburse the Non-Participating Physician or Provider at the Usual and Customary rate or at an agreed rate.

Before denying a request for a referral to Non-Participating Provider, We will provide for review of the request by a specialist of the same or similar type of specialty as Non-Participating Provider to whom the referral is requested.

Not all Healthcare Practitioners who provide services at Participating Hospitals are Participating Providers. If services are provided by Non-Participating Providers, including but not limited to pathologists, anesthesiologists, radiologists, and emergency room physicians (facility-based physicians) at a Participating Hospital, We will pay for those services at the Usual and Customary rate or at an agreed rate. If You receive a bill from the Non-Participating Provider, please contact Us at 1-855-315-5386.

Texas law requires if Covered Services are not available through Participating Providers as described above, You are only responsible for any applicable Copayment or other out-of-pocket amounts that You would have paid if Community's network included Participating-Providers from whom You could obtain services. If You receive a bill from the Non-Participating Provider, please contact Us at 1-855-315-5386 or 713-295-6704.

It is Your responsibility to verify the network participation status of all providers prior to receiving all non-emergency services. You should verify network participation status, only from Us, by either calling the Member Services telephone number on the back of Your Member Identification Card or accessing Our Web site, at www.communityhealthchoice.org. We are not responsible for the accuracy or inaccuracy of network participation representations made by any PCP, Specialty Care Physician, Hospital, or other Provider whether contracted with Us

or not. In other words, if the network PCP, Specialty Care Physician, or other provider recommends that services be received from another entity, it is Your responsibility to verify the network participation status of that entity before receiving such services.

2. Utilization Management

a. Prior Authorization

Prior Authorization means a determination by Us that Services proposed to be provided to a Covered Person are Medically Necessary and appropriate. If We have provided a Prior Authorization, We will not reduce or deny payment to a Physician or Provider based on the Services being Medically Necessary unless the Physician or Provider has materially misrepresented the proposed Services or has substantially failed to perform the proposed Services. Prior Authorization does NOT guarantee coverage of or the payment for the service. For Prescription Drugs, Prior Authorization is a confirmation of the dosage, quantity, and duration as appropriate for the Covered Person's age, diagnosis and gender. For all other services or procedures, it is a confirmation of medical necessity and appropriateness only. Prior Authorization is not a representation that the healthcare services are covered or that the patient is a Covered Person.

All benefits payable under this Contract must be for services or Prescription Drugs that are Medically Necessary or for Preventive Services as stated in this Contract. Prior Authorization by Us is required for certain services and Prescription Drugs. Visit our Web site at www.communityhealthchoice.org or call the Member Services telephone number on Your Member Identification Card to obtain a list of services that requires Prior Authorization or the Prescription Drug Formulary that indicates when Prior Authorization is required for Prescription Drugs. The list of services and Prescription Drugs that require Prior Authorization is subject to change. Coverage provided in the past for services or Prescription Drugs that did not receive or require Prior Authorization is not a guarantee of future coverage of the same service or Prescription Drug.

You are responsible for informing Your Physician or Provider of the Prior Authorization requirements. Your Physician or Provider must contact Us by telephone, electronically or in writing to request the appropriate authorization. The telephone number to call to request authorization is on Your Member Identification Card. No benefits are payable for services or Prescription Drugs that are not Covered Services.

We will issue a determination on a request for Prior Authorization no later than 3 calendar days of receiving the request. If the Prior Authorization involves a concurrent Hospital care, We will issue a determination within 24 hours of receiving the request. If the Prior Authorization involves post-stabilization treatment or a life threatening condition, We will issue a determination within the timeframe appropriate for the circumstances relating to the delivery of the services and conditions of the enrollee, but in no case to exceed one hour from receipt of the request. Your Physician or Provider may request a renewal of an existing Prior Authorization request 60 days before the date the Prior Authorization expires. If We receive a request for renewal of a Prior Authorization before the existing Prior Authorization expires, We will, if practicable, review the request and issue a determination before the existing Prior Authorization expires.

b. Reduction of Payment

If We are not contacted for Prior Authorization for services or supplies that require Prior Authorization, but the services or supplies are ultimately determined to be Medically Necessary, the covered benefits may be denied for failure to obtain the Prior Authorization.

3. Your Contract Benefits Management

We will pay benefits for Covered Services as stated in the Schedule of Benefits and this Contract section, and according to the General Exclusions and Prescription Drug Exclusions sections and any amendments or riders which are a part of Your Contract that may modify Your benefits.

If You obtain non-Covered Services, You are responsible for making the full payment to the Physician or Provider. The fact that a Physician or Provider has performed or prescribed a medically appropriate service, or the fact that it may be the only available treatment for a Bodily Injury or Illness, does not mean that the service is covered under this Contract.

If You have a Deductible under this Contract, You must pay Your Deductible in full before We make any payments. You are responsible for demonstrating that You have paid these Copayments and will then no longer be responsible for Copayments for Participating Providers for the remainder of the Plan Year. You are required to pay any Copayments directly to the Physician or Provider. Once You have met Your Out-of-Pocket Maximum, You will no longer be responsible for Copayments for Participating Providers for the remainder of the Plan Year. There are no Deductibles or Copayments for Preventive Services.

A Covered Person who has Special Circumstances may be eligible for continuation of services from a terminated provider through continuity of care. A terminated provider is a Participating Provider whose Contract is terminated or not renewed.

All terms and provisions of this Contract are applicable to Covered Services provided during the period of continued care by the terminated provider.

Continuity of care is not available:

a. If the provider was terminated due to reason of medical competence or professional behavior;

b. After the 90th day after the Effective Date of the provider's termination; or

c. After the expiration of the nine-month period after the Effective Date of the provider's termination if the Covered Person was diagnosed as having a terminal Illness at the time of the termination.

If a Covered Person has Special Circumstances is past the 24th week of pregnancy at the time of the provider's termination, continuity of care extends through delivery of the child and applies to the immediate postpartum care and follow-up checkup within the six-week period after delivery.

If a claim is denied as being Experimental, Investigational, You have the right to seek review of the denial by an Independent Review Organization. Refer to the Appeals, Complaints and External Review Rights provision in the General Provisions section in this Contract for more information.

BENEFITS

Refer to the General Exclusions and Prescription Drug Exclusions sections in this Contract. All terms and provisions of this Contract, including the Prior Authorization requirement specified in this Contract are applicable to Covered Services. Cost sharing and limitations depend on type and site of service.

a. Acquired Brain Injury

Rehabilitative and habilitative therapy and services that are Medically Necessary for the treatment of an Acquired Brain Injury, including Cognitive Rehabilitation Therapy, Cognitive Communication Therapy, Neurocognitive Therapy, Neurocognitive Rehabilitation, Neurobehavioral Testing, Neurobehavioral Treatment, Neurophysiological Testing, Neurophysiological Treatment, Neuropsychological Testing, Neuropsychological Treatment, Psychophysiological Testing and Psychophysiological Treatment, Neurofeedback Therapy, Remediation and Post-Acute Transition Services, Community Reintegration Services, including outpatient day treatment services, or other Post-Acute Treatment services, if such services are necessary as a result of and related to an Acquired Brain Injury.

Reasonable expenses related to periodic reevaluation of the care of an individual who:

1. has incurred an Acquired Brain Injury;
2. has been unresponsive to treatment; and
3. becomes responsive to treatment at a later date.

Rehabilitative and habilitative therapy and services for an Acquired Brain Injury may be provided at a hospital, an acute or post-acute rehabilitation hospital, an assisted living facility or any other facility at which appropriate services or therapies may be provided.

Treatment goals for therapy or services related to the treatment of an Acquired Brain Injury may include maintenance of functioning or the prevention of or slowing of further deterioration.

In this section, therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an Acquired Brain Injury and service means the work of testing, treatment, and providing therapies to an individual with an Acquired Brain Injury.

b. Autism Spectrum Disorder

Generally recognized services prescribed in relation to Autism Spectrum Disorder by a Covered Person's PCP or Specialty Care Physicians in a treatment plan recommended by that physician.

Individuals providing treatment prescribed under that plan must be a Healthcare Practitioner:

- 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
  - who is certified as a provider under the TRICARE military health system; or
  - an individual acting under the supervision of a health practitioner

For purposes of this section, 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.

c. Dental Services

Limited treatment for a Dental Injury to a Sound Natural Tooth. Covered Person must seek treatment within 48 hours of the time of the acc ident or upon the effective date of coverage, whichever comes later. We will limit Covered Services to the least expensive service that We determine will produce professionally adequate results. Cost sharing and limitations depend on type and site of service.

The plan would also cover dental services necessary for the treatment or correction of a congenital defect and oral surgery defined as maxillofacial surgical procedure limited to:

1. Excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths;
2. Incision and drainage of facial abscess;
3. Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses; and
4. Reduction of a dislocation of, excision of, and injection of the temporomandibular joint, except as excluded under the Plan; and
5. Removal of complete bony impacted teeth.

d. Diabetes Services

The following services are for a Covered Person with diabetes:

1. Routine foot care; (refer to Exclusions in Section 4, number 25); and
2. Outpatient self-management training and education, including medical nutritional therapy prescribed by a Healthcare Practitioner for the treatment of:

   a. Diabetes mellitus;

   b. Gestational diabetes;

   c. Insulin dependent or non-insulin dependent diabetes; and

   d. Medical conditions associated with elevated blood glucose levels.

Equipment and supplies for diabetes are covered under Durable Medical Equipment and Medical Supplies. Prescription Drugs for the treatment of diabetes are covered under the Prescription Drug provision.

e. Durable Medical Equipment and Medical Supplies

Equipment or devices specifically designed and intended for the care and treatment of a Bodily Injury or Illness for the following:

1. Non-motorized wheelchair;
2. Hospital bed;

3. Ventilator

4. Oxygen and rental of equipment for its administration;

5. Initial prosthetic and orthotic devices or supplies, including, but not limited to, limbs and eyes. The benefit is limited to the most appropriate model of prosthetic or orthotic device that adequately meets the medical needs of the Covered Person as determined by the Covered Person's treating physician, podiatrist and prosthetist or orthotist. Replacement or repair of prosthetic and orthotic devices is a Covered Expense unless the repair or replacement is necessitated by misuse or loss;

6. Services related to the fitting and use of prosthetic devices and orthotic devices.

7. Casts, splints (other than dental), trusses, braces (other than orthodontic), and crutches;

8. Standard wigs following cancer treatment (not to exceed one per lifetime). Member is responsible for applicable deductible and/or DME coinsurance. Community will cover up to maximum of $250;

9. The following special supplies, when prescribed by the Healthcare Practitioner:

   a. Surgical Dressings;

   b. Catheters;

   c. Colostomy bags, rings, and belts;

   d. Flotation pads;

10. Diabetic equipment and supplies;

11. Dietary formulas necessary for the treatment of phenylketonuria (PKU) or other heritable diseases;

12. Amino-acid based elemental formulas, regardless of the formula delivery method, used for the diagnosis and treatment of:

    a. Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;

    b. Severe food protein-induced enterocolitis syndromes;

    c. Eosinophilic disorders, as evidenced by the results of biopsy; and

    d. Disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

13. Hearing aids for each ear, every three years, and supplies for a Covered Person, including fitting and dispensing services and the provision of ear molds as necessary to maintain optimal fit of hearing aids;

14. One cochlear implant in each ear for a Covered Person and an external speech processor and controller with necessary component replacement parts as medically and audiologically necessary every three years.

15. Other Durable Medical Equipment. Visit Our Web site www.communityhealthchoice.org or call Member Services telephone line on Your Member Identification Card; and Costs for these items will be limited to the lesser of the rental cost or the purchase price. If We determine the lesser cost is the purchase option, any amount paid as rent for such Durable Medical Equipment shall be credited toward the purchase price. If the Covered Person chooses to upgrade the equipment or device, they will be responsible for the price difference between the cost of the standard item and the cost of the upgraded item.

If the equipment and device include comfort or convenience items or features that exceed what is Medically Necessary, We will not pay more than is Medically Necessary. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair is all that is Medically Necessary.

No benefits will be provided for, or on account of Duplicate or similar rentals of Durable Medical Equipment.

f. Emergency Services

Covered Services for Emergency Care in a hospital emergency facility, a freestanding emergency medical care facility; or Comparable Emergency Facility. We will pay Non-Participating Physicians and Providers at the Usual and Customary rate or an agreed rate.

Texas law requires if You receive Covered Services for Emergency Care that You are only responsible for any applicable Copayment or other out-of-pocket amounts that You would have paid if You had received Emergency Care from a Participating-Provider. If You receive a bill from the Non-Participating Provider even for Emergency Care, please contact Us at 1-855-315-5386. With the exception of Emergency Care, Covered Services are available only within the Service Area.

g. Healthcare Treatment Facility Services

1. Daily room and board and general nursing care up to the semi-private room rate for each day of Confinement, including, but not limited to:

   a. not less than 48 hours following a mastectomy and 24 hours following a lymph node dissection for the treatment of breast cancer unless You and Your attending physician determines a shorter period is appropriate;

   b. not less than 48 hours after an uncomplicated vaginal delivery and 96 hours after an uncomplicated delivery by cesarean section;

2. Confinement in a critical care unit or intensive care unit and related services;
3. Operating room and related facilities;
4. Ancillary services;
5. Whole blood including cost of blood, blood plasma, and blood plasma expanders, that are not by or for the Member and administration of whole blood and blood plasma;
6. Other Healthcare Treatment Facility charges;
7. Drugs, medicines and biologics that are provided or administered to the Covered Person while Confined in a Hospital or Skilled Nursing Facility;
8. Regularly scheduled treatment such as dialysis, chemotherapy, inhalation therapy or radiation therapy in a Healthcare Treatment Facility as ordered by the Covered Person's Healthcare Practitioner;
9. Outpatient services in a Hospital or Free-Standing Surgical Facility;
10. Short-term rehabilitation therapy services in an acute care Hospital setting;
11. Laboratory, pathology services and other diagnostic tests;
12. Meals and special diets when Medically Necessary;
13. Inpatient private duty nursing when Medically Necessary;
14. Special duty nursing when Medically Necessary;
15. Anesthesia and oxygen services; and
16. X-ray services.

h. Healthcare Practitioner Services

1. Healthcare Practitioner visits;
2. Diagnostic laboratory and radiology tests;
3. Diagnostic follow-up care related to the hearing impairment for a Dependent child from birth through 24 months of age;
4. Second surgical opinions;
5. Surgery;
6. Services of a surgical assistant and/or assistant;
7. Services of a physician assistant (PA), registered Nurse (RN), or a certified operating room technician when Medically Necessary;
8. Anesthesia administered by a Healthcare Practitioner or certified registered anesthetist attendant to a Surgery;
9. Services of a pathologist;
10. Services of a radiologist;
11. Services related to the administration of amino acid-based elemental formulas as provided under the Prescription Drugs provision;
12. Injections and allergy injections, therapy, testing, and serum;
13. Nutritional counseling;
14. Telemedicine Medical Services or Telehealth Medical Services.

A Healthcare Practitioner's office visit includes only the following services:

1. Taking a history;
2. Performing an examination;
3. Making a diagnosis or medical decision and associated treatment;
4. Administering allergy or other injections; and
5. Diagnostic laboratory and radiology tests;
6. Electrocardiogram (EKG).

i. Home Healthcare

Services provided by a Home Healthcare Agency at the Covered Person's home. Home Healthcare Services are subject to authorization guidelines. All home healthcare services must be provided on a part-time or intermittent basis in conjunction with a home healthcare plan.

No benefits will be provided for, or on account of:

1. Charges for mileage or travel time to and from the Covered Person's home;
2. Wage or shift differentials for any representative of a Home Healthcare Agency;
3. Charges for supervision of home healthcare agencies;

4. Custodial Care; and
5. Provision or administration of Self-Administered Injectable Drugs that the member is capable of administering.

j. Hospice Care

Covered Services provided under a Hospice Care Program furnished in a Facility or in the Covered Person's home by a Hospice Care Agency. A Healthcare Practitioner must certify that the Covered Person is terminally ill.

1. Room and board in a Hospice Facility;
2. Part-time nursing care provided by or supervised by a Nurse for up to eight hours per day;
3. Hospice consultation for the Hospice Patient by a licensed clinical social worker or pastoral counselor;
4. Medical social services for the terminally ill Covered Person including:
   a. Assessment of social, emotional, and medical needs and the home and family situation; and
   b. Identification of the community resources available;
5. Psychological and dietary counseling;
6. Part-time home health aide services for up to eight hours in any one day; and
7. Medical supplies, drugs and medicines prescribed by a Healthcare Practitioner for Palliative Care. No benefits will be provided for, or on account of:
   1. Funeral arrangements;
   2. Financial or legal counseling, including estate planning or drafting of a will;
   3. Homemaker or caretaker services, including:
      a. Sitter or companion services;
      b. Housecleaning;
      c. Household maintenance; and
   4. Services of a social worker other than a licensed clinical social worker;
   5. Services by a licensed pastoral counselor to a member of his/her congregation. These are services in the course of the duties to which he/ she is called as a pastor or minister; and
   6. Respite care.

k. Mental Health Services

Covered Services for Mental Health are provided under the same terms and conditions applicable to medical and surgical benefits, including the imposition of any quantitative or non-quantitative treatment limits that are more restrictive than those applicable to medical and surgical benefits.

Covered Services provided by a:

1. Healthcare Practitioner;
2. Hospital; or

3. Healthcare Treatment Facility.

Covered Inpatient Mental Health Care Services for:

1. Inpatient services including room and board; and
2. Healthcare practitioner visits.

Covered Outpatient Mental Health Care Services— care and office services for Mental Health incurred for:

1. Office exams or consultations including laboratory tests and X-rays; and
2. Psychotherapy.

Additional covered services for Mental Health:

1. Intensive Outpatient Program;
2. A partial Hospitalization program;
3. A Residential Treatment Center.

No benefits will be provided for, or on account of:

1. A halfway house.

l. Maternity Care and Newborn Services

Prenatal, delivery and inpatient services for Maternity Care and postnatal Care.

Covered Services for a covered Dependent newborn child include, but are not limited to, the following:

1. Bodily injury or Illness;
2. Care and treatment for premature birth; and
3. Medically diagnosed birth defects and abnormalities.

Congenital defects will be treated the same as any other Bodily Injury or Illness for which Covered Services are provided.

You or Your newborn is discharged from inpatient care before a minimum of 48 hours following an uncomplicated vaginal delivery, and 96 hours following an uncomplicated delivery by cesarean section, Covered Services include post-delivery outpatient services.

Post-delivery care includes maternal and neonatal physical assessments (physical evaluations for both You and Your newborn); administration of the newborn screening test, newborn screening test kit, parent education, assistance and training in breast-feeding and bottle-feeding. Post-delivery outpatient visit may be provided at the mother's home, healthcare provider's office or a health care facility. A Physician, registered nurse, or other licensed health care professional may provide the services. This visit is in addition to Your coverage for outpatient post-natal obstetrical care.

m. Outpatient Therapies

Rehabilitative and habilitative Outpatient Services ordered and performed by a Healthcare Practitioner for the following:

1. Services for:

   a. Documented loss of physical function;

b. Pain;

c. Developmental defect; or d. Developmental delay;

2. Physical therapy services;
3. Occupational therapy services;
4. Chiropractic services such as spinal manipulations, adjustments and modalities;
5. Speech therapy or speech pathology services;
6. Cognitive Rehabilitation Services;
7. Audiology therapy services;
8. Treatment related to hearing aids and cochlear implants, including habilitation and rehabilitation as Medically Necessary for educational gain;
9. Radiation therapy services;
10. Chemotherapy;
11. Respiratory or pulmonary therapy services;
12. Cardiac Rehabilitation Services; and
13. Nutritional counseling for a child with developmental delays.

Covered Services include therapies that result in a practical improvement in the level of functioning within a reasonable period of time and the therapy is not considered Maintenance Care. When determined to be Medically Necessary by the Healthcare Practitioner, therapy services for a Covered Person who has a physical disability will not be considered Maintenance Care. These therapy services are provided without regard as to whether the purpose of the therapy is to maintain or improve functional capacity.

Therapy services for a dependent child with a developmental delay must be provided in accordance with an individual family service plan issued by the Interagency Council on Early Childhood Intervention under Chapter 73 of the Texas Human Resources Code.

Therapy services rendered during a Home Healthcare Visit are covered under the Home Healthcare provision.

n. Prescription Drugs

Any payments under this provision apply toward the Covered Person's Out-of-Pocket Maximum. Benefits may be subject to Dispensing Limits, Prior Authorization or Step Therapy requirements, if any.

If the dispensing Pharmacy's charge is less than the Prescription Drug Copayment, the Covered Person will be responsible for the lesser amount.

The amount paid by Us to the dispensing Pharmacy may not reflect the ultimate cost to Us for the drug. Prescription Drug Copayments are made on a per Prescription or refill basis and will not be adjusted if We receive any retrospective volume discounts or Prescription Drug rebates.

Some retail pharmacies participate in Our 90-day refill program, which allows a Covered Person to receive a 90-day supply of a Prescription or refill for eligible maintenance drugs. The cost is 2.5 times the applicable Copayment as shown on the Schedule of Benefits. Specialty Drugs or Self-Administered Injectable Drugs are limited to a maximum of a 30-day supply.

Tablet splitting is a voluntary program in which the PBM may designate certain Formulary Drugs that the member can split the tablet of a higher strength dosage at home. Under this program, the member gets half the usual

quantity for a 30-day supply, for example 15 tablets for a 30-day supply. Participants who use tablet splitting will pay half the normal Copayment amount.

We must be notified of any Cost Share that is applicable to a Covered Person's claim that is waived by the Pharmacy. Any amount thus waived and not paid by the Covered Person would not apply to any Prescription Drug Out-of-Pocket Maximum.

We may allow for the synchronization of refills for maintenance Prescription Drugs and the proration of the Cost Share for a partial supply of certain Prescription Drugs.

For prescription eye drops, a refill will be allowed if the Covered Person pays timely at the point of sale and the original prescription states that additional quantities of eye drops are needed, the refill does not exceed the total quantity of dosage units authorized by the prescribing Physician or Provider on the original prescription, including refills, and the refill is dispensed on or before the last day of the prescribed dosage period and not earlier than the 21st day after the date a prescription for a 30-day supply of eye drops is dispensed, not earlier than the 42nd day after the date a prescription for a 60-day supply of eye drops is dispensed, or not earlier than the 63rd day after the date a prescription for a 90-day supply of eye drops is dispensed.

Members requesting higher tier drugs or brand name drugs when a generic equivalent is available, and the physician did not specifically prescribe the requested drug are responsible for the higher tier cost sharing amount plus any difference in cost. If the brand name drug is on the same tier as the generic equivalent, members are responsible for the cost sharing amount plus any difference in cost. This cost difference does not apply to any out of pocket maximum. Physicians prescribing a higher tier drug or brand name drug when a generic equivalent is available must request a Prior Authorization through our PBM (pharmacy benefit management), Navitus. Certain high cost generic drugs may be included on a higher tier and thus have a higher copay.

The Specialty Pharmacy program is part of Your pharmacy benefit and is mandatory after Your first fill at retail for all specialty prescriptions that meet the following criteria. We will allow enrollees to access prescriptions drug benefits at in-network retail pharmacies, unless:

1. The drug is subject to restricted distribution by the U.S. Food and Drug Administration; or
2. The drug requires special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy.

We may charge enrollees a different cost-sharing amount for obtaining a covered drug at a retail pharmacy, but all cost sharing will count towards the plan's annual limitation on cost sharing.

Additional information can be obtained by calling Navitus Customer Care at 866-333-2757. You may also access the pharmacy handbook online at www.communityhealthchoice.org. Navitus SpecialtyRx works with a specialty pharmacy to offer services with the highest standard of care. Should You wish to use an alternative Specialty Pharmacy, please contact Navitus Customer Care at 866-333-2757. With Navitus SpecialtyRx, delivery of Your specialty medications is free, and right to Your door or prescriber's office via FedEx. Local courier service is available for emergency, same-day medication needs. To start using Navitus SpecialtyRx, please call toll-free 1-855-847-3553. We will work with Your prescriber for current or new specialty prescriptions.

Covered Prescription Drugs are:

1. Drugs, medicines or medications, and the necessary services associated with the administration of those drugs, medicines or medications, prescribed to treat a chronic, disabling, or life-threatening Illness that:

   a. have been approved by the U.S. Food and Drug Administration for at least one indication;

      and

   b. are recognized by the following for the treatment of the indication for which drug is prescribed (1) a prescription drug reference compendium approved by the Department of Insurance, or (2) substantially accepted peer reviewed medical literature.

2. Drugs, medicines or medications that under Federal or state law may be dispensed only by Prescription from a Healthcare Practitioner;
3. Drugs, medicines or medications that are included on the Drug Formulary;
4. Insulin and Diabetic Supplies that are included on the Drug Formulary;
5. Hypodermic needles or syringes when prescribed by a Healthcare Practitioner for use with insulin or Self-Administered Injectable Drugs that are included on the Drug Formulary. Hypodermic needles and syringes used in conjunction with covered drugs may be available at no cost to the Covered Person;
6. Hypodermic needles, syringes or other method of delivery necessary for administration of a Specialty Drug, if included with the charge for the Specialty Drug. These may be available at no cost to the Covered Person;
7. Specialty drugs and Self-Administered Injectable Drugs that are included on the Drug Formulary approved by Us limited to a 30-day supply, unless otherwise determined by Us;
8. Drugs, medicines or medications required under the Affordable Care Act with a Prescription from a Healthcare Practitioner;
9. Prescribed, orally administered anticancer medication that is used to kill or slow the growth of cancerous cells;
10. Spacers and/or peak flow meters for the treatment of asthma; and
11. Enteral formulas and nutritional supplements necessary for the treatment of phenylketonuria (PKU) or other inherited diseases.

The most commonly prescribed drugs, medicines, and medications covered by Us are specified on Our Drug Formulary. The Drug Formulary identifies categories of drugs, medicines or medications by levels. It also indicates Dispensing Limits and any applicable prior authorization or Step Therapy requirements. This information is reviewed on a regular basis by a Pharmacy and Therapeutics committee made up of physicians and Pharmacists. Placement on the Drug Formulary does not guarantee Your Healthcare Practitioner will prescribe that Prescription Drug, medicine or medication for a particular medical or Mental Health condition.

You can obtain a copy of Our Drug Formulary by visiting Our Web site at www.navitus.com or calling Navitus Member Services telephone number on Your Member Identification Card. If a specific drug, medicine or medication is not listed on the Drug Formulary, You may c all us or contact Us in writing with a request to determine whether a specific drug is included on Our Drug Formulary. We will respond to Your request no later than three business days after the receipt date of request.

If a specific drug, medicine or medication is not listed on the Drug Formulary (or otherwise covered by Us), a Covered Person or a Covered Person's designee or a prescribing physician may request an exception orally or in writing. We will respond to Your request no later than 72 hours after the receipt date of the request. An expedited review is available for exigent circumstances such as when a Covered Person is suffering from a health condition that may seriously jeopardize the Covered person's life, health or ability to regain maximum function or when a Covered Person is undergoing a current course of treatment using a non-Drug Formulary Drug. We will respond to an expedited request based on exigent circumstances and notify the Covered Person or their designee and the prescribing physician no later than 24 hours following receipt date of the request.

A prescribing Physician or Provider, on behalf of a Covered Person, may submit a request for an exception to a Step Therapy requirement. Additional information can be found on our website at www.communityhealthchoice.org. If We do not deny an exception request before 72 hours after the request was made, the request is considered granted. If the prescribing Physician or Provider states in the request that they reasonably believe that a denial of the request makes the death or serious harm to the Covered Person probable, if We do not deny an exception request before 24 hours after the request was made, the request is considered granted.

If We do not approve an exception request for a prescription, You have the right to appeal that decision. Please

refer to Section 9.a., Appeals, Grievances and External Review Rights process in the General Provisions section. In addition, the plan will provide coverage of the non-formulary drug for the duration of the exigency.

Step Therapy is not required for prescription drugs associated with the treatment of stage-four advanced, metastatic cancer or associated conditions. This exception applies only to a prescription drug, the use of which is: (1) consistent with best practices for the treatment of stage-four advanced, metastatic cancer or an associated condition; (2) supported by peer-reviewed, evidence-based literature; and (3) approved by the U.S. Food and Drug Administration.

Physicians prescribing a higher tier drug or brand name drug when a generic equivalent is available must request a Prior Authorization through our PBM (pharmacy benefit management). Certain high cost generic drugs may be included on a higher tier and thus have a higher copay.

Prescription Drug coverage is subject to change. Based on state law, advanced written notice to You are required for the following modifications that affect Prescription Drug coverage:

1. Removal of a drug from the Drug Formulary;
2. Requirement that You receive prior authorization for a drug;
3. An imposed or altered quantity limit;
4. An imposed step-therapy restriction;
5. Moving a drug to a higher cost-sharing level unless a generic alternative to the drug is available.

We will only make these types of changes to Prescription Drug coverage at the renewal of the Contract. We will provide written notice no later than 60 days prior to the Effective Date of the change.

o. Preventive Care Services

Services for well child and adult care Preventive Services recommended by the U.S. Department of Health and Human Services (HHS) or as mandated by the State on the date the service is incurred. This does not include Routine Nursery Care.

For Preventive Services that apply to Your Contract, refer to the HHS Web site at www.HHS.gov or call the Community's Member Services telephone number on the back of Your Member Identification Card.

Deductible and Copayment requirements do not apply to Preventive Services. Diagnosis and treatment for non-preventive services during a preventive visit are subject to deductibles and copays.

Covered Services include, but are not limited to, the following:

1. Office visit to a Healthcare Practitioner for a routine or annual physical exam to detect or prevent Illness;
2. Routine radiology, laboratory and/or, endoscopic services to detect or prevent Illness related to routine or annual exam;
3. Routine mammogram and Diagnostic Mammogram (by all forms of Low-Dose Mammography). For routine mammogram every 1 year for a female Covered Person age 35 years of age or older;
4. An annual medically recognized diagnostic examination for a female Covered Person 18 years of age or older for the early detection of cervical and ovarian cancer in accordance with guidelines adopted by the American College of Obstetricians and Gynecologists or another similar national organization of medical processionals recognized by the Commissioner. Minimum requirements for the diagnostic examination to detect the human papillomavirus include a conventional Pap smear screening and CA 125 blood test, alone or in combination with a test approved by the U.S. Food and Drug Administration;

5. An annual prostate cancer detection exam, including a Prostate Specific Antigen test (PSA) for a male Covered Person age 40 or older;

6. A medically recognized screening examination for the detection of colorectal cancer for a Covered Person at normal risk for developing colon cancer. Covered Services include:

   a. An annual fecal occult blood test;

   b. An annual stool DNA test;

   c. A flexible sigmoidoscopy every five years; or

   d. A colonoscopy once every 10 years for a computed tomography (CT) colonography (virtual colonoscopy) every 5 years if standard colonoscopy is contraindicated or failed

7. Non-invasive screening tests for atherosclerosis and abnormal artery structure and function for a Covered Person who is:

   a. A male over 45 and under 76 years of age; or

   b. A female over 55 and under 76 years of age; and i. Is a diabetic; or

      ii. Is at risk of developing heart disease based on a score derived from Framingham Health Study coronary prediction algorithm that is intermediate or higher.

   Covered Services include one of the following screenings every five years:

   a. A computed tomography (CT) scanning measuring coronary artery calcification; or

   b. An ultrasonography measuring carotid intima-media thickness and plaque;

8. Routine immunizations (TB tine and allergy desensitization injections are not considered routine immunizations);

9. Immunizations against influenza and pneumonia;

10. Alcohol Misuse screening and counseling to assess alcohol consumption, drinking behaviors, and alcohol – related problems;

11. Blood Pressure screening;

12. Diabetes screening;

13. Diet counseling for Covered Persons at higher risk for chronic disease;

14. Depression and anxiety screening;

15. HIV screening;

17. Sexually Transmitted Infection (STI) prevention counseling for adults;

18. Tobacco use screening for all adults and cessation interventions for tobacco users;

19. Syphilis screening for adults;

20. Anemia screening on a routine basis for pregnant women;

21. Urinary tract infection or other infection screening for pregnant women;

22. BRCA counseling about genetic testing for women at higher risk;

23. Breast Cancer Chemoprevention for women at higher risk;
24. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women;
25. Cervical Cancer screening for sexually active women;
26. Chlamydia Infection screening;
27. Contraception — Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs;
28. Domestic and interpersonal violence screening and counseling for all women;
29. Folic Acid supplements for women who may become pregnant;
30. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes;
31. Gonorrhea screening for all women;
32. Hepatitis B screening for pregnant women at their first prenatal visit;
33. Human Immunodeficiency Virus (HIV) screening and counseling for all adults;
34. Human Papillomavirus (HPV) DNA Test--high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older;
35. Osteoporosis screening for women depending on risk factors;
36. Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk;
37. Tobacco Use screening and interventions for all women, and expanding counseling for pregnant tobacco users;
38. Well-woman visits to obtain recommended preventive services;
39. Alcohol and Drug Use assessment for adolescents;
40. Autism screening for children at 18 and 24 months;
41. Behavioral assessments for children of all ages;
42. Blood Pressure screening for children;
43. Cervical Dysplasia screening for sexually active females;
44. Congenital Hypothyroidism screening for newborns;
45. Depression screening for adolescents;
46. Developmental screening for children under age 3, and surveillance throughout childhood;
47. Dyslipidemia screening for children at higher risk of lipid disorders;
48. Fluoride Chemoprevention supplements for children without fluoride in their water source;
49. Gonorrhea preventive medication for the eyes of all newborns;
50. A hearing impairment screening for a Dependent child from birth through 30 days of age;
51. Height, Weight and Body Mass Index measurements for children;

52. Hematocrit and Hemoglobin screening for children;

53. Hemoglobinopathies or sickle cell screening for newborns;

54. HIV screening for adolescents at higher risk;

55. Immunization vaccines for children from birth to age 18--doses, recommended ages, and recommended populations vary;

56. Iron supplements for children ages 6 to 12 months for anemia;

57. Lead screening for children at risk of exposure;

58. Medical History for all children throughout development;

59. Obesity screening and counseling;

60. Oral Health risk assessment for young children;

61. Phenylketonuria (PKU) screening for this genetic disorder in newborns;

62. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents;

63. Tuberculin testing for children at higher risk of tuberculosis; and

64. Vision and hearing screening for children 18 and under.

p. Reconstructive Surgery

We will provide benefits for Covered Services for Reconstructive Surgery incurred for the following:

1. To restore function for conditions resulting from a Bodily Injury;
2. That is incidental to or follows a covered Surgery resulting from Illness or a Bodily Injury of the involved part if the trauma, infection or other disease occurred;
3. Following a Medically Necessary mastectomy. Reconstructive Surgery includes all stages and revisions of reconstruction of the breast on which the mastectomy has been performed, reconstruction of the other breast to establish symmetry, prostheses and physical complications in all stages of mastectomy, including lymphedemas;
4. Reconstructive Surgery for Craniofacial Abnormalities; and
5. Because of a congenital Illness or anomaly of a member to improve the function of or attempt to create a normal appearance of the abnormal body structure.

No benefits are available for Surgery or treatment to change the texture or appearance of the skin or to change the size, shape or appearance of facial or body features (including but not limited to a Covered Person's nose, eyes, ears, cheeks, chin, chest or breasts).

Except as otherwise provided in this Contract, Cosmetic services and services for complications from cosmetic services are not covered regardless of whether the initial Surgery occurred while the Covered Person was covered under this Contract or under any prior coverage.

q. Routine Care During Clinical Trials

We will pay for Covered Services that are Routine Patient Care Costs furnished to a Covered Person participating in a Phase I, Phase II, Phase III, or Phase IV Clinical Trial if the service, item or drug is otherwise covered under this Contract.

No benefits will be provided for services that are a part of the subject matter of the Clinical Trial and that are customarily paid for by the Research Institution conducting the Clinical Trial.

r. Skilled Nursing Facility and Rehabilitation Services

Covered Services include:

1. Daily room and board;
2. General nursing services for each day of Confinement; and
3. Rehabilitation services.

Rendered while Confined in a Sub-Acute Rehabilitation Facility or Skilled Nursing Facility, provided the Covered Person is under the regular care of a Healthcare Practitioner who has reviewed and approved the Confinement. Services in a Sub-Acute Rehabilitation Facility or Skilled Nursing Facility must be:

1. Provided in lieu of care in a Hospital; or
2. For the same condition that required Confinement in a Hospital. The Covered Person must enter the Sub-Acute Rehabilitation Facility or Skilled Nursing Facility within 14 days after discharge from the Hospital.

Coverage for Sub-Acute Rehabilitation Facility or Skilled Nursing Facility will cease when measurable and significant progress toward expected and reasonable outcomes has been achieved or has plateaued.

Rehabilitation services provided in a skilled nursing facility include but are not limited to:

1. Treatment of complications of the condition that required an inpatient Hospital stay;
2. Physical therapy, occupational therapy and speech therapy;
3. Pulmonary rehabilitation programs; and
4. The evaluation of the need for the services listed above.

s. Transplant Services

If a Covered Person requires an organ transplant or is a donor to a Covered Person, all related services including, but not limited to the following, must be preauthorized in advance by Us;

1. Hospital and Healthcare Practitioner services; and
2. Organ acquisition and donor costs, including pre-transplant services, the acquisition procedure, and any complications resulting from the acquisition.

Donor costs will not exceed the Organ Transplant Treatment Period. After the benefits of a Covered Person who is a recipient have been paid, We will provide reimbursement of Covered Services of a live donor to the extent that the benefits remain and are available under this Contract. Any existing benefits available through the health coverage of the donor will be secondary to the benefits available under this Contract.

Prior Authorization from Us is required in advance of the organ transplant. The Covered Person's Healthcare Practitioner must notify Us in advance of the need for an initial evaluation for the organ transplant in order for Us to determine if the organ transplant will be covered. For approval of the organ transplant itself, We must be given a reasonable opportunity to review the clinical results of the evaluation before rendering a determination.

Once coverage for the organ transplant is approved, We will advise the Healthcare Practitioner. Benefits are payable only if the pre-transplant services, the organ transplant and post-discharge services are approved by Us. Coverage for post-discharge services and treatment of complications after transplantation are limited to the Organ Transplant Treatment Period.

Covered Services for a Covered Organ Transplant includes pre-transplant services, transplant inclusive of any chemotherapy and associated services, post-discharge services and treatment of complications after transplantation of the following organs or procedures only:

1. Heart;
2. Lung(s);
3. Liver;
4. Kidney;
5. Bone marrow;
6. Pancreas;
7. Auto-islet cell;
8. Intestine;
9. Multivisceral;
10. Any combination of the above listed organs; and
11. Any organ not listed above, if required by state or federal law.

Corneal transplants and porcine heart valve implants, which are tissues rather than organs, are considered part of regular Contract benefits and are subject to other applicable provisions of this Contract.

No benefits will be provided for, or on account of:

1. Transplants which are Experimental or Investigational;
2. A transplant that does not meet Our pre-transplant criteria;
3. Expenses that are eligible to be paid under any private or public research fund, government program except Medicaid, or another funding program, whether or not such funding was applied for or received;
4. Expenses related to a transplant for which We do not approve coverage based on Our established criteria;
5. A denied transplant. This includes the pre-transplant evaluation, pre-transplant services, the transplant procedure, post discharge services, immunosuppressive drugs and expenses related to complications of such transplant;
6. Expenses related to the storage of cord blood and stem cells unless it is an integral part of an organ transplant approved by Us; or
7. Expenses related to an organ transplant performed outside of the United States and any care resulting from that organ transplant.

t. Transplant Transportation and Lodging

Direct non-medical costs for:

1. The Covered Person receiving the organ transplant when the Hospital performing the Covered Organ Transplant is more than 100 miles away from the Covered Person's residence; and

2. One designated caregiver or support person (two, if the Covered Person receiving the Covered Organ Transplant is under 18 years of age), if they live more than 100 miles from the Hospital performing the Covered Organ Transplant.

Direct non-medical costs include:

1. Transportation Covered Services to and from the Hospital where the Covered Organ Transplant is performed limited to two round trips per Covered Organ Transplant; and

2. Temporary lodging at a prearranged location when requested by the Hospital performing the Covered Organ Transplant and approved by Us.

All direct, non-medical costs for the Covered Person receiving the Covered Organ Transplant and the designated caregiver(s) or support person(s) are limited to a combined maximum per Covered Organ Transplant as shown on the Schedule of Benefits.

u. Transportation

Professional Air and Ground Ambulance service from the scene of a medical emergency to the nearest appropriate medical facility equipped to provide treatment for Emergency Care. We will pay Non-Participating providers at the Usual and Customary rate or an agreed rate.

v. Urgent Care Services

Covered services include Urgent Care Services in an Urgent Care Center participating in the Provider Network.

w. Pediatric Vision Services

Covered services include

- One (1) routine eye exam visit annually for children 18 (up to the end of the month in which the enrollee turns 19) and under.

- In addition to one routine eye care visit per year, coverage for comprehensive low vision evaluation every five years and four follow-up care visits in any five-year period.

- One (1) pair of select frames and prescription lenses every 12 months for children 18 (up to the end of the month in which the enrollee turns 19) and under OR one (1) pair of prescription contact lenses (in lieu of frames and prescription lenses) every 12 months for children 18 (up to the end of the month in which the enrollee turns 19) and under.

- This includes choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, ultraviolet protective coating, oversized and glass-grey #3 prescription sunglass lenses, polycarbonate lenses, scratch resistant coating and low vision items.

- Medically necessary contact lenses for the following conditions keratoconus; pathological myopia; aphakia; anisometropia; aniseikonia; aniridia; corneal disorders; post-traumatic disorders; and, irregular astigmatism require prior authorization.

Vision screening is a brief evaluation (like an eye chart) and can be performed by a primary care doctor as part of a routine or annual physical exam. A vision screening does not diagnose or correct vision or eye health issues. This is not the same as a routine eye exam. A routine eye exam (with or without dilation) to determine the health of the eyes and related structures, visual acuity, and determination of the patient's refractive state, prescribing corrective lenses if necessary. This can be done by Optometrists or Ophthalmologists with specialized diagnostic equipment to check vision, screen for diseases, and update the prescription for eyewear.

4. General Exclusions and Limitations

Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service, however, the service will not be a Covered Service paid for by Us.

If a claim is denied as being Experimental or Investigational, You have the right to seek review of the denial by an Independent Review Organization. Refer to the Appeals, Complaints and External Review Rights provision in the General Provisions section in this Contract for more information.

Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items:

1. Services provided by a non-Participating Provider, except when:

   a. Authorized by Us; or

   b. The following services are Medically Necessary to render Emergency Care:

      i. Professional ambulance service; or

      ii. Services in a Hospital emergency room, freestanding emergency medical care facility or Comparable Emergency Facility;

2. Services incurred before the Effective Date or after the termination date of this Contract;

3. Services not Medically Necessary to prevent, alleviate, cure or heal Bodily Injury or Illness, except for the specified routine Preventive Services;

4. Charges for prophylactic services including, but not limited to, prophylactic mastectomy or any other services performed to prevent a disease process from becoming evident in the organ tissue at a later date unless Medically Necessary;

5. Services which are Experimental or Investigational, or related to such, whether incurred prior to, in connection with, or subsequent to the service which is Experimental or Investigational except as expressly provided in this Contract. The fact that a service is the only available treatment for a condition may not make it eligible for coverage if We deem it to be Experimental or Investigational;

6. Complications directly related to a service that is not a Covered Service under this Contract because it was determined by Us to be Experimental or Investigational or not Medically Necessary, except as expressly provided in this Contract. Directly related means that the service occurred as a direct result of the Experimental or Investigational or not Medically Necessary service and would not have taken place in the absence of the Experimental or Investigational or not Medically Necessary service;

7. Services exceeding the amount of benefits available for a particular service;

8. Services for, or the treatment of complications of, non-covered procedures or services;

9. Services, except for Emergency Care, relating to an Illness or Bodily Injury incurred as a result of the Covered Person;

   a. Being intoxicated, as defined by applicable state law in the state in which the loss occurred; or

   b. Being under the influence of illegal narcotics or controlled substance unless administered or prescribed by a Healthcare Practitioner,

10. Services relating to an Illness or Bodily Injury as a result of:

    a. Intentionally self-inflicted bodily harm or attempted suicide whether sane or insane, when not specifically the result of mental illness;

    b. War or an act of war, whether declared or not;

    c. Taking part in a riot;

    d. Engaging in an illegal occupation; or

    e. Any act of armed conflict, or any conflict involving armed forces or any authority;

11. Services:

    a. For charges which are not authorized, furnished or prescribed by a Participating Provider;

    b. For which no charge is made, or for which the Covered Person would not be required to pay if he/she did not have this coverage, unless charges are received from and reimbursable to the United States government, or any of its agencies as required by law;

    c. Furnished by or payable under any plan or law through a government or any political subdivision, except Medicaid, unless prohibited by law which You or the Covered Person is not legally obligated to pay;

    d. Furnished while a Covered Person is Confined in a Hospital or institution owned or operated by the United States government or any of its agencies for any service-connected Illness or Bodily Injury;

    e. Which are not rendered or not substantiated in the medical records;

    f. Provided by a Family Member or person who resides with the Covered Person;

    g. Performed in association with a non-covered service.

12. Except as otherwise provided in this Contract, cosmetic services, or any complication there from;

13. Custodial Care and Maintenance Care;

14. Ambulance services for routine transportation to, from or between medical facilities and/or a Healthcare Practitioner's office;

15. Elective medical or surgical abortion other than an abortion performed due to medical emergency. For purposes of this section, medical emergency means a life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that, as certified by a physician, places the Member in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed;

16. Reversal of sterilization;

17. Infertility Treatment;

18. Sexual dysfunction;

19. Vision examinations or testing for the purposes of prescribing corrective lenses; radial keratotomy; refractive keratoplasty; or any other Surgery or procedure to correct myopia, hyperopia or stigmatic error; orthoptic treatment (eye exercises); or the purchase or fitting of eyeglasses or contact lenses, unless specified in this Contract;

20. Dental services, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes including, but not limited to, excision of partially or completely un-erupted impacted teeth (other than complete bony impacted teeth), any oral or periodontal Surgery and preoperative and postoperative care, implants and

related procedures, orthodontic procedures, and any dental services related to a Bodily Injury or Illness except as expressly provided in this Contract;

21. Pre-surgical/procedural testing duplicated during a Hospital Confinement;

22. Any treatment for obesity, regardless of any potential benefits for co-morbid conditions, including but not limited to:

    a. Surgical procedures for Morbid Obesity;

    b. Services or procedures for the purpose of treating an Illness or Bodily Injury caused by, complicated by, or exacerbated by the obesity; or

    c. Complications related to any services rendered for weight reduction;

23. Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or a weight loss Surgery;

24. Foot care services, in the absence of diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency, including but not limited to:

    a. Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses or hyperkeratosis;

    b. Cutting of toenails, except removal of nail matrix; and

    c. Any services or supplies in connection with foot care for flat feet, fallen arches or chronic foot strain including; arch supports, heel wedges, lifts shoe inserts, the fitting or provision of foot orthotics or orthopedic shoes, unless orthopedic shoe is an integral part of a covered leg brace.

25. Hair prosthesis, hair transplants or implants, except as expressly provided in this contract;

26. Services rendered in a premenstrual syndrome clinic or holistic medicine clinic;

27. Transplant services except as expressly provided in this Contract;

28. Over the counter medical items or supplies that can may be prescribed by a Healthcare Practitioner but are also available without a written order or Prescription, except for Preventive Services;

29. Immunizations including those required for foreign travel for Covered Persons of any age except as expressly provided in this Contract;

30. Genetic testing when not Medically Necessary including when:

    a. the diagnosis can be made clinically or by biochemical or another laboratory test;

    b. testing of family member not covered under this plan;

    c. testing for screening purposes or without a reasonable suspicion of genetic disorder;

    d. testing does not impact medical management;

    e. the test has not been established by clear and convincing evidence in the scientific literature to be reliably associated with a specific disease, disorder, or specific therapy;

31. Expense for employment, school, sports or camp physical examinations or for the purpose of obtaining insurance, premarital tests/examinations;

32. Services received in an emergency room unless Emergency Care;

33. Any Expense Incurred for services received outside of the United States except for Emergency Care services;

34. Services received during an inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness;

35. Services and supplies which are:

    a. Rendered in connection with Mental Illnesses not classified in the current Diagnostic and Statistical Manual of Mental Disorders;

    b. Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities, intellectual disability or for mental retardation; and

    c. Specifically excluded as marriage counseling;

36. No benefits will be provided for:

    a. Immunotherapy for recurrent abortion;

    b. Chemonucleolysis;

    c. Biliary lithotripsy;

    d. Home uterine activity monitoring;

    e. Light treatment for Seasonal Affective Disorder (S.A.D.);

    f. Immunotherapy for food allergy;

    g. Prolotherapy;

    h. Cranial banding;

    i. Hyperhidrosis Surgery; and

    j. Sensory integration therapy;

37. Charges for alternative medicine, including medical diagnosis, treatment and therapy. Alternative medicine services include, but are not limited to:

    a. Acupressure;

    b. Acupuncture; c. Aromatherapy; d. Ayurveda;

    e. Biofeedback (except to the extent it includes Neurofeedback Therapy that is Medically Necessary for the treatment of an Acquired Brain Injury);

    f. Faith healing;

    g. Guided mental imagery;

    h. Herbal medicine;

    i. Holistic medicine;

    j. Homeopathy;

    k. Hypnosis;

    l. Macrobiotic;

m. Massage therapy;

n. Naturopathy;

o. Ozone therapy;

p. Reflexology;

q. Relaxation response;

r. Rolfing;

s. Shiatsu; and

t. Yoga;

u. Movement therapies such as Tai Chi and Qi Gong

v. Healing Touch

w. Music and Expressive Arts Therapies

x. Wilderness Therapies

y. Horse-Assisted Therapies

39. Living expenses; travel; transportation, except as expressly provided in the Ambulance services provision or Transplants provision in the Your Contract Benefits section of this Contract; and

40. Charges for services that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement (whether or not prescribed by a Healthcare Practitioner) including but not limited to:

    a. Common household items such as air conditioners, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows, or exercise equipment;

    b. Scooters or motorized transportation equipment, escalators, elevators, ramps, modifications or additions to living/working quarters or transportation vehicles;

    d. Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools or spas or saunas;

    e. Medical equipment including blood pressure monitoring devices, PUVA lights and stethoscopes;

    f. Charges for any membership fees or program fees paid by a Covered Person, including but not limited to, health clubs, health spas, aerobic and strength conditioning, work-hardening programs and Weight loss or similar programs and any related material or products related to these programs;

    g. Communication system, telephone, television or computer systems and related equipment or similar items or equipment; and

    h. Communication devices except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.

41. Services for in vitro fertilization and promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct intra-peritoneal insemination, trans-uterine tubal insemination, gamete intra-fallopian transfer, pronuclear oocyte stage transfer, zygote intra-fallopian transfer, and tubal embryo transfer.

5. Prescription Drug Exclusions

Except as expressly stated otherwise, no benefit will be provided for, or on account of, the following items:

1. Drugs which are not included on the Drug Formulary;
2. Nutritional products including formulas for any indication or route of administration;
3. Fluoride supplements except when prescribed to preschool children older than 6 months of age whose primary water source is deficient in fluoride;
4. Legend (prescription) drugs that are not deemed Medically Necessary by Us;
5. Any drug prescribed for any Illness or Bodily Injury for which services are not covered under this Contract;
6. Any drug prescribed for intended use other than for:
   a. Indications approved by the FDA; or
   b. Off-label indications recognized through peer-reviewed medical literature;
7. Any drug, medicine or medication that is either:
   a. Labeled "Caution-limited by Federal law to investigational use"; or
   b. Experimental or investigational, even though a charge is made to the Covered Person;
8. Allergy serum and allergy testing materials;
9. The administration or injection of any drugs;
10. Therapeutic devices or appliances, except as expressly provided in this Contract, including, but not limited to:
    a. Hypodermic needles and syringes except needles and syringes for use with insulin, and Self-Administered Injectable Drugs whose coverage is approved by Us;
    b. Support garments;
    c. Mechanical pumps for delivery of medication; and d. Other non-medical substances;
11. Anorectic or any drug used for the purpose of Weight control;
12. Abortifacients (drugs used to induce abortions), other than due to medical emergency, if used solely for the purpose to induce elective abortions;
13. Any drug used for cosmetic purposes, including, but not limited to:
    a. Tretinoin, e.g., Retin A, except if the Covered Person is under the age of 35 or is diagnosed as having adult acne;
    b. Dermatologicals or hair growth stimulants; or
    c. Pigmenting or de-pigmenting agents, e.g., Solaquin;
14. Contrary to any other provisions of this Contract, We may decline coverage or, if applicable, exclude from the Drug Formulary any and all drugs, including new indications for an existing drug, until the conclusion of a review period not to exceed 6 months following FDA approval for the use and release of the drug, including new indications for an existing drug into the market;

15. Any drug or medicine that is:

    a. Lawfully obtainable without a Prescription (over the counter drugs), except insulin; or drugs, medicines or medications required as part of Healthcare reform with a Prescription from a Healthcare Practitioner;

    b. Available in Prescription strength without a Prescription;

16. Compounded testosterone for the treatment of hormone replacement therapy;

17. Infertility and Fertility Treatment including medications;

18. Any drug prescribed for impotence and/or sexual dysfunction, e.g., Viagra;

19. Any drug, medicine or medication that is consumed, applied or injected at the place where the Prescription is given or dispensed by the Healthcare Practitioner;

20. Drug delivery implants;

21. Prescriptions that are to be taken by, applied or administered to the Covered Person, in whole or in part, while he/she is a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. This includes drugs discharged with the Covered Person from the facility. Inpatient facilities include, but are not limited to:

    a. Hospital;

    b. Skilled nursing facility; or c. Hospice facility;

22. Injectable drugs, including, but not limited to:

    a. Immunizing agents;

    b. Biological sera;

    c. Blood;

    d. Blood plasma; or platelet rich plasma injection

    e. Adipose tissue derived stem cell injection

    f. Self-administered injectable drugs or Specialty Drugs for which we do not approve coverage.

23. Prescription refills:

    a. In excess of the number specified by the Healthcare Practitioner, or b. Dispensed more than one year from the date of the original order;

24. Any portion of a Prescription or refill that exceeds a 90-day supply when received from either a mail-order Pharmacy or from a retail Pharmacy that participates in Our program which allows a Covered Person to receive a 90-day supply of a Prescription or refill;

25. Any portion of a Prescription or refill that exceeds a 30-day supply when received from a retail Pharmacy that does not participate in Our program which allows a Covered Person to receive a 30-day supply of a Prescription or refill;

26. Any portion of a Specialty Drug or Self-Administered Injectable Drug that exceeds a 30-day supply;

27. Any portion of a drug for which Prior Authorization or Step Therapy is required and not obtained;

28. Any drug for which a charge is customarily not made;

29. Any portion of a Prescription or refill that:

a. Exceeds Our drug specific Dispensing Limit (i.e., IMITREX);

b. Is dispensed to a Covered Person whose age is outside the drug specific age limits defined by Us;

c. Is refilled early, as defined by Us; or

d. Exceeds the duration-specific Dispensing Limit;

30. Any drug, medicine or medication received by the Covered Person:

a. Before becoming covered under this benefit; or

b. After the date the Covered Person's coverage under this Contract has ended;

31. Any costs related to the mailing, sending or delivery of Prescription Drugs;

32. Any intentional misuse of this benefit, including Prescriptions purchased for consumption by someone other than the Covered Person;

33. Any Prescription or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled or damaged;

34. Any amount the Covered Person paid for a Prescription that has been filled, regardless of whether the Prescription is revoked or changed due to adverse reaction or change in dosage or Prescription;

35. Drugs that are repackaged by anyone other than the original manufacturer.

36. Covered Drugs, devices, or other Pharmacy services or supplies provided or available under the Workers' Compensation law.

37. Athletic performance enhancement drugs If a claim is denied as being Experimental Investigation, You have the right to seek review of the denial by an Independent Review Organization. Refer to the Appeal Complaints and External Review provision in the General Provisions section in this Contract for more information.

6. Premium Payment

a. Your Duty to Pay Premium

You must pay the required premium to Us as it becomes due. If You do not pay Your premium on time, subject to the grace period, We will terminate coverage.

Please be advised that any past due premium that is due to Community within the past 12 months is due prior to the effective date of coverage. Any outstanding premium that is not paid, may affect Your ability to be enrolled in a Community health plan.

d. Grace Period

Contract Holders have 30 days from the premium due date to remit the required funds. If premium is not paid, We will terminate coverage effective the last day of the premium period for which premium was paid and You may be held liable for cost of services received during the grace period.

f. Changes to Your Premium

Premium may change when:

1. Family members are added or removed;

2. Any Covered Person's rating classification changes;

3. The Covered Person moves to a different zip code or county; or

4. A misstatement on the application resulting in the proper amount due not being charged.

Premiums may change upon 60-days written notice, upon a Covered Person's rating classification changing or if a misstatement on the application results in the proper amount due not being charged.

Your continued payment of premium will constitute Your agreement to the change.

g. Return of Premium

In no event, except for the following reasons will premium be returned:

1. The Contract Holder returns the Contract as described in the Right to Return Contract provision;

2. Rescission of coverage as described in the Incontestability provision in the General Provisions section; or

3. The Contract Holder requests in writing for coverage to end and premium has been paid for any period of time after the later of the date requested by You or the date We receive Your notice to cancel.

In the event that You cancel this Contract, the premium shall be computed pro rata. Cancellation of this Contract will not affect claims incurred prior to the cancellation.

7. Changes to Contract

a. Your Rights to Make Changes to the Contract

You have several rights to make changes to Your Contract.

1. Change in Residence/Phone Number

   We must be notified of any change in Your residential or mailing address.

   At least 14 days prior to Your move, call or write Us informing Us of Your new address and phone number. When We receive this information, We will inform You of any changes to Your plan on such topics as new networks, benefits, and premium. If the Contract Holder moves outside of this Contract's Service Area, the Contract will be terminated. See the Renewability and Termination section for the events that will cause this Contract and/or a Covered Person's coverage to end. Such change will be effective on the date We assign.

   We have the right to change Your residence address in Our records upon Our receipt of an address change from a third party and after confirmation from You that Your address changed.

2. Changes to Covered Persons

   You may request a change to the persons covered under Your Contract due to certain changes in Your family.

   i. Removing Dependents

      If You wish to remove a Covered Person from Your Contract, simply call or write Us at the address on Your Member Identification Card.

   ii. Adding Dependents

      If a child is born to a Contract Holder, or any Covered Person, a Contract Holder adopts a child, or a child is placed with the Contract Holder for the purpose of adoption, or the Contract Holder is a party in a suit in which adoption of a child is sought, We must be notified of the event verbally or in writing and receive any required premium on or before 60 days of the event. If We do not receive notice and premium for the first 60 days and forward, the child will not be a Covered Person under this Contract.

      If a Dependent child is the subject of a medical support order, coverage will be automatic for the first 60 days after receipt or date of the medical support order or notice of the medical support order and any required premium.

      A Dependent not falling under the previous paragraph must apply to be added as a Covered Person and be accepted by Us during the annual open enrollment period. A Dependent child is eligible to apply if they are under age 26. If accepted, the Covered Person will be covered on the date We specify.

   iii. Effective Date of Dependent Changes

      (a) Coverage for a newborn or adopted child will be effective for the first 31 days following the date of the birth, placement, adoption, or date the court grants the petition for adoption. To continue coverage for the newborn or adopted child beyond the initial period, You must provide notice to Us and remit the premium within 31 days of the child's date of birth or adoption;

      (b) Coverage of a Dependent child who is the subject of a medical support order will be effective for the first 31 days after receipt of the medical support order or notice of the medical support order;

(c) If We receive the application or notification as applicable, and any required premium more than 31 days after the newborn's date of birth or the child's adoption, placement for adoption, or date the court grants the petition for adoption, such child will not be eligible;

(d) For changes for other Dependents, the Dependent will not be eligible for coverage until receipt of premium and acceptance by Us, or until the next open annual enrollment period, qualifying event or special enrollment.

b. Our Rights to Make Changes to the Contract

We have the right to make certain changes to Your Contract. Changes to this Contract can be made by Us at any time without prior consent when the changes are required by state or federal law.

c. Continuation of Coverage for Surviving Dependents

If this Contract has been in-force for at least 90 days and the Contract Holder dies while Dependent coverage is in-force, the surviving Dependents that are covered under this Contract on the date of death may be eligible to continue coverage under this Contract.

The surviving spouse or legal guardian of the covered Dependent child(ren) must notify Us in writing within 31 days of the Contract Holder's death. Premium must continue to be paid in order for coverage to continue. The premium may change and will be based upon the classification of age of those continuing coverage.

The surviving Dependent spouse will become the Contract Holder if covered under this Contract on the date of death. In the case of child-only coverage, the surviving Dependent's parent or legal guardian will become the Contract Holder of the continued Contract.

All conditions, limitations, exclusions, and maximums of this Contract will continue to apply.

d. Continuation of Coverage Due to Marital Change

If a Covered Person is no longer eligible due to change in marital status, We will offer coverage that most nearly approximates the coverage in effect prior to change in marital status including the expiration date.

8. Renewability and Termination

a. Reasons We Will Terminate Your Contract

This Contract is renewable at the option of the Contract Holder, except for the conditions stated below. We will terminate Your Contract at the end of the month in which the following events occur unless stated otherwise:

1. The required premium was due to Us, including any grace period and not received by Us, including any outstanding premium balance. Termination will be effective on the last day for which the premium was paid.
2. Fraud or intentional misrepresentation of a material fact, in which case, termination will be effective not less than 15 days after written notice.
3. Fraud in the use of services or facilities, in which case, termination will be effective not less than 15 days after written notice.
4. The Contract Holder no longer resides, lives or works within the Service Area as determined by Us, but only if coverage is terminated uniformly without regard to any health status-related factor of the member. A map of the Service Area is located at www.communityhealthchoice. org, in the Provider Directory, or You may call Our Member Services telephone number on Your Member Identification Card. Termination will be effective not less than 30 days after written notice. This provision does not apply to dependents including those dependents who may under a medical support order.
5. The Contract Holder requests termination of the Contract in writing.
6. We cease to offer a particular type of individual coverage or cease to do business in the individual basic health care market as allowed by federal or state law.

If We decide to cease to offer particular type of individual coverage, the Contract Holder will be:

1. Notified of such discontinuation at least 90 days prior to the date of discontinuation of such coverage; and
2. Given the option to purchase any other individual Community health plan that is being offered by Us at such time.

If We decide to cease doing business in the individual health plan market, the Contract Holders covered by such policies and the Commissioner of Insurance will be notified of such discontinuation at least 180 days prior to the date of discontinuation of such coverage.

If a policy is terminated and leads to a break in coverage it may result in deductibles and maximum out of pockets amounts to restart.

b. Reasons We Will Terminate a Covered Person

We will terminate coverage for a Covered Person at the end of the month in which the following events occur unless stated otherwise:

1. When the Covered Person no longer qualifies as a Dependent as defined in the Definitions section of this Contract or no longer meets eligibility criteria;
2. The date the Contract Holder no longer resides, lives or works within the Service Area. A map of the Service Area is located at www.communityhealthchoice.org, in the Provider Directory, or You may call Our Member Services telephone number on Your Member Identification Card. This provision does not apply to dependents including those dependents who are subject of a medical support order;

3. The Covered Person commits fraud or makes an intentional misrepresentation of a material fact, in which case, We will provide 15 days' notice of Our intent to terminate this Contract with regard to the Covered Person.

4. The date this Contract terminates.

   If We accept premium for any Covered Person extending beyond the date, age or event specified in this section as a reason for termination, then coverage for that Covered Person will continue during the period for which an identifiable premium was accepted.

c. Your Duty to Notify Us

You are responsible to notify Us of any of the events stated above which would result in termination of this Contract or a Covered Person.

d. Reinstatement

If this Contract is terminated due to lack of premium payment, other than Your initial premium payment, You may request reinstatement. We will reinstate Your Contract provided all of the following are met:

1. Coverage has not been terminated for more than 90 days from the termination date;
2. We approve the reinstatement; and
3. All unpaid premiums have been paid in full.

If Your request for reinstatement is approved, coverage will be reinstated on the date We approve the reinstatement.

e. Fraud

You commit fraud against Us or make an intentional misrepresentation of a material fact by intentionally not telling Us the correct facts or withholding information necessary for Us to administer this Contract.

Fraud may be a criminal offense that can be prosecuted. Any person(s) who willingly and knowingly engages in an activity intended to defraud Us by filing a claim or form that contains a false or deceptive statement may be committing insurance fraud.

If You or the Covered Person commits fraud against Us, as determined by a court of law, coverage will be terminated. We will provide 30 days' notice of Our intent to terminate. Such termination may be made on a retroactive basis as of the date the fraud was committed or as of the date otherwise determined by Us.

f. Reasons You May Terminate Your Contract

You may terminate Your Contract after not less than 30 days' written notice to Us in the case of a material change by Us to any provision of the Contract that is required to be disclosed to You or a Covered Person pursuant to state or federal law. Termination will be effective the last day of the month following receipt of the written request.

You may request voluntary termination of Your Contract in writing to Us and will be granted same-day or prospective coverage termination dates based on the date of Your request.

9. General Provisions

a. Appeals, Complaints and External Review Rights

You have a right to Appeal any decision We make that denies payment on Your claim, Your request for coverage of a health care service or treatment or any decision we make regarding rescission of Your coverage. Included in Your rights are the right to appeal an Adverse Determination to Us and to external review by an Independent Review Organization, to appeal a Contractual Denial, and to file a Complaint. We may not engage in any retaliatory action against You for filing a complaint against Us or appealing an Adverse Determination.

Adverse Determinations

If We determine that health care services provided or proposed to be provided are not Medically Necessary or appropriate, We will notify You or an individual acting on Your behalf and Your provider of record of Our determination and of Your right to Appeal the Adverse Determination and the process for requesting an Appeal.

We will notify You, the individual acting on Your behalf and Your provider of record of the Adverse Determination within the time appropriate to the circumstances relating to the delivery of the services and Your condition, but in no case to exceed one hour from notification when denying post-stabilization care subsequent to emergency treatment as requested by a treating Healthcare Practitioner. If You are hospitalized, notification will be provided within one working day by telephone or electronic transmission, followed by written notice within three working days. An expedited review is available for urgent care claims, such as when you are suffering from a health condition that may seriously jeopardize your life, health or ability to regain maximum function, or in the opinion of a Healthcare Practitioner with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the care or treatment. If You are not hospitalized and it is not an urgent care situation, written notification will be provided within 3 working days or within the time appropriate to the circumstances relating to the delivery of the services and Your condition.

Notice of Adverse Determination for concurrent review of provision of prescription drugs or intravenous infusions for which You are currently receiving benefits, will be provided not later than the 30th day before the date on which the provision of prescription drugs or intravenous infusion will be discontinued. If a request for additional benefits is made at least 24 hours prior to the end of the initially prescribed and previously approved treatment, notice will be provided within 24 hours of receipt of the request, if the request is for urgent care benefits. If a retrospective review is conducted, notification will be provided within 30 days of the request. Certain extensions for retrospective review may be made as permitted by state law.

Appeal of Adverse Determinations

If Your case involves a life-threatening condition, circumstances involving the provision of prescription drugs or intravenous infusions for which You are currently receiving benefits, a denial of a Drug Formulary exception request, or if We do not meet internal timeframes, You are entitled to an immediate external review by an Independent Review Organization (IRO). You are not required to comply with procedures for an internal review.

Expedited Appeal

You or an individual acting on Your behalf or Your provider of record may ask for an expedited (fast) Appeal for emergency care denials, denials of care for life-threatening conditions denials of continued stays for hospitalization and denials of prescription drugs and intravenous infusions for which You are receiving benefits. The expedited review will be a review by a Healthcare Practitioner who has not previously reviewed the case and who is of the same or a similar specialty as the health care provider that typically manages the medical condition, procedure, or treatment under review. Expedited Appeal requests will be decided based on the medical immediacy of Your condition, procedure or treatment, but in no event later than one working day from the date all information necessary to complete the appeal is received.

Expedited Appeal for Urgent Care Claims

An expedited Appeal is also available for urgent care claims, such as when you are suffering from a health condition that may seriously jeopardize your life, health or ability to regain maximum function, or in the opinion of

a Healthcare Practitioner with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the care or treatment. Expedited Appeal requests for urgent care claims will be decided as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the appeal.

For expedited Appeals for emergency care denials, denials of care for life-threatening conditions denials of continued stays for hospitalization and denials of prescription drugs and intravenous infusions for which You are receiving benefits and urgent care clams, Community will a make its determination as soon as possible and if two timeframes apply due to the nature of the appeal, apply the shorter of the two.

Standard Appeals

When We receive an Appeal, We will, within no later than five working days from the receipt of the Appeal, send to the appealing party a letter acknowledging the date of Our receipt of the Appeal. This letter will include the Appeal procedures, a request for required documentation, and the timeframes required for resolution. If an Appeal of an Adverse Determination is received orally, included in the acknowledgement letter will be a one-page Appeal form.

After review of the Appeal of an Adverse Determination, We will issue a response letter to You or the person acting on Your behalf and Your Healthcare Practitioner explaining the resolution of the appeal as soon as practical, but in no case later than the 30th calendar day after the date We receive the Appeal.

External Review by an Independent Review Organization (IRO)

You or an individual acting on Your behalf or Your provider has the right to request an immediate review of Our appeal decision by an IRO by submitting a request to Us within four months after receipt of the notice of the determination of Your appeal. There is no cost to You for the independent review.

You will not be required to exhaust Our internal appeal process before requesting an independent review if:

(a) the Appeal process timelines are not met; or

(b) in cases involving life threatening conditions; or

(c) an Adverse Determination that involves denial of prescription drugs or intravenous infusions for which You are currently receiving benefits or a formulary exception request.

By Fax: 713-295-7033
By Phone: 713.295.6704 and 1.855.315.5386

Community contracts with Maximus to perform external review. Upon receipt of Your request for an external review, Community will refer the request to one of these IROs. Referrals are made on a rotating basis to ensure an unbiased and independent process.

The IRO will give You and Us written notice of the final external review decision as soon as possible, but not later than the 45 days after the IRO receives the request for a standard external review. For an expedited external review, the IRO will give You and Us the external review decision as quickly as medical circumstances require, but no later than 72 hours of receiving the request.

If We do not approve a Drug Formulary exception request as described in Section 3 "Your Contract Benefits Management", section n "Prescription Drugs", You may request an external review. The IRO will issue a response to you or your legal representative no later than 72 hours from receipt of your request. For an expedited appeal for prescription drugs, the IRO will issue a response to you or your legal representative no later than 24 hours from receipt.

Appeal from Denial of Benefits

If We determine that a health care service provided or proposed to be provided is not covered for reasons other than an Adverse Determination, for example, it is not covered or it is expressly excluded, You have the right to

appeal that determination by requesting an appeal orally or in writing. In which case, We will follow the procedure below for Complaints.

Request for Additional Information

You may request more explanation when You receive Denial of Benefits. Contact Us when You:

- Do not understand the reason for the denial;
- Do not understand why the health care service or treatment was not fully covered;
- Do not understand why a request for coverage of a health care service or treatment was denied;
- Cannot find the applicable provision in Your Evidence of Coverage;
- Want a copy (free of charge) of the guideline, criteria or clinical rationale that We used to make Our decision; or
- Disagree with the denial or the amount not covered, and You want to Appeal.

If Your claim was denied due to missing or incomplete information, You or Your health care provider may resubmit the claim to Us with the necessary information to complete the claim.

The appeal process does not prohibit the Covered Person 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 the Covered Person's health in serious jeopardy.

For questions on appeal and external review rights, a Covered Person can call Our Member Services Department at the number on his/her Member Identification Card.

Complaint Process

If You notify Us orally or in writing of a Complaint, We will, not later than the fifth business day after the date of the receipt of the Complaint, send You a letter acknowledging the date We received the complaint. This letter will also include Our complaint procedures and time frames for resolution. 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 of the complaint.

After receipt of the written Complaint or one-page Complaint Form, We will investigate and send a letter with Our resolution to the Covered Person. We will notify You of Our determination within 30 calendar days after the date We received the complaint.

If a Complaint involves an emergency or denial of continued hospitalization, We will investigate and resolve the Complaint within one business day of receiving the complaint.

Appeals from a Complaint to the Plan

If the complaint is not resolved to the Covered Person's satisfaction, the Covered Person has the right either to appear in person before a complaint appeal panel where the Covered Person normally receives healthcare services, unless another site is agreed to by the Covered Person, or to address a written appeal to the complaint appeal panel. We shall complete the complaint appeal process not later than the 30th calendar day after the date of the receipt of the request for appeal.

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

b. We shall appoint members to the complaint appeal panel, which shall advise Us on the resolution of the dispute. The complaint appeal panel shall be composed of an equal number of Our staff, Healthcare Practitioners, and other persons covered under a Community health plan. A member of the complaint appeal panel may not have been previously involved in the disputed decision.

c. Not later than the fifth business day before the scheduled meeting of the panel, unless the Covered Person agrees otherwise, We shall provide to the Covered Person or Covered Person's designated representative:

   1. Any documentation to be presented to the panel by Our staff;

   2. The specialization of any Healthcare Practitioner consulted during the investigation; and

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

d. The Covered Person or the Covered Person's designated representative if the Covered Person is a minor or disabled, are entitled to:

   1. Appear in person before the complaint appeal panel;

   2. Present alternative expert testimony; and

   3. Request the presence of and question any person responsible for making prior determination that resulted in the appeal.

Where to Send Appeals, Complaints and Requests for IRO

All Appeals must be sent to:
Fax: 713-295-7033
By Phone: 713.295.6704 and 1.855.315.5386

All Complaints must be sent to:
Fax: 713-295-7036
By Phone: 713-295-6704 and 1-800-315-5386

Mail: 2636 South Loop West
Houston, Texas 77054
Attn: Service Improvement

For an IRO request, please refer to the "Review by an Independent Review Organization (IRO)" provision.

Filing Complaints with the Texas Department of Insurance

Any Covered Person, including persons who have attempted to resolve Complaints through Our complaint and appeal process and who are dissatisfied with the resolution, may report the information to:

Texas Department of Insurance
1-800-252-3439
P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007
Web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

The Commissioner will investigate a complaint against Us to determine compliance within 60 days after the TDI's receipt of the complaint and all information necessary for the department to determine compliance. The Commissioner may extend the time necessary to complete an investigation in the event any of the following circumstances occur:

1. Additional information is needed;

2. An on-site review is necessary;

3. We, the Healthcare Practitioner, or the Covered Person does not provide all documentation necessary to complete the investigation; or

4. Other circumstances beyond the control of the department occur.

b. Exhaustion of Remedies

You must complete levels of the Appeal, Complaints and External Review Rights process applicable to You and any regulatory/statutory review process available to You under state or federal law before You file a legal action. Completion of these administrative and/or regulatory processes assures that both You and We have a full and fair opportunity to resolve any disputes regarding the terms and conditions contained in this Contract.

c. Assignment of Benefits

Assignment of benefits may be made only with Our consent. An assignment is not binding until We receive and acknowledge in writing the original or copy of the assignment before payment of the benefit. We do not guarantee the legal validity or effect of such assignment.

d. Conformity with State Statutes

If the Contract contains any provision not in conformity with Texas Insurance Code section 1271 or other applicable laws, it shall not be rendered invalid but shall be construed and applied as if it were in full compliance with the Insurance Code Chapter 1271 and other applicable laws.

e. Cost of Legal Representation

The costs of Our legal representation in matters related to Our rights under this Contract shall be borne solely by Us. The costs of legal representation incurred by or on behalf of a Covered Person shall be borne solely by You or the Covered Person, unless We were given timely notice of the claim and an opportunity to protect Our Own interests and We failed or declined to do so.

f. Duplicating Provisions

If any charge is described as covered under two or more benefit provisions, We will pay only under the provision allowing the greater benefit. This may require Us to make a recalculation based upon both the amounts already paid and the amounts due to be paid. We have no obligation to pay for benefits other than those this Contract provides.

g. Entire Contract

The application, endorsements, amendments, riders and Contract constitute the entire agreement between the parties.

No modification or amendment to this Contract will be valid unless approved by a committee and legal review. The approval must be endorsed on or attached to this Contract. No agent has authority to modify this Contract, waive any of the Contract provisions, extend the time for premium payment, or bind Us by making any promise or representation.

h. Incontestability

All statements made by You on Your application are considered to be representations, not warranties. A statement may not be used to contest or void, cancel or non-renew this Contract unless it is in the written

enrollment application signed by You and a signed copy of the enrollment application was furnished to You or Your personal representative. A Contract may only be contested because of fraud or intentional misrepresentation of material fact on an enrollment application.

i. Rescission

Rescission is the retroactive cancellation or discontinuance of coverage due to an act, practice, or omission that constitutes fraud or an intentional misrepresentation of a material fact by You or by a person seeking coverage

on Your behalf. Rescission is subject to 30 days' prior notification and is retroactive to the Effective Date. In the event of such cancellation, We may deduct from the Premium refund any amounts made in claim payments during this period and You may be liable for any claims payment amount greater than the total amount of Premiums paid during the period for which cancellation is affected.

j. Legal Action

The Covered Person must have exhausted his or her rights under the Appeal, Complaints and External Review Rights provisions before bringing legal action against Us. No lawsuit with respect to benefits under this Contract may be brought after the expiration of three years after the later of:

1. The date on which We first denied the service or claim, paid less than You believe appropriate, or failed to timely pay the claim; or
2. 180 days after a final determination of a timely filed appeal.

k. Premium Adjustment

If it is determined that information about the age or smoking status of a Covered Person was omitted or misstated, We will make an equitable premium adjustment. This provision applies equally to the Covered Person and to Us.

l. Notice of Claim

Generally, any services You receive will be billed to Us by the Physician or Provider.

If You receive a service that will not be billed to Us by the Physician or Provider, You can submit a claim for reimbursement to Our address shown on Your Member Identification Card.

Please include the following information:

- Your name, the services received and member number
- Community Medical Claim Form found on our website
- Authorization for the release of medical information including the names of all providers that rendered services to You
- An itemized bill including procedures and diagnosis
- If possible, a letter of medical necessity and procedure notes from the treating provider
- Proof of payment for the medical care
- Information about other insurance coverage

Except for emergency services, your plan does not cover any benefits outside of your plan's service delivery area. If you received care outside of the United States, in addition to the information above, please also submit:

- Proof of travel outside the United States such as airline tickets or passport stamps
- An explanation of care outside the United States

We must receive Your claim no later than 95 days after the date of service

Not later than the 15th day after We receive the claim, We will acknowledge receipt of the claim and investigate the claim. We may need additional information We reasonably believe will be required and will inform you if so.

We will notify You in writing of the acceptance or rejection of the claim no later than 15 business days after the date We receive all information required to make a determination. If We reject the claim, We will state the

reason(s). If We are unable to accept or reject the claim by the end of the 15th business day, We will notify You of the reasons why We need additional time. We will accept or reject the claim no later than the 45th day after the date of Our notice.

If We notify You that We will pay the claim or part of the claim, We will pay not later than the 5th business day after Our notice. If payment is conditioned on an act to be performed by You, We will pay the claim no later than the 5th business day after You perform.

If You fail to cooperate or provide the necessary information, We may recover payments made by Us and deny any pending or subsequent claims for which the information is requested, unless the services were preauthorized by Us and determined to be Medically Necessary or appropriate.

However, Your claims will not be reduced or denied if it was not reasonably possible to give such proof.

m. Our Relationship with Providers

Participating Providers are not Our agents, employees or partners. Participating Providers are independent contractors. We do not endorse or control the clinical judgment or treatment recommendation made by Participating Physician or Participating Providers.

Nothing contained in this Contract or any agreement or reimbursement document shall, nor is it intended to, interfere with communication between You and Your Healthcare Practitioner regarding Your medical condition or treatment options. When requesting authorizations and ordering services, Participating Physicians or Participating Providers are acting on Your behalf. All decisions related to patient care are the responsibility of the patient and the treating Participating Physicians or Participating Providers regardless of any coverage determination(s) We have made or will make. We are not responsible for any misstatements made by any provider with regard to the scope of Covered Services and/or non-Covered Services under Your Contract. If You have any questions concerning Your coverage, please call the Member Services Department at the telephone number on Your Member Identification Card.

n. Rights That Affect Our Obligation to Pay

1. You are obligated to cooperate and assist Us and Our agents in order to protect Our recovery rights by:

   a. Promptly notifying Us that You may have a claim;

   b. Obtaining our consent before releasing any party from liability for payment of medical expenses;

   c. Providing Us with a copy of any legal notices arising from the Covered Person's injury and its treatment;

   d. Taking all action to assist our enforcement of recovery rights and doing nothing after the Illness, Bodily Injury or accident to prejudice our recovery rights; and

   e. Refraining from designating all (or any disproportionate part) of any recovery as exclusively for pain and suffering.

   If You fail to cooperate with Us, We shall be entitled to recover from You any payments made by Us.

2. Right to Request Information

   The Covered Person must cooperate with Us and when asked, assist Us by:

   a. Authorizing the release of medical information including the names of all providers from whom medical attention was received;

   b. Obtaining medical information/or records from any Physician or Provider as requested by Us;

   c. Providing information regarding the circumstances of the Illness, Bodily Injury or accident;

d. Providing information about other coverage benefits, including information related to any Bodily Injury or Illness for which another party may be liable to pay compensation or benefits; and

e. Providing information We request to administer the Contract.

If You fail to cooperate or provide the necessary information, We may recover payments made by Us and deny any pending or subsequent claims for which the information is requested, unless the services were approved by Us in advance.

3. Non-duplication of Medicare benefits We will not duplicate benefits for expenses that are paid by Medicare if it is the primary payer.

   In all cases, coordination of benefits with Medicare and the provisions of Title XVIII of the Social Security Act as amended will conform with Federal Statutes and Regulations.

   For purposes of this section, Medicare means Title XVIII, Part B, of the Social Security Act, as enacted or amended.

4. Coordination of Benefits

   This Coordination of Benefits (COB) provision applies when a Covered Person has health care coverage under more than one plan. Plan is defined below.

   a. Following are definitions applicable to this COB provision

      1. "Plan" is any of the following that provides benefits or services for medical or dental care or treatment.

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

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

         Each contract for coverage is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan. 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.

      3. "This Plan" is the part of the contract providing the health care benefits to which the COB provision applies.

         The order of benefit determination rules determines whether this Plan is a primary plan or secondary plan when the person has health care coverage under more than one plan. When this Plan is primary,

it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this Plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits equal 100 percent of the total allowable expense.

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

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

5. "Allowable amount" is the amount of a billed charge that a carrier determines to be covered for services provided by a Non-Participating Provider or Physician. The allowed amount includes both the carrier's payment and any applicable deductible or copayment amounts for which the insured is responsible.

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

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

b. Order of Benefit Determination Rules

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

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

2. Except as provided in Section 3 below, a plan that does not contain a COB provision that is consistent with this policy is always primary unless the provisions of both plans state that the complying plan is primary.

3. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage must be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

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

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

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

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

8. Each plan determines its order of benefits using the first of the following rules that apply.

i. Nondependent or Dependent. The plan that covers the Member other than as a dependent, for example as an employee, member, policyholder, subscriber, or retiree, is the primary plan, and the plan that covers the Member as a dependent is the secondary plan. However, if the Member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the Member as a dependent and primary to the plan covering the Member as other than a dependent, then the order of benefits between the two plans is reversed so that the plan covering the Member as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other plan is the primary plan.

ii. Dependent Child Covered Under More Than One Plan.

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

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

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

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

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

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

(2) if a court order states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Section 8.ii.(a) must determine the order of benefits.

(3) if a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Section 8.ii.(a) must determine the order of benefits.

(4) If there is no court order allocating responsibility for the dependent child's health care expenses or health care, the order of benefits for the childcare as follows:

(i) the plan covering the custodial parent;

(ii) the plan covering the spouse of the custodial parent; (iii) the plan covering the noncustodial parent; then

(iv) the plan covering the spouse of the noncustodial parent.

(c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of Section 8.ii.(a) or 8.ii.(b) must determine the order of benefits as if those individuals were the parents of the child.

(d) For a dependent child who has coverage under either or both parents' plans and has his or her own coverage as a dependent under a spouse's plan, Section 8.v. applies.

(e) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits must be determined by applying the birthday rule in Section 8.ii.(a) to the dependent child's parent(s) and the dependent's spouse.

iii. Active, Retired, or Laid-off Employee. The plan that covers a Member as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan that covers that same Member as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the plan that covers the same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if 8.i. can determine the order of benefits.

iv. COBRA or State Continuation Coverage. If a Member whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree or covering the Member as a dependent of an employee, member, subscriber, or retiree is the primary plan, and the COBRA, state, or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if 8.i. can determine the order of benefits.

Longer or Shorter Length of Coverage. If none of the above rules determine the order of benefits, the plan that has covered the Member as an employee, member, policyholder, subscriber, or retiree longer is the primary plan, and the plan that has covered the person the shorter period is the secondary plan.

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

c. Effect on the Benefits of This Plan

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

d. Facility of Payment

A payment made under another plan may include an amount that should have been paid under this Plan.

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

e. Release of Information

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

f. Right of Recovery

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

5. Right of Reimbursement

If We pay benefits and You recover or are entitled to recover benefits from other coverage or from any legally responsible party, We have the right to recover from You the amount We paid.

You must notify Us, in writing, within 31 days of any benefit payment, settlement, compromise or judgment. If You waive or impair Our right to reimbursement, We will suspend payment of past or future services until all outstanding lien(s) are resolved.

If You recover payment from and release any legally responsible party for future medical expenses relating to an Illness or Bodily Injury, We shall have a continuing right to seek reimbursement from You. This right, however, shall apply only to the extent allowed by law.

This reimbursement obligation exists in full regardless of whether the settlement, compromise, or judgment designates the recovery as including or excluding medical expenses.

6. Our Right of Subrogation

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

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

7. Assignment of Recovery Rights

If Your claim against another insurer is denied or partially paid, We will process such claim according to the terms and conditions of this Contract. If payment is made by Us on behalf of a You, You agree that any right You have against the other insurer for medical expenses We pay will be assigned to Us.

o. Right to Request Overpayments

We reserve the right to recover any payments made by Us that were:

1. Made in error;

2. Made to You and/or any party on Your behalf, where We determine that such payment made is greater than the amount payable under this Contract;
3. Made to You and/or any party on Your behalf, based on fraudulent or intentional misrepresentation of a material fact; or
4. Made to You and/or any party on Your behalf for charges that were discounted, waived or rebated. We reserve the right to adjust any amount applied in error to any Deductible or Out-of-Pocket Maximum.

p. Right to Require Medical Examinations

We have the right to have the Covered Person examined or autopsied during the pendency of a claim, unless prohibited by law. These procedures will be conducted as often as We deem reasonably necessary to determine Contract benefits, at Our expense.

q. State Public Medical Assistance

If a Covered Person received medical assistance from a program under the Texas Health and Human Services Commission while insured under this Contract, We will reimburse the program for the actual cost of medical expenses the program pays through medical assistance, if such assistance was paid for a Covered Expense for which benefits are payable under this Contract, and if We received timely notice from the Commission, or its designed health plan, of payment of such assistance. Any reimbursement to the Commission or its designated health plan made by Us will discharge Us to the extent of the reimbursement. This provision applies only to the extent We have not already made payment of the claim to You or to the provider.

If the Texas Health and Human Services Commission is paying financial and medical assistance for a child and You are a parent who purchased this Contract or a parent covered by this Contract and have possession or access to the child, or are not entitled to access or possession of the child but are required by the court to pay child support, all benefits paid on behalf of the child or children under this Contract must be paid to the Texas Health and Human Services Commission.

We must receive written notice affixed to the claim when first submitted that benefits must be paid directly to the Texas Health and Human Services Commission.

r. Time of Payment of Claims

Payments due under this Contract to Participating Physicians and Participating Providers will be paid in accordance with applicable Texas Prompt Payment of Claims laws.

s. Workers' Compensation

This Contract is not in lieu of any Workers' Compensation or Occupational Disease insurance.

10. Definitions

Acquired Brain Injury means 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.

Advanced Imaging for the purpose of this definition, includes Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron Emission Tomography (PET), Single Photon Emission Computed Tomography (SPECT), Computed Tomography (CT) imaging, and Nuclear Medicine.

Adverse Determination means a determination by Us or a designee that the healthcare Services furnished or proposed to be furnished to a Covered Person are not Medically Necessary or are Experimental or Investigational. The term does not include a denial of health care Services due to the failure to request prospective or concurrent utilization review. In the case of a Prescription drug, it is an Adverse Determination if We refuse to provide benefits if the drug is not included in the Drug Formulary and Your Physician has determined that the drug is Medically Necessary.

Affordable Care Act means the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152).

Appeal means Our formal process by which a Covered Person, an individual acting on behalf of a Covered Person, or a Covered Person's Provider of record may request reconsideration of an Adverse Determination or Denial of Benefits.

Autism Spectrum Disorder means a neurobiological disorder that includes autism, Asperger's syndrome, or pervasive developmental disorder—not otherwise specified. A neurobiological disorder means an Illness of the nervous system caused by genetic, metabolic, or other biological factors.

Bodily Injury means bodily damage other than Illness, including all related conditions and recurrent symptoms, resulting from sudden physical trauma which could not be avoided or predicted in advance. The Bodily Injury must be the direct cause of the loss, independent of disease, bodily infirmity, or any other cause. Bodily damage resulting from infection or muscle strain due to athletic or physical activity is considered an Illness and not a Bodily Injury.

Bone Marrow Transplant means the transplant of human blood precursor cells that are administered to a patient following high-dose, ablative or myelosuppresive chemotherapy. Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant from a matched related or unrelated donor or cord blood. If chemotherapy is an integral part of the treatment involving a Covered Organ Transplant of bone marrow, the term bone marrow includes the harvesting, the transplantation, and the chemotherapy components.

Brand-Name Drug means a drug, medicine or medication that is manufactured and distributed by only one pharmaceutical manufacturer, or any drug product that has been designed as brand name by an industry- recognized source used by Us.

Calendar Year means the period of time beginning on any January 1st and ending on the following December 31st. The first Calendar Year begins for a Covered Person on the date benefits under this Contract first become effective for that Covered Person and ends on the following December 31st.

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

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

Community means Community Health Choice, Inc., a licensed health maintenance organization.

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

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

Clinical Trial means a clinical research study or clinical investigation that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease and is approved by:

1. The Centers for Disease Control (CDC) and Prevention of the U.S. Department of Health and Human Services;
2. The National Institutes of Health (NIH);
3. The U.S. Food and Drug Administration (FDA);
4. The U.S. Department of Defense (DOD);
5. The U.S. Department of Veterans Affairs (VA); or
6. An Institutional review board of an institution in the state that has an agreement with the Office for Human Research Protection (OHRP) of the U.S. Department of Health and Human Services (HHS);
7. The Agency for Health Care Research and Quality;
8. The Centers for Medicare and Medicaid Services; or
9. The Department of Energy.

Comparable Emergency Facility means (i) any stationary or mobile facility, including, but not limited to, Level V Trauma Faculties and Rural Health Clinics that have licensed or certified or both licensed and certified which personnel and equipment to provide Advanced Cardiac Life Support (ACLS) consistent with American Heart Association (AHA) and American Trauma Society (ATS) standards of care and a free-standing emergency medical care facility as that term is defined in Texas Insurance Code section 843.002: (ii) for purposes of Emergency Care related to Mental Illness, Mental Health facility that can provide 24-hour residential and psychiatric Services and that is: (I) a facility operated by the Texas Department of State Health Services; (II) a private mental Hospital licensed by the Texas Department of State Health Services; (III) a community center as defined by the Texas Health and Safety Code section 534.001; (IV) a facility operated by a community center or other entity the Texas Department of State Health Services designates to provide Mental Healthcare; (V) an identifiable part of a general Hospital in which diagnosis, treatment, and care for persons with mental Illness is provided and that is licensed by the Texas Department of State Health Services; or (VI) a Hospital operated by a federal agency.

Complaint means any dissatisfaction expressed orally or in writing by a Complainant to a health maintenance organization regarding any aspect of the health maintenance organization's operation. The term includes dissatisfaction relating to 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 manner in which a service is provided, and a disenrollment decision. A Complaint 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 enrollee; or a Provider's or Covered Person's oral or written expression of dissatisfaction or disagreement with an adverse determination.

Complainant means a Covered Person, or a Physician, Provider, or other person designated to act on behalf of a Covered Person, who files a Complaint.

Complications of Pregnancy means conditions, requiring Hospital Confinement (when a pregnancy is not terminated), whose diagnoses are distinct from pregnancy, but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity. Complications of Pregnancy do not include false labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsis, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

Confined/Confinement means the status of being a resident patient in a Hospital or Healthcare Treatment Facility receiving Inpatient Services. Confinement does not mean detainment in Observation Status. Successive Confinements are considered to be one Confinement if they are:

1. Due to the same Bodily Injury or Illness; and

2. Separated by fewer than 30 consecutive days when the Covered Person is not Confined.

Consumer Choice Health Benefit Plan means group or individual accident or sickness insurance policy, or evidence of coverage that, in whole or in part, does not offer or provide state-mandated health benefits, but provides creditable coverage as defined by the Texas Insurance Code § 1205.004(a) or 1501.102(a).

Contract means this document, together with any amendments, riders, and endorsements that describe the agreement between You and Us.

Contract Holder means a person who meets all eligibility requirements and enrollment requirements of this

Contract and whose application as the Primary Applicant and premium payment have been received by Us.

Contractual Denial means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of the Contract Holder or Your eligibility to participate in a plan and rescission of this Contract.

Copayment/Copay means a specified dollar amount or amount expressed as a percentage shown on the Schedule of Benefits You are obligated to pay to a Physician or Provider toward covered expenses of certain benefits specified in this Contract each time a Covered Service is received, regardless of any amounts that may be paid by Us. Any Copayments do not apply toward the Deductible.

Cosmetic Surgery means Surgery, procedure, injection, medication, or treatment primarily designed to improve appearance, self-esteem or body image and/or to relieve or prevent social, emotional or psychological distress.

Cost Share means the Deductible and/or Copayment that must be paid by the Covered Person for Prescription Drugs.

Covered Service means a service or supply that is covered under this Contract, is Medically Necessary, and appropriate. To be a Covered Service, the Service must not be Experimental or Investigational or otherwise excluded or limited by this Contract or by any amendment. With the exception of Emergency Care, Covered Services are available only within the Service Area.

Covered Organ Transplant means only the Services, care and treatment received for or in connection with the pre-approved transplant of the organs identified in the "Your Contract Benefits" section, which are Medically Necessary Services, and which are not Experimental or Investigational. Transplantation of multiple organs, when performed simultaneously, is considered one organ transplant.

Covered Person means the Contract Holder eligible to receive Contract benefits.

Custodial Care means Services given to a Covered Person if:

1. The Covered Person needs Services that include, but are not limited to, assistance with dressing, bathing, preparation and feeding of special diets, walking, supervision of medication that is ordinarily self- administered, getting in and out of bed, and maintaining continence;

2. The Services are required to primarily maintain and not likely to improve the Covered Person's condition; or

3. Long-Term Care Services whether provided at home, in the community, in assisted living, or in-nursing homes.

Services may still be considered Custodial Care by Us even if:

1. The Covered Person is under the care of a Healthcare Practitioner,

2. The Services are prescribed by a Healthcare Practitioner to support or maintain the Covered Person's condition;

3. Services are being provided by a Nurse; or

4. The Services involve the use of skills which can be taught to a layperson and do not require the technical skills of a Nurse.

Deductible means the amount of covered expense that an individual and/or family must incur in a Plan Year and is responsible to pay before any Copayment is applied. This amount will be applied on a Plan-Year basis and does not apply to certain Services. The Deductible is shown on the Schedule of Benefits.

One or more of the following Deductibles may apply to Covered Services:

1. Deductible. The amount of Covered Expense an individual and/or a family must incur in the plan year before benefits become payable and before any Copayment is applied. Deductible does not apply to Preventive Services.

2. Family Deductible. Each Calendar Year, once the number of individual

When Deductibles, as shown on the Schedule of Benefits, are fulfilled, no further individual Deductibles will have to be paid for the rest of that same Calendar Year.

Denial of Benefits means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of the Contract Holder or Your eligibility to participate in a plan and rescission of this Contract.

Dental Injury means an injury to a Sound Natural Tooth caused by a sudden and external force that could not be predicted in advance and could not be avoided. It does not include biting or chewing injuries.

Dependent means Contract Holder's legally recognized spouse, natural born child, step-child, legally adopted child, a child placed for adoption, or a child for whom the Contract Holder is a party in a suit in which adoption of the child is sought by the Contract Holder, whose age is less than the Limiting Age, a child whose age is less than the Limiting Age and for whom You have received a court or administrative order to provide coverage until such court or administrative order is no longer in effect, the child is enrolled for comparable health insurance or will be enrolled in comparable coverage that will take effect no later than the Effective Date of the cancellation or non-renewal, an unmarried grandchild, if the grandchild is a Dependent for Federal Income Tax purposes at the time of application, whose age is less than the Limiting Age or the Contract Holder's adult child who meets the following conditions:

1. Is beyond the Limiting Age of a child;

2. Is unmarried;

3. Is permanently mentally or physically handicapped; and

4. Incapable of self-sustaining employment.

In order for the covered adult Dependent child to remain eligible as specified above, We must receive notification within 31 days of the covered Dependent child's attainment of the Limiting Age of these conditions.

Each child, other than the child who qualifies because of a court or administrative order, must meet all of the qualifications of a Dependent as determined by Us.

You must furnish satisfactory proof to Us upon Our request that the condition as defined in the items above continuously exists on and after the date the Limiting Age is reached. After two years from the date the first proof was furnished, We may not request such proof more often than annually. If satisfactory proof is not submitted to Us, the child's coverage will not continue beyond the last date of eligibility.

The Limiting Age for each child to be considered a Dependent under this Contract is the child's 26th birthday.

Diabetes Equipment means:

1. Blood glucose monitors, including noninvasive glucose monitors and glucose monitors designed to be used by blind individuals;

2. Insulin pumps and associated appurtenances;

3. Insulin infusion devices;
4. Podiatric appliances for the prevention of complications associated with diabetes; and
5. New or improved Diabetes Equipment approved by the United States Food and Drug Administration.

Diabetic Supplies means:

1. Test strips for blood glucose monitors;
2. Visual reading and urine test strips;
3. Lancets and lancet devices;
4. Insulin and insulin analogs;
5. Injection aids;
6. Syringes;
7. Prescriptive and non-Prescription oral agents for controlling blood sugar levels;
8. Glucagon emergency kits;
9. Alcohol swabs; and
10. New or improved Diabetic Supplies, including improved insulin or another Prescription drug, approved by the United States Food and Drug Administration.

Diagnostic Mammogram means an imaging examination designed to evaluate:

1. a subjective or objective abnormality detected by a Physician in a breast;
2. an abnormality seen by a Physician on a screening mammogram;
3. an abnormality previously identified by a Physician as probably benign in a breast for which follow-up imaging is recommended by a Physician; or
4. an individual with a personal history of breast cancer.

Dispensing Limit means the monthly drug dosage limit and/or the number of months the drug usage is usually needed to treat a particular condition.

Drug Formulary means a list of Prescription Drugs, medicines, medications, and supplies specified by Us and indicates applicable Dispensing Limits and/or any Prior Authorization or Step Therapy requirements. Visit Our website at www.communityhealthchoice.org or call Our Member Services Department at the telephone number on Your Member Identification Card to obtain the Drug Formulary. The Drug Formulary is subject to change without notice.

Durable Medical Equipment means equipment, defined by Medicare Part B, which meets the following criteria:

1. It can withstand repeated use;
2. It is primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience;
3. It is usually not useful to a person except to treat a Bodily Injury or Illness;
4. It is Medically Necessary and necessitated by the Covered Person's Bodily Injury or Illness;

5. It is not typically furnished by a Hospital or Skilled-Nursing Facility; and

6. It is prescribed by a Healthcare Practitioner as appropriate for use in the home.

Effective Date means the first date all the terms and provisions of this Contract apply. It is the date that appears on Your Member Identification Card.

Electronic/Electronically means relating to technology having electrical, digital, magnetic, wireless, optical, electromagnetic or similar capabilities.

Emergency Care means any service provided for a Bodily Injury or Illness manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of that individual in serious jeopardy;

2. Serious impairment of bodily functions;

3. Serious disfigurement;

4. Serious dysfunction of any bodily organ or part; or

5. For pregnant women, result in serious jeopardy to the health of the fetus.

Emergency Care does not mean any service for the convenience of the Covered Person or the Provider of treatment or Services.

Experimental or **Investigational** means any procedure, treatment, supply, device, equipment, facility or drug (all Services) determined by Our Medical Director or his/her designee to:

1. Not be a benefit for diagnosis or treatment of an Illness or a Bodily Injury;

2. Not be as beneficial as any established alternative; or

3. Not show improvement outside the Investigational setting.

A drug, biological product, device, treatment or procedure that meets any one of the following criteria will be considered Experimental or Investigational:

1. Cannot be lawfully marketed without the final approval of the United States Food and Drug Administration (FDA) for the particular Illness or Bodily Injury and which lacks such final FDA approval for the use or proposed use, unless:

   a. Found to be accepted for that use in the most recently published edition of the United States Pharmacopoedia-Drug Information for Healthcare Professional (USP-DI) or in the most recently published edition of the American Hospital Formulary Service (AHFS) Drug Information;

   b. Identified as safe, widely used and generally accepted as effective for that use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service; or

   c. Is mandated by state law.

2. Is a device required to receive Premarket Approval (PMA) or 510K approval by the FDA, but has not received a PMA or 510K approval;

3. Is not identified as safe, widely used, and generally accepted as effective for the proposed use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service;

4. Is the subject of a National Cancer Institute (NCI) Phase I, II or Ill trial, or any trial not recognized by NCI regardless of the Phase except as expressly provided in this Contract;

5. Is identified as not covered by the Centers for Medicare and Medicaid Services (CMS) Medicare Coverage Issues Manual, a CMS Operational Policy Letter or a CMS National Coverage Decision except as required by state or federal law;

6. The FDA has not determined the device to be contraindicated for the particular Illness or Bodily Injury for which the device has been prescribed; or

7. The treatment, Services or supplies are:

   a. Not as effective in improving health outcomes and not as cost effective as established technology; or b. Not usable in appropriate clinical contexts in which established technology is not employable.

Any service which is not covered due to being Experimental or Investigational is eligible for review of that determination by an Independent Review Organization (IRO). See the Appeals Process to Independent Review Organization provision in the "General Provisions" section of this Contract.

Family Member means You or Your spouse, or You or Your spouse's child, brother, sister or parent.

Family Out-of-Pocket Maximum means each Plan Year once a family has fulfilled the Family Out-of-Pocket Maximum amount, as shown on the Schedule of Benefits, no Covered Person in that family will have any additional out-of-pocket responsibility for Covered Services for the rest of that same Plan Year. The maximum amount any one Covered Person in a family can contribute toward the Family Out-of-Pocket Maximum in a Calendar Year is the amount applied toward the individual Out-of-Pocket Maximum.

Federally Facilitated Health Insurance Marketplace means a structured Marketplace created by the Affordable Care Act where qualified individuals and small business can shop for private health insurance coverage.

Free-Standing Surgical Facility means any licensed public or private establishment that has permanent facilities that are equipped and operated primarily for the purpose of performing outpatient Surgery. It does not provide Services or accommodations for patients to stay overnight.

Generic Drug means a drug, medicine or medication that is manufactured, distributed, and available from a pharmaceutical manufacturer and identified by a chemical name, or any drug product that has been designated as generic by an industry-recognized source used by Us.

Healthcare Practitioner means an individual practitioner, professionally licensed by the appropriate state agency, to diagnose or treat a Bodily Injury or Illness, and who provides Services within the scope of that license. A Healthcare Practitioner's Services are not covered if the practitioner resides in the Covered Person's home or is a Family Member.

Healthcare Treatment Facility means only a facility, institution or clinic duly licensed by the appropriate state agency and is primarily established and operating within the scope of its license. Healthcare Treatment Facility does not include a Residential Treatment Center or halfway house.

Home Healthcare Agency means a Home Healthcare Agency or Hospital which meets all of the following requirements:

1. It must primarily provide skilled nursing Services and other therapeutic Services under the supervision of Healthcare Practitioners or Nurses;

2. It must be operated according to established processes and procedures by a group of professional medical people, including Healthcare Practitioners and Nurses;

3. It must maintain clinical records on all patients; and

4. It must be licensed by the jurisdiction where it is located, if licensure is required. It must be operated according to the laws of that jurisdiction which pertains to agencies providing home healthcare.

Home Healthcare Plan means a plan of healthcare established with a home healthcare Provider. The Home Healthcare Plan must consist of:

1. Care by or under the supervision of a Nurse or another Healthcare Practitioner and not for Custodial Care;

2. Physical, speech, occupational and respiratory therapy;

3. Medical social work and nutrition Services; or

4. Medical appliances, equipment and laboratory Services, if expenses incurred for such supplies would have been Covered Services during a Confinement.

A Healthcare Practitioner must:

1. Review and approve the Home Healthcare Plan;

2. Certify and verify that the Home Healthcare Plan is required in lieu of Confinement or a continued Confinement; and

3. Not be related to the Home Healthcare Agency by ownership or Contract.

Home Healthcare Visit means home healthcare Services provided by any one Healthcare Practitioner for four consecutive hours or any portion thereof.

Hospice Care Agency means an agency that:

1. Has the primary purpose of providing hospice Services to Hospice Patients;

2. Is licensed and operated according to the laws of the state in which it is located;

3. Meets the following requirements:

   a. Has obtained any required certificate of need;

   b. Provides 24-hour-a-day, seven-day-a-week service, supervised by a Healthcare Practitioner, c. Has a full-time administrator;

   d. Keeps written records of Services provided to each patient;

   e. Has a coordinator who:

      i. Is a Nurse; and

      ii. Has four years of full-time clinical experience, of which at least two were involved in caring for terminally ill patients; and

4. Has a licensed social service coordinator.

Hospice Care Program means a coordinated, interdisciplinary program provided by a hospice designed to meet the special physical, psychological, spiritual, and social needs of a terminally ill Covered Person and his/her immediate Family Members, by providing Palliative Care and supportive medical, nursing, and other Services through at-home or inpatient care. A hospice must:

1. Be licensed by the laws of the jurisdiction where it is located and run as a hospice as defined by those laws; and

2. Provide a program of treatment for a least two unrelated individuals who have been medically diagnosed as having no reasonable prospect for cure for their Illness; and as estimated by their Healthcare Practitioners, are expected to live less than six months as a result of that Illness.

For purposes of the Hospice Care benefit only, immediate Family Member is considered to be the Covered Person's parent, spouse, and children or stepchildren.

Hospice Facility means a licensed facility or part of a facility that:

1. Principally provides hospice care;

2. Keeps medical records of each patient;

3. Has an ongoing quality assurance program;

4. Has a Healthcare Practitioner on call at all times;

5. Provides 24-hour-a-day skilled nursing Services under the direction of a Nurse; and

6. Has a full-time administrator.

Hospice Patient means a terminally ill person who has six months or less to live, as certified by a Healthcare Practitioner.

Hospital means an institution that meets all of the following requirements:

1. It must provide, for a fee, medical care and treatment of sick or injured patients on an inpatient basis;
2. It must provide or operate, either on its premises or in facilities available to the Hospital on a pre- arranged basis, medical, diagnostic, and surgical facilities;
3. Care and treatment must be given by and supervised by Healthcare Practitioners. Nursing Services must be provided on a 24-hour basis and must be given by or supervised by Nurses;
4. It must be licensed by the laws of the jurisdiction where it is located;
5. It must be operated as a Hospital as defined by those laws; and
   a. It must not be primarily a convalescent, rest or nursing home; or
   b. Facility providing custodial, educational or rehabilitative care. The Hospital must be accredited by one of the following:

1. The Joint Commission on the Accreditation of Hospitals;

2. The American Osteopathic Hospital Association;

3. The Commission on the Accreditation of Rehabilitative Facilities; or

4. DNV (Det Norske Veritas).

Identification or **ID Cards** means cards each Covered Person receives that contain Our address and telephone number.

Illness means disturbance in function or structure of the Covered Person's body that causes physical signs or symptoms that if left untreated, will result in a deterioration of the health state of the structure or system(s) of the Covered Person's body. Congenital defects will be treated the same as any other Illness. Complications of Pregnancy will be treated the same as any other Illness.

Infertility Treatment means any treatment, supply, medication or service given to achieve pregnancy or to achieve or maintain ovulation. This includes, but is not limited to:

1. Artificial insemination;
2. In vitro fertilization;
3. GIFT;
4. ZIFT;
5. Tubal ovum transfer;
6. Embryo freezing or transfer;
7. Sperm storage or banking;
8. Ovum storage or banking;

9. Embryo or zygote banking;

10. Diagnostic and/or therapeutic laparoscopy;

11. Hysterosalpingography;

12. Ultrasonography;

13. Endometrial biopsy; and

14. Any other assisted reproductive techniques or cloning methods.

Inpatient Services are Services rendered to a Covered Person during their Confinement.

Intensive Outpatient Program means a freestanding or Hospital-based program that provides services for at least 3 hours per day, two or more days per week, to treat Mental Illness, Chemical Dependency, or specializes in the treatment of co-occurring Mental Illness with Chemical Dependency.

Legend Drug means any medicinal substance the label of which, under the Federal Food, Drug and Cosmetic Act, is required to bear the legend: Caution: Federal Law prohibits dispensing without Prescription.

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

Limiting Age means the Dependent's 26th birthday.

Low-Dose Mammography means:

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

2. Digital mammography; or

3. Breast tomosynthesis.

Mail-Order Pharmacy means a Pharmacy that provides covered mail-order Pharmacy Services, as defined by Us and delivers covered Prescriptions or refills through the mail to Covered Persons.

Maintenance Care means Services furnished mainly to:

1. Maintain, rather than improve, a level of physical or mental function; or

2. Provide a protected environment free from exposure that can worsen the Covered Person's physical or mental condition.

Marketplace means the Federally Facilitated Health Insurance Marketplace through which Qualified Health Plans are offered to eligible persons in Texas.

Medical Home is a team health care delivery model led by a Physician, P.A., or N.P. that provides comprehensive and continuous medical care to patients with the goal of obtaining maximized health outcomes.

Medically Necessary means the required extent of a healthcare service, treatment or procedure that a Healthcare Practitioner would provide to his/her patient for the purpose of diagnosing, palliating, or treating an Illness or Bodily Injury or its symptoms. The fact that a Healthcare Practitioner may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered under this Illness. Such healthcare service, treatment or procedure must be:

1. In accordance with nationally recognized standards of medical practice and identified as safe, widely used, and generally accepted as effective for the proposed use;

2. Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration;
3. Not primarily for the convenience of the patient or Healthcare Practitioner;
4. Clearly substantiated and supported by the medical records and documentation concerning the patient's condition;
5. Performed in the most cost-effective setting required by the patient's condition;
6. Supported by the preponderance of nationally recognized peer reviewed medical literature, if any, published in the English language as of the date of service; and
7. Not Experimental or Investigational.

Mental Health means Mental Illness and Chemical Dependency.

Mental Illness means the diagnostic testing and treatment of a neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind. This is true regardless of the original cause of the disorder.

Morbid Obesity (clinically severe obesity) means a body mass index (BMI) as determined by a Healthcare Practitioner as of the date of service of:

1. 40 kilograms or greater per meter squared (kg/m2); or
2. 35 kilograms or greater per meter squared (kg/m2) with an associated co-morbid condition such as hypertension, type II diabetes, life-threatening cardiopulmonary conditions or joint disease that is treatable, if not for the obesity.

Neurobehavioral Testing means 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 means interventions that focus on behavior and the variables that control behavior.

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

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

Neurophysiological Testing means an evaluation of the functions of the nervous system. Neurophysiological Treatment means interventions that focus on the functions of the nervous system. Neuropsychological Testing means the administering of a comprehensive battery of tests that evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

Neuropsychological Treatment means interventions designed to improve or minimize deficits in behavioral and cognitive processes.

Non-Participating Pharmacy means a Pharmacy that has not signed a direct agreement with Us or has not signed a direct agreement with Us as an independent contractor or been contracted by Us to provide covered Pharmacy Services, covered Specialty Pharmacy Services, or covered Mail-Order Pharmacy Services as defined by Us, to Covered Persons including covered Prescription or refills delivered through the mail.

Non-Participating Physician means a Physician who has not signed a direct agreement with Us as an independent Contractor or been Contracted by Us as a Participating Provider.

Non-Participating Provider means a Hospital, Healthcare Treatment Facility, Healthcare Practitioner, or other Provider who has not signed a direct agreement with Us as an independent contractor or contracted by Us as a Participating Provider.

Nuclear Medicine means radiology in which radioisotopes (compounds containing radioactive forms of atoms) are introduced into the body for the purpose of imaging, evaluating organ function or localizing disease or tumors. Nurse means a registered Nurse (R.N.), a licensed practical Nurse (L.P.N.), or a licensed vocational Nurse (L.V.N.).

Observation Status means a stay in a Hospital or Healthcare Treatment Facility for up to 72 hours if the Covered Person:

1. Has not been admitted as a resident inpatient;
2. Is physically detained in an emergency room, treatment room, observation room or other such area; or
3. Is being observed to determine whether a Confinement will be required.

Off-Label Drug means an approved drug legally prescribed for a purpose for which it has not been specifically approved by the United States Food and Drug Administration.

Organ Transplant Treatment Period means 365 days from the date of discharge from the Hospital following a Covered Organ Transplant received while covered by Us.

Out-of-Pocket Maximum means the maximum amount an individual and/or family pays each Plan Year for Services covered under this Contract. This amount includes Copayments, Prescription Drug Deductibles and Medical Deductibles but does not include:

1. Utilization management or Prescription Drug penalties;
2. Non-covered Services; or
3. Other Contract limits.

There are separate individual and family Participating Provider Out-of-Pocket Maximums. See the Schedule of Benefits for the specific amounts.

Outpatient Day-Treatment Services means structured Services provided to address deficits in physiological, behavioral, and/or cognitive functions. Such Services may be delivered in settings that include transitional residential, community integration, or nonresidential treatment settings.

Outpatient Services means Services that are rendered to a Covered Person while they are not Confined as a registered inpatient. Outpatient Services include, but are not limited to, Services provided in:

1. A Healthcare Practitioner's office;
2. A Hospital outpatient setting;
3. A free-standing surgical facility;
4. A licensed birthing center; or
5. An independent laboratory or clinic.

Palliative Care means care given to a Covered Person to relieve, ease or alleviate, but not to cure, a Bodily Injury or Illness.

Partial Hospitalization means Services provided in an outpatient program by a Hospital or Healthcare Treatment Facility in which patients do not reside for a full 24-hour period.

1. For a comprehensive and intensive multidisciplinary interdisciplinary Mental Health or Substance Abuse Disorder treatment for a minimum of five hours a day, five days per week;

2. That provides for social, psychological, and rehabilitative training programs with a focus on reintegration back into the community and admits children and adolescents or adults who must have a treatment program designed to meet the special needs of that age range; and

3. That has Healthcare Practitioners readily available for the emergent and urgent needs of the patients. The partial Hospitalization program must be accredited by the Joint Commission of the Accreditation of Hospitals or in compliance with an equivalent standard.

Licensed drug abuse rehabilitation programs and alcohol rehabilitation programs accredited by the Joint Commission on the Accreditation of Health Care Organizations or approved by the appropriate state agency are also considered partial Hospitalization Services.

Partial Hospitalization does not include Services that are for:

1. Custodial Care; or

2. Day care.

Participating Pharmacy means a Pharmacy that has signed a direct agreement with Us or has been Contracted by Us to provide covered Pharmacy Services, covered Specialty Pharmacy Services or covered Mail-Order Pharmacy Services as defined by Us, to Covered Persons including covered Prescription or refills delivered through the mail.

Participating Physician means a Physician that is designated as such and has signed a direct agreement with Us as an independent contractor, or who has been contracted by Us to provide Services to Covered Persons.

Participating Provider means a Hospital, Healthcare Treatment Facility, Healthcare Practitioner or other Provider who is designated as such and has signed a direct agreement with Us as an independent contractor, or who has been contracted by Us to provide Services to Covered Persons.

Pharmacist means a person who is licensed to prepare, compound, and dispense medication and who is practicing within the scope of his/her license.

Pharmacy means a licensed establishment where Prescription medications are dispensed by a Pharmacist.

Physician means: 1) an individual licensed to practice medicine in this state; 2) a professional association organized under the Texas Professional Association Act (Article 1528f, Vernon's Texas Civil Statutes); 3) an approved nonprofit health corporation certified under Chapter 162, Occupations Code; 4) a medical school or medical and dental unit, as defined or described by Section 61.003, 61.501, or 74.601, Education Code, that employs or contracts with Physicians to teach or provide medical Services or employs Physicians and contracts with Physicians in a practice plan; or 5) another person wholly owned by Physicians.

Plan Year means the period of time beginning on the date benefits under this Contract become effective for that Covered Person and end December 31 of that year.

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

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

Prescription means a direct order for the preparation and use of a drug, medicine, or medication, or biological. The drug, medicine, or medication, or biological must be obtainable only by Prescription.

The Prescription must be given by a Healthcare Practitioner to a Pharmacist for the benefit of and use by a Covered Person for the treatment of a Bodily Injury or Illness which is covered under this Contract. The Prescription may be given

to the Pharmacist verbally, Electronically, or in writing by the Healthcare Practitioner.

The Prescription must include at least:

1. The name of the Covered Person;
2. The type and quantity of the drug, medicine, medication, or biological prescribed and the directions for its use;
3. The date the Prescription was prescribed; and
4. The name and address of the prescribing Healthcare Practitioner.

Pre-Surgical/Procedural Testing means:

1. Laboratory tests or radiological examinations done on an outpatient basis in a Hospital or other facility accepted by the Hospital before Hospital Confinement or outpatient Surgery or procedures; and
2. The tests must be for the same Bodily Injury or Illness causing the Covered Person to be Hospital Confined or to have the outpatient Surgery or procedure.

Preventive Services means Services in the following recommendations appropriate for a Covered Person:

1. Services with an A or B rating in the current recommendations of the U.S; Preventive Services Task Force (USPSTF). The recommendations by the USPSTF for breast cancer screenings, mammography and preventions issued prior to November 2009 will be considered current;
2. Immunizations recommended by the Advisory Committee on Immunizations Practices of the Centers for Disease Control and Prevention (CDC);
3. Preventive care for infants, children and adolescents provided in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
4. Preventive care for women provided in the comprehensive guidelines supported by HRSA.

For the recommended Preventive Services that apply to Your policy, refer to the U. S. Department of Health and Human Services (HHS) website at www.HHS.gov or call the Member Services telephone number on the back of Your ID card.

Primary Care Physician or **Primary Care Provider (PCP)** means a Physician or Provider who has agreed with Community to provide a Medical Home to You and who is responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care. Provider types that can be PCPs are from any of the following practice areas: General Practice, Family Practice, Internal Medicine, Pediatrics, Obstetrics/Gynecology (OB/GYN), Advanced Practice Nurses (APNs) and Physician Assistants (when APNs and PAs are practicing under the supervision of a Physician specializing in Family Practice, Internal Medicine, Pediatrics or Obstetrics/Gynecology who also qualifies as a PCP under this Contract), Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and similar community clinics; and specialist Physicians who are willing to provide a Medical Home to selected Members with special needs and conditions.

Prior Authorization means a determination by Us, or Our designee, that a Service or Prescription Drug is Medically Necessary prior to it being provided. Prior Authorization does not guarantee that the proposed service or Prescription Drug is covered under this Contract.

Provider means:

1. A person, other than a Physician, who is licensed or otherwise authorized to provide a health care service in this state, including:
   a. a Chiropractor, registered Nurse, Pharmacist, Optometrist, registered Optician, or Acupuncturist; or b. a Pharmacy, Hospital, or other institution or organization;
2. A person who is wholly owned or controlled by a Provider or by a group of Providers who are licensed or otherwise authorized to provide the same health care service; or

3. A person who is wholly owned or controlled by one or more Hospitals and Physicians, including a Physician-Hospital organization.

Psychophysiological Testing means an evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

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

Reconstructive Surgery means Surgery to improve the function of, or attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Reconstructive Surgery for Craniofacial Abnormalities means Surgery on the face or head to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Rehabilitation Services means specialized treatment for Illness or a Bodily Injury which meets all of the following requirements:

1. Is a program of Services provided by one or more members of a multi-disciplinary team;
2. Is designed to improve the patient's function and independence;
3. Is under the direction of a qualified Healthcare Practitioner,
4. Includes a formal written treatment plan with specific attainable and measurable goals and objections;

and

5. May be provided in either an inpatient or outpatient setting.

Remediation means the process or processes of restoring or improving a specific function.

Research Institution means the institution or other person or entity conducting a phase I, phase II, phase Ill or phase IV Clinical Trial.

Residential Treatment Center means an institution that:

1. Is licensed as a 24-hour residential, intensive facility where individuals live at the facility while in treatment and are monitored by trained staff.
2. The facility is NOT licensed as a Hospital;
3. Provides a multidisciplinary or interdisciplinary treatment plan in a controlled environment, with periodic supervision of a licensed Healthcare Practitioner, such as a Physician with a specialty in psychiatry, other psychiatric prescriber and/or or Ph.D or PsyD. psychologist; and
4. Provides programs such as social, psychological, and rehabilitative training, age appropriate for the special needs of the age group of individuals, with a focus on reintegration back into the community.

Residential treatment is utilized to provide structure, support, and reinforcement of the treatment required to reverse the course of behavioral and emotional deterioration and/or provide treatment to support relapse prevention in the case of a substance abuse.

Routine Nursery Care means the charges made by a Hospital or licensed birthing center for the use of the Nursery. It includes normal Services and supplies given to well newborn children following birth. Healthcare practitioner visits are not considered Routine Nursery Care. Treatment of Bodily Injury, Illness, birth abnormality or congenital defect following birth and care resulting from prematurity are not considered Routine Nursery Care.

Routine Patient Care Costs mean the costs of any Medically Necessary healthcare service for which coverage is provided under this Contract, without regard to whether the Covered Person is participating in a Clinical Trial.

Routine Patient Care Costs do not include:

1. The cost of an Investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration (FDA), including a drug or device that is the subject of the Clinical Trial;
2. The cost of a service that is not a healthcare service, regardless of whether the service is required in connection with participation in a Clinical Trial;
3. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
4. The cost associated with managing a Clinical Trial; or
5. The cost of a healthcare service that is specifically excluded from coverage under this Contract.

Self-Administered Injectable Drug means an FDA-approved medication that a person may administer to himself/herself by means of intramuscular, intravenous or subcutaneous injection excluding insulin, and prescribed for use by the Covered Person.

Service Area means the geographic area designated by Us and approved by the Department of Insurance of the state in which this Contract is issued, if such approval is required. The Service Area is the geographic area within which Covered Services are available and accessible to Covered Persons. The Service Area is listed at www.communityhealthchoice.org, in the HMO Provider Directory, and You may call the HMO Member Services Department at the telephone number on Your Member Identification Card.

Services means procedures, surgeries, consultations, advice, diagnosis, referrals, treatment, supplies, drugs, devices or technologies.

Skilled-Nursing Facility means a facility that provides continuous Skilled-Nursing Services on an inpatient basis for persons recovering from an Illness or a Bodily Injury. The facility must meet all of the following requirements:

1. Be licensed by the state to provide Skilled-Nursing Services;
2. Be staffed by an on-call Healthcare Practitioner 24-hours-per-day;
3. Provide Skilled-Nursing Services supervised by an on-duty Nurse 24-hours-per-day;
4. Maintain full and complete daily medical records for each patient; and
5. Not primarily be a place for rest, for the aged or for Custodial Care or provide care for Mental Health although these Services may be provided in a distinct section of the same physical facility. The facility may also provide extended care or Custodial Care which would not be covered under this Contract.

Sound Natural Tooth means a tooth that:

1. Is organic and formed by the natural development of the body (not manufactured, capped, crowned or bonded);
2. Has not been extensively restored;
3. Has not become extensively decayed or involved in periodontal disease; and
4. Is not more susceptible to injury than a whole natural tooth (for example a tooth that has been previously broken, chipped, filled, cracked or fractured).

Special Circumstances means a condition for which the treating Healthcare Practitioner or Healthcare Provider reasonably believes that discontinuing care by the treating Healthcare Practitioner or Provider could cause harm to the Covered Person. Examples of Special Circumstances include:

1. A Covered Person with a disability;
2. A Covered Person with an acute condition;
3. A Covered Person with a Life-Threatening Disease; or
4. A Covered Person who is past the 24th week of pregnancy.

Specialty Care Physician means a network Healthcare Practitioner who has received training in a specific medical field other than the specialties listed for a PCP.

Specialty Drug means a drug, medicine, or medication, or biological used as a specialized therapy developed for chronic, complex Illnesses or Bodily Injuries. Specialty drugs may:

1. Require Nursing Services or special programs to support patient compliance;
2. Require disease-specific treatment programs;
3. Have limited distribution requirements; or
4. Have special handling, storage or shipping requirements.

Specialty Pharmacy means a Pharmacy that provides covered specialty Pharmacy Services, as defined by Us, to Covered Persons.

Step Therapy means a type of Prior Authorization. We may require a Covered Person to follow certain steps prior to Our coverage of some high-cost drugs, medicines, or medications, or biologicals. We may require a Covered Person to try a similar drug, medicine or medication that has been determined to be safe, effective, and less costly for most people that have the same condition as the Covered Person. Alternatives may include over-the-counter drugs, Generic Medications, and brand-name medications.

Sub-Acute Medical Care means a short-term comprehensive inpatient program of care for a Covered Person who has an Illness or a Bodily Injury that:

1. Does not require the Covered Person to have a prior admission as an inpatient in a Healthcare Treatment Facility;
2. Does not require intensive diagnostic and/or invasive procedures; and
3. Requires Healthcare Practitioner direction, intensive nursing care, significant use of ancillaries, and an outcome-focused, interdisciplinary approach using a professional medical team to deliver complex clinical interventions.

Sub-Acute Rehabilitation Facility means a facility that provides Sub-Acute Medical Care for Rehabilitation Services for Illness or a Bodily Injury on an inpatient basis. This type of facility must meet all of the following requirements:

1. Be licensed by the state in which the Services are rendered to provide Sub-Acute Medical Care for Rehabilitation Services;
2. Be staffed by an on-call Healthcare Practitioner 24-hours-per-day;
3. Provide Nursing Services supervised by an on-duty Nurse 24-hours-per-day;
4. Maintain full and complete daily medical records for each patient; and
5. Not primarily provide care for Mental Health although these Services may be provided in a distinct section of the same physical facility. The facility may also provide extended care or Custodial Care, which would not be covered under this Contract.

Surgery means categorized as Surgery in the Current Procedural Terminology (CPT) Manuals published by the American Medical Association. The term Surgery includes, but is not limited to:

1. Excision or incision of the skin or mucosal tissues or insertion for exploratory purposes into a natural body opening;
2. Insertion of instruments into any body opening, natural or otherwise, done for diagnostic or other therapeutic purposes; and
3. Treatment of fractures.

Telehealth Services means a Health Care Service, other than Telemedicine Medical Service, delivered by a health professional licensed, certified, or otherwise entitled to practice in this state and acting within the scope of the health professional's license, certification, or entitlement to a Covered Person at a different location than the health professional using telecommunications or information technology. Covered Services delivered to a Covered Person as a Telehealth Service are covered on the same basis and to the same extent they would be if delivered in an in-person setting.

Telemedicine Medical Services means a Health Care Service delivered by a Physician licensed in this state, or a health professional acting under the delegation and supervision of a Physician licensed in this state, and acting within the scope of the Physician or healthcare professional's license to a patient at a different physical location than the Physician or health professional using telecommunications or information technology. Covered Services delivered to a Covered Person as a Telemedicine Medical Service are covered on the same basis and to the same extent they would be if delivered in an in-person setting.

Urgent Care means Health Services or Mental Health Services provided in a setting other than an emergency, which are typically provided in a setting such as a Physician or Provider's office or Urgent Care Center, as a result of acute injury or Illness that is severe or painful enough to lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, Illness or Injury is of such nature that failure to obtain treatment within a reasonable period of time would result in serious deterioration of the condition of his or her health.

Urgent Care Center means any licensed public or private Non-Hospital free standing facility that has permanent facilities equipped to provide Urgent Care Services on an outpatient basis.

Usual and Customary means the customary fee in the geographic area in which Services are provided, which is reasonably based on the circumstances.

We, Us or **Our** means or otherwise refers to the insurer as shown on the cover page of this Contract.

Workers' Compensation means coverage provided under an insurance policy pursuant to the Texas Workers Compensation Act, Texas Labor Code Title 5, Subtitle A, as compensation for a compensable injury during the course and scope of employment.

You/Your means the Covered Person.

Schedule of Benefits – Community Elite Gold HSA14

This Schedule of Benefits summarizes benefit information for Covered Services that are fully described in the Contract Benefit Management section of this Contract. Please read Your entire Contract carefully to fully understand all terms, conditions, exclusions, and limitations that apply.

Medical and Pharmacy (Combined) Deductible	
Deductible, per individual, per Plan Year	$2000
Deductible, per family, per Plan year	$4000
Out-of-Pocket Maximum	
Out-of-Pocket Maximum, per individual, per Plan Year	$6000
Out-of-Pocket Maximum, per family, per Plan Year	$12,000

Benefit	Description	Copayment/ Percentage of Allowed
Ambulatory Patient Services		
Primary Care Office Visit	Physician Office Visit not for Preventive Care Services. (See Section 3(h).	$20 after deductible
Specialist Visit	See Section 3(h).	$35 after deductible
Outpatient Services	Outpatient Services and Habilitation Services are subject to different cost- sharing depending on whether the service is an office visit or other outpatient service. Office visits are subject to copays, while facility-based services are subject to coinsurance.	
Outpatient Surgery Facility Fee	Outpatient Hospital Services performed in an outpatient facility or in a hospital without admission. See Section 3(g).	20% after deductible
Outpatient Surgery Physician/ Surgical Services	Professional fees for outpatient or ambulatory surgical procedures. See Section 3(h).	20% after deductible
Outpatient Laboratory	See Section 3(g) and 3(h).	$20 after deductible
Outpatient X-Rays and Diagnostic Imaging	See Section 3(g) and 3(h).	$20 after deductible
Outpatient Ct/Pet/Mri and Other Outpatient Diagnostic Procedures	See Section 3(g) and 3(h).	20% after deductible
Dialysis	Per Visit for Dialysis. See Section 3(g).	$35 after deductible
Allergy Testing and Treatments	Per Visit for Allergy Treatments. See Section 3(h).	$35 after deductible
Chemotherapy, Radiation, and Infusion Therapy	See Section 3(m).	$35 after deductible
Nutritional Counseling	See Section 3(h).	$35 after deductible

Benefit	Description	Copayment/ Percentage of Allowed
Preventive Care Services		
Preventive Care Services	Preventive Care Services are covered by the Plan at 100%, with no deductible. Refer to https://www.healthcare.gov/what-are-my-preventive-care-benefits/ for current list of covered Preventive Care Services. See Section 3(o).	$0
Immunizations	Age appropriate immunizations are covered by the Plan at 100%, with no deductible. Refer to https://www.healthcare.gov/what-are-my-preventive-care-benefits/ for current list of covered Preventive Care. See Section 3(o).	$0
Hospital Services		
Inpatient Hospital Services	See Section 3(g).	20% after deductible
Inpatient Physician snd Surgical Services	Professional fees for inpatient surge and other inpatient physician services Se Section 3(h).	$0 after deductible
Emergency Services		
Emergency Room Services	Per episode of Emergency Room Services. See Section 3(f).	20% after deductible
Emergency Transportation Services	See Section 3(u).	$35 after deductible
Urgent Care Services		
Urgent Care Facility	See Section 3(v).	$35 after deductible
Outpatient Mental Health Care And Substance Abuse Disorder Treatment	Mental/Behavioral Health Outpatient Services, Substance Abuse Disorder Outpatient Services, and Habilitation Services are subject to different cost-sharing depending on whether the service is an office visit or other outpatient service. Office visits are subject to copays, while facility-based services are subject to coinsurance	
Outpatient Mental Health Services	Outpatient mental health care visit to or by a Health Professional. See Section 3(k)	$20 per office visit after deductible Outpatient Services: 20% after deductible
Outpatient Substance Abuse Disorder Services	Outpatient substance abuse disorder visit to or by a Health Professional. See Section 3(k).	$20 per office visit after deductible Outpatient Services: 20% after deductible
Inpatient Mental Health Care		
Inpatient Mental Health Care Services	See Section 3(k).	20% after deductible
Inpatient Mental Health Physician Services	Professional fees for inpatient mental health physician services. See Section 3(k).	$0 after deductible
Inpatient Substance Abuse Disorder Services	See Section 3(k)	20% after deductible
Inpatient Substance Abuse Disorder Physician Services	Professional fees for inpatient substance abuse disorder physician services. See Section 3(k).	$0 after deductible

Benefit	Description	Copayment/ Percentage of Allowed
Rehabilitative Therapy		
Outpatient Rehabilitative Therapy	Limited to Medically Necessary Outpatient Rehabilitative Therapy visits to or by a Participating Provider other than a Primary Care Physician.	$35 after deductible
Habilitation Services	See Section 3(m).	$35 after deductible
Speech Therapy	Limited to Medical Necessity.	$35 after deductible
Rehabilitative Occupational And Rehabilitative Physical Therapy	Limited to Medically Necessary Rehabilitative Therapy, including occupational, and physical therapy.	$35 after deductible
Chiropractic Care		
Chiropractic Care Visit	Chiropractic Care is limited to 35 visits per year. See Section 3(m).	$35 after deductible
Home Healthcare		
Home Health Visit	Home health visit to or by a Participating Provider other than a Primary Care Physician. Coverage for all Home Health Services is limited to 60 visits per Plan Year. See Section 3(i).	$35 after deductible
Skilled Nursing Facility		
Skilled Nursing Facility	Coverage is limited to 25 days per Plan Year. See Section 3(r).	20% after deductible
Hospice Services		
Hospice Services	See Section 3(j). Cost sharing and limitations depends on type and site of service.	$35 after deductible
Inpatient Hospice Services	See Section 3(j). Cost sharing and limitations depends on type and site of service.	20% after deductible
Maternity Services		
Professional Services For Prenatal And Postnatal Care	Copayment for maternity care by a Participating Provider. See Section 3(l).	$35 after deductible per occurrence
Delivery And All Inpatient Facility Services For Maternity Care	See Section 3(l).	20% after deductible
Pediatric Vision Services		
Routine Eye Exam For Children 18 (Until Child Turns 19) And Under	See Section 3(w).	$35 after deductible
Eyeglasses For Children 18 (Until Child Turns 19) And Under	See Section 3(w).	$35 after deductible
Dme/Orthotics/Prosthetic Medical Appliances and Hearing Aids		
Durable Medical Equipment	See Section 3(e).	30% after deductible
Hearing Aids	See Section 3(e).	30% after deductible
Diabetic Services and Education		
Routine Foot Care	See Section 3(d).	$35 per visit after deductible
Diabetes Education	See Section 3(d).	$20 after deductible
Diabetes Care Management	See Section 3(d).	$20 after deductible

Benefit	Description	Copayment/ Percentage of Allowed
Transplant Services		
Inpatient Transplant Services	For other covered transplant services, copayments for other benefits will apply, as appropriate. See Section 3(s).	20% after deductible
Prescription Drugs		
Preventive Drugs	Certain Preventive drugs are covered by the Plan at 100%, with no deductible. Refer to https://www.healthcare.gov/what-are-my-preventive-care-benefits/ for current covered preventive drugs. See Section 3(n).	$0
Generic Drugs	See Section 3(n).	$5 after deductible
Preferred Brand Drugs	See Section 3(n).	$80 after deductible
Non-Preferred Brand Drugs	See Section 3(n).	$100 after deductible
Specialty Drugs	See Section 3(n).	40% after deductible
Mail Order Prescription Drugs		
Generic Drugs	Formulary Generic Drugs obtained through Mail Order Service. See Section 3(n).	$5 (30 day supply) $12.5 (90 day supply) Deductible applies
Preferred Brand Drugs	Formulary Preferred Brand Drugs obtained through Mail Order Service. See Section 3(n).	$80 (30 day supply) $200 (90 day supply) Deductible applies
Non-Preferred Brand Drugs	Formulary Non-Preferred Brand Drugs obtained through Mail Order Service. See Section 3(n).	$100 (30 day supply) $250 (90 day supply) Deductible applies
Not Covered Services		
Services Your Plan Does NOT Cover	- Acupuncture - Bariatric Surgery - Dental Care (Adult and Child) - Vision (Adult) - Long-Term Care - Non-emergency care when traveling outside the U.S. - Routine Eye Care (Adult) - Weight Loss Programs - Infertility Treatment - Cosmetic Surgery	Review Evidence of Coverage for complete list under "General Exclusions and Limitations." See Section 5.

EVIDENCE OF COVERAGE AMENDMENT

This amendment is attached to and made part of the Contract to which it is attached. Except as modified below, all Contract terms, conditions, exclusions and limitation apply.

Community Rewards

The mission of Community Health Choice (Community) is to improve the health and wellbeing of our Members. As such, Community offers a robust Member health promotion, education and rewards program known as Community Rewards. Community Rewards is included in Your Contract. Members will have access to the program and an opportunity to earn wellness rewards and incentives by completing a Health Questionnaire and other wellness educational or informational programs.

The rewards may include health related services such as gift cards, obtaining preventive services, discounts for local restaurants and recreational activities, and disease or activity-focused discussion groups in which You may participate. The reward may also include benefits such as a premium reduction of up to ten percent (10%) known as Community Rewards Wellness Incentive. In order to receive the Community Rewards Wellness Incentive, You must create an account at www.communityhealthchoice.org and then log into the Community Rewards program. Once logged into the Community Rewards program page, click "Health Questionnaire" and complete the survey. If You are unable to complete the questionnaire online, You may call our staff for assistance.

Upon completion of the Health Questionnaire, You will receive an acknowledgement of completion. If You enroll during the Open Enrollment Period, You have until March 31, 2021 to complete the questionnaire. The reduction will be reflected in the following months invoice (e.g., for a Health Questionnaire completed on December 20th the monthly incentive will be reflected on Your January invoice for February coverage). You must maintain continuous enrollment to retain the reduction throughout the year. If You enroll outside of the annual Open Enrollment Period, during a Special Enrollment Period, You must complete the Health Questionnaire within the first ninety (90) days of coverage in order to receive the reduction for the remaining 2021 premiums.

Note: Depending on the timing of Your completion of the Health Questionnaire, You may be required to pay the full premium amount for the effective months until the premium incentive is reflected on Your invoice.

The Community Rewards program, including the Community Rewards Wellness Incentive, may be terminated with prior notification to You and is subject to state and federal laws.

The decision to participate in the Community Rewards program is voluntary. If this Contract terminates, You will no longer be eligible for the Community Rewards program. To resolve a complaint or issue, You may call 855.315.5386.

LANGUAGE ASSISTANCE

Community Health Choice, Inc. is required by federal law to provide the following information.

COMMUNITY HEALTH CHOICE

NON-DISCRIMINATION STATEMENT (MARKETPLACE)

Community Health Choice, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Community Health Choice, Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Community Health Choice, Inc. provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats). Community Health Choice, Inc. provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Community Health Choice, Inc. Member Services Department at 1.855.315.5386. If you believe that Community Health Choice, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance.

You can file a grievance in person or by mail, fax or email:

Service Improvement Department
2636 South Loop West, Suite 125
Houston, Texas 77054

Phone: 1.855.315.5386
Email: ServiceImprovement@CommunityHealthChoice.org

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1.800.368.1019, 800.537.7697 (TDD)

Arabic

يتضمن هذا الإشعار معلومات مهمة. وتتعلق هذه المعلومات الهامة في الإشعار بخصوص طلبك أو التغطية تحت التأمين الصحي Community Health Choice. ابحث عن التواريخ الهامة في هذا الإشعار. قد تحتاج لاتخاذ إجراءات قبل مواعيد محددة للحفاظ على تأمينك الصحي أو مساعدتك في دفع التكاليف. لديك الحق في الحصول على هذه المعلومات والمساعدة بلغتك دون أي تكلفة. اتصل على 1.855.315.5386.

English

This Notice has Important Information. This notice has important information about your application or coverage through Community Health Choice. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 1.855.315.5386.

German

Diese Mitteilung enthält wichtige Informationen. Diese Mitteilung enthält wichtige Informationen zu Ihrem Antrag auf Krankenversicherung bzw. Ihren Versicherungsschutz mit Community Health Choice. Achten Sie auf wichtige Termine in dieser Mitteilung. Eventuell müssen Sie zu bestimmten Stichtagen Ma nahmen ergreifen, um die Beibehaltung Ihres Versicherungsschutzes bzw. finanzieller Unterstützung in Ihrer Sprache. Rufen Sie an unter 1.855.315.5386.

Hindi

इस सूचना में महत्वपूर्ण जानकारी है। इस सूचना में आपके आवेदन या Community Health Choice द्वारा कवरेज के बारे में महत्वपूर्ण जानकारी है। इस सूचना में महत्वपूर्ण तारीखों के लिए खोजिये। आपको अपने स्वास्थ्य के कवरेज रखने के लिए या लागत की मदद के लिए निश्चित समय सीमा से कार्रवाई करने की ज़रूरत हो सकती है। आपको अपनी भाषा में यह जानकारी और सहायता निःशुल्क प्राप्त करने का अधिकार है। 1.855.315.5386 पर कॉल कीजिए।

Korean

이 통지서는 중요한 정보를 담고 있습니다. 이 통지서는 Community Health Choice를 통한 귀하의 신청이나 보험보장에 대해 중요한 정보를 담고 있습니다. 이 통지서에서 주요 날짜를 확인하십시오. 귀하의 건강보험 보장을 유지하거나 비용에서 도움을 받기 위해서는 일정한 마감일까지 조치를 취해야 할 수 있습니다. 귀하에게는, 이러한 정보를 받고 무료로 귀하의 언어로 도움을 받을 권리가 있습니다. 1.855.315.5386로 연락하십시오.

Persian

این اطلاعیه حاوی اطلاعات مهمی می باشد. این اطلاعیه حاوی نکات مهمی درباره تقاضانامه و پوشش بیمه ای شما توسط Community Health Choice می باشد. به تاریخ های ذکر شده در این اطلاعیه توجه نمایید. به منظور برقرار نگهداشتن پوشش بیمه ای با دریافت کمک هزینه، ممکن است نیاز باشد که تا مهلت های مقرر، اقداماتی را انجام دهید. حق شماست که این اطلاعات و کمک را بطور رایگان به زبان خودتان دریافت نمایید. با شماره تلفن 1.855.315.5386.. تماس بگیرید.

Spanish or Spanish Creole

Este aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de Community Health Choice. Preste atención a las fechas clave que se incluyen en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al teléfono 1.855.315.5386.

Urdu

اس نوٹس میں اہم معلومات ہیں. اس نوٹس میں Community Health Choice کے ذریعے اپ کی درخواست یا بیمے کی تحفظ سے متعلق اہم معلومات ہیں- اس نوٹس میں اہم تاریخوں کو دیکھیے – اپنی صحت کے بیمے کے تحفظ کو برقرار رکھنے یا اخراجات میں مدد کے لیے آپ کو کچھ خاص تاریخوں تک کارروائی کرنے کی ضرورت ہوسکتی ہیں. آپ کو ان معلومات اور مدد کو اپنی زبان میں مفت حاصل کرنے کا حق حاصل ہے. 1.855.315.5386 پر رابطہ کریں.

Chinese

本通知有重要信息。本通知包含關于您透過Community Health Choice提交的申請或保險的重要訊息。請留意本通知內的重要日期。您可能需要在截止日期之前采取行動，以保留您的健康保險或費用補貼。您有權免費以您的母語得到本訊息和幫助。請撥電話1.855.315.5386。

French

Cet avis contient d'importantes informations. Cet avis contient d'importantes informations concernant votre demande ou votre couverture avec Community Health Choice. Consultez les dates figurant dans le présent avis car il est possible que vous ayez à prendre certaines mesures avant ces dates pour conserver votre assurance santé ou profiter de meilleurs coûts. Vous êtes en droit de recevoir ces informations et de bénéficier gratuitement d'une aide dans votre langue. Appelez le 1.855.315.5386.

Gujarati

આ નોટિસમાં મહત્વની માહિતી છે. આ નોટિસમાં Community Health Choice દ્વારા તમારી અરજી અને કવરેજ વિશે મહત્વની જાણકારી છે. આ નોટિસમાં મહત્વની તારીખો માટે જુઓ. તમારા આરોગ્ય કવરેજને રાખવા અથવા ખર્ચ બાબતે મદદ કરવા માટે અમુક ચોક્કસ મુદત સુધી પગલાં લેવાની તમારે જરૂર પડી શકે છે. તમને કોઈ પણ ખર્ચ વગર તમારી ભાષામાં આ જાણકારી અને મદદ મેળવવાનો અધિકાર છે. 1.855.315.5386 પર કૉલ કરો.

Japanese

こと通知には必要な情報が含まれています。この通知にはCommunity Health Choiceの申請または補償範囲に関する重要な情報が含まれています。この通知に記載されている重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。1.855.315.5386までお電話ください。

Laotian

ໜັງສືແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສຳຄັນ. ໜັງສືແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບການສະໝັກຫຼືການຄຸ້ມຄອງຂອງທ່ານໂດຍຜ່ານ Community Health Choice. ໃຫຊອກຫາຂໍ້ມູນວັນທີທີ່ສຳຄັນໃນໜັງສືແຈ້ງການນີ້ ທ່ານຄວນຈະຕ້ອງປະຕິບັດພາຍໃນກຳນົດເວລາເພື່ອທີ່ຈະຮັກສາການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານພາຍຫຼັງການຊວຍເຫຼືອໃນເລື່ອງຄາໃຊ້ຈ່າຍ. ມັນເປັນສິດທິຂອງທ່ານທີ່ຈະໄດ້ຮັບຂໍ້ມູນສຳຄັນນີ້ແລະການຊວຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທລະສັບ: 1.855.315.5386.

Russian

Настоящее уведомление содержит важную информацию. Настоящее уведомление содержит важную информацию о вашем заявлении или страховом покрытии, предоставляемым Community Health Choice. Обратите внимание на основные даты, указанные в настоящем уведомлении. Возможно, будет необходимо предпринять действия до наступления конечного срока для сохранения страхового полиса или для получения помощи в оплате расходов. Вы имеете право на бесплатное получение этой информации и помощи на вашем языке. Звоните по телефону: 1.855.315.5386.

Tagalog

Ang Notisyang ito ay naglalaman ng Importanteng Impormasyon. Maayroon itong importanteng impormasyon tungkol sa inyong aplikasyon o pagpapaseguro sa pamamagitan Community Health Choice. Hanapin ang mga importanteng petsa sa notisyang ito. Maaaring may kailangan kayong gawin bago ang mga itinakdang deadline para manatiling nakaseguro o para matulungan kayo sa mga kailangang babayaran. Kayo ay may karapatang makatanggap nitong impormasyon at makatanggap ng pagsasalin sa inyong wika na wala kayong babayaran. Tawagan ang 1.855.315.5386.

Vietnamese

Thông báo này có Thông Tin Quan Trọng. Thông báo này có thông tin quan trọng về mẫu đơn của bạn hoặc bảo hiểm qua chương trình Community Health Choice. Xem những ngày quan trọng trong thông báo này. Bạn có thể cần phải thực hiện trong thời gian nhất định để giữ bảo hiểm sức khỏe của bạn hay giúp đỡ chi phí. Bạn có quyền được thông tin này và giúp đỡ trong ngôn ngữ của mình miễn phí. Xin gọi 1.855.315.5386.