



Exclusive Provider Organization Major Medical Expense Coverage OUTLINE OF COVERAGE AND PLAN DESCRIPTION

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

Baylor Scott & White Insurance Company (herein called "Issuer") is responsible for the coverage in this plan which is designed to provide you with coverage for major hospital, medical, and surgical expenses which you incur as the result of a covered injury or sickness. Coverage is provided for the benefits outlined under **Benefits**. The benefits described may be limited by **Exclusions and Limitations**. This plan only provides benefits for services received from a Participating Provider, except as otherwise noted in the Policy.

For any questions regarding this Outline of Coverage or your plan, visit our website at **BSWHealthPlan.com** or call **844.633.5325**.

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

You have a network of Participating Providers throughout the Service Area. When you use these Participating Providers, you receive benefits. You may visit us at **BSWHealthPlan.com** or call us at **844.633.5325** for a list of Participating Providers. You will not receive benefits when you use a Non-Participating Provider, except in special situations as explained in your Policy. The benefits under the Policy include but are not limited to:

This Consumer Choice of Benefits Health Maintenance Organization health care 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 the Evidence of Coverage. The following is a summary of the copayment amounts members must pay when receiving the covered benefits listed below. Refer to the Evidence of Coverage for a detailed explanation of covered and non-covered benefits. If you have any questions or would like more information about the Issuer's medical and pharmacy benefits go to **BSWHealthPlan.com** or contact Customer Service, Monday through Friday, 7:00 AM – 7:00 PM CT, at **844.633.5325, TTY Line 711**.

The Issuer does not discriminate based on race, color, national origin, disability, age, sex, gender identity, sexual orientation, political affiliation or expression, or health status in the administration of the plan, including enrollment and benefit determinations.

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|---|---|
| Plan Year | Calendar Year |
| Medical Deductible | \$7,600 per Member \$15,200 per Family |
| Pharmacy Deductible | Tier 1: \$0 per Member, \$0 per Family Tier 2-4 : Integrated with Medical |
| Maximum Out-of-Pocket <i>Includes Medical Deductible, Pharmacy Deductible and Copayments.</i> | \$9,100 per Member \$18,200 per Family |
| Annual Maximum | Unlimited |

| Medical Benefits | Participating Provider Member Copayment | Non-Participating Provider Member Copayment |
|---|--|--|
| Adult PCP Office Visit <i>Office visit charge applies when seen by a physician and/or a licensed clinician under the supervision of the physician.</i> | No charge for the first sick visit, \$35 copayment per visit for subsequent visits in that plan year | Not covered |
| Pediatric PCP Office Visit For a covered dependent through the age of 18. <i>Office visit charge applies when seen by a physician and/or a licensed clinician under the supervision of the physician.</i> | No charge, deductible does not apply | Not covered |
| Specialist Physician Office Visit <i>Office visit charge applies when seen by a physician and/or a licensed clinician under the supervision of the physician.</i> | \$100 copayment per visit, deductible does not apply | Not covered |
| Adult Annual Routine Eye Exam | Not covered | Not covered |
| Pediatric Annual Routine Eye Exam For a covered dependent through the age of 18. | \$100 copayment per visit, deductible does not apply | Not covered |

| Medical Benefits | Participating Provider Member Copayment | Non-Participating Provider Member Copayment |
|---|--|--|
| Pediatric Prescription Eyewear* For a covered dependent through the age of 18. | \$100 copayment per pair, deductible does not apply | Not covered |
| Dental Care For a covered dependent through the age of 18. See dental plans available through the Issuer. | Not covered | Not covered |
| Preventive Care Routine Annual Physical Exam, Immunizations, Well-Baby Care, Well-Child Care, Mammography Screening, Osteoporosis Screening, Prostate Cancer Screening, Colorectal Cancer Screening, Ovarian Cancer Screening, Cervical Cancer Screening, Prenatal Visits, Tubal Ligation, any evidence-based items, or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force. | No charge | Not covered |
| Allergy Testing, Serum, and Injections | 30% after deductible | Not covered |
| Diagnostic Test Routine lab, EKG, and X-rays. | 30% after deductible | Not covered |
| Imaging and Radiology (Including Facility and Physician charges) Angiography, CT Scans, MRIs, Myelography, PET Scans, Stress Tests. | 30% after deductible | Not covered |
| Cardiovascular Disease Screening* | 30% after deductible | Not covered |
| Outpatient Surgery (Including Facility charges) Covered Prescription Drugs, Specialty Drugs, Medical Supplies, Observation Unit, Surgical Procedures, Pain Management. | 30% after deductible | Not covered |
| Outpatient Physician Services | 30% after deductible | Not covered |
| Emergency Care Copayment waived if episode results in hospitalization for the same condition within 24 hours. | 30% after deductible | 30% after deductible |
| Ambulance Transportation Ground, Sea, or Air. | 30% after deductible | 30% after deductible |
| Urgent Care | \$100 copayment per visit, deductible does not apply | \$100 copayment per visit, deductible does not apply |

| Medical Benefits | Participating Provider Member Copayment | Non-Participating Provider Member Copayment |
|--|--|--|
| Inpatient Care (Including Facility and Physician charges) Pre-admission Testing, Covered Prescription Drugs, Specialty Drugs, Medical Injectables, Medical Supplies, Blood and Blood Products, Laboratory Tests and X-rays, Pain Management, Maternity Labor and Delivery, Surgical Procedures, Operating and Recovery Room, Neonatal Intensive Care Unit (NICU), Intensive Care Unit (ICU), Coronary Care Unit, Rehabilitation Facility, Mental Health Care, Serious Mental Illness, Chemical Dependency. | 30% after deductible | Not covered |
| Skilled Nursing Facility* | 30% after deductible | Not covered |
| Adult Outpatient Mental Health Care, Serious Mental Illness and Chemical Dependency | \$35 copayment per office visit, deductible does not apply; 30% after deductible for all other outpatient services | Not covered |
| Pediatric Outpatient Mental Health Care, Serious Mental Illness and Chemical Dependency | No charge per office visit, deductible does not apply; 30% after deductible for all other outpatient services | Not covered |
| Maternity Care and Family Planning Postnatal Care, Family Planning (as medically necessary). | \$35 copayment per visit, deductible does not apply | Not covered |
| Infertility (Diagnosis Only) | \$100 copayment per visit, deductible does not apply | Not covered |
| Rehabilitation* Physical Therapy, Occupational Therapy, Speech Therapy, Chiropractic Care. | \$35 copayment per visit, deductible does not apply | Not covered |
| Habilitation* Physical Therapy, Occupational Therapy, Speech Therapy, Chiropractic Care. | \$35 copayment per visit, deductible does not apply | Not covered |
| Home Health Care* | 30% after deductible | Not covered |
| Hospice Care | 30% after deductible | Not covered |
| Durable Medical Equipment (DME) Orthotics, Prosthetics. | 30% after deductible | Not covered |
| Diabetes Management Diabetes Self-Management Training, Diabetes Education, Diabetes Care Management. | \$35 copayment per visit, deductible does not apply | Not covered |
| Diabetes Equipment and Supplies | Same as DME or pharmacy, as appropriate | Not covered |
| Nutritional Counseling | \$35 copayment per visit, deductible does not apply | Not covered |
| Hearing Aids* and Cochlear Implants | 30% after deductible | Not covered |
| Telehealth Service and Virtual Visits | No charge, deductible does not apply | Not covered |

| Medical Benefits | Participating Provider Member Copayment | Non-Participating Provider Member Copayment |
|--|--|--|
| Other Telehealth Service and Telemedicine Medical Service | The amount of the deductible or copayment may not exceed the amount of the deductible or copayment required for a comparable medical service provided through a face-to-face consultation. | Not covered |
| Amino Acid Based Elemental Formulas | 30% after deductible | Not covered |
| Other Medical Benefits Including, but not limited to Acquired Brain Injury, Autism Spectrum Disorder, Chemotherapy, Craniofacial Abnormalities, Limited Accidental Dental, Organ and Tissue Transplants, Phenylketonuria (PKU) or Heritable Metabolic Disease, Covered Prescription Drugs, Specialty Drugs, Temporomandibular Joint Pain Dysfunction Syndrome (TMJ). | Depending upon location of service, benefits will be the same as those stated under each covered benefit category in this Schedule of Benefits. | Not covered |
| All Other Covered Medical Benefits (not specified herein) | 30% after deductible | Not covered |

| Pharmacy Benefits | Participating Provider Member Copayment | | Non-Participating Provider Member Copayment |
|--|--|--|--|
| | <i>30-day Standard</i> | <i>90-day Maintenance**</i> | |
| ACA preventive drugs | No charge | No charge | Not covered |
| Tier 1 Generic drugs | \$25 copayment per prescription, deductible does not apply | \$75 copayment per prescription, deductible does not apply | Not covered |
| Tier 2 Preferred drugs | \$55 copayment per prescription after deductible | \$165 copayment per prescription after deductible | Not covered |
| Tier 3 Non-preferred drugs | \$150 copayment per prescription after deductible | \$450 copayment per prescription after deductible | Not covered |
| Tier 4 Specialty drugs and oral anticancer medications | \$500 copayment per prescription after deductible | Not covered | Not covered |
| Preferred diabetes test strips for blood glucose monitors | \$55 copayment per prescription after deductible | \$165 copayment per prescription after deductible | Not covered |
| Non-preferred diabetes test strips for blood glucose monitors | Non-formulary | Non-formulary | Not covered |

**Maintenance drugs are allowed up to a 90-day supply if obtained through a participating pharmacy. Mail Order: Available for a 1- to 90-day supply. Non-maintenance drugs obtained through mail order are limited to a 30-day supply maximum. Specialty drugs limited to a 30-day supply. Formulary insulin prescriptions have a maximum copayment of \$25 per prescription per 30-day supply.

Covered Benefit Limitations*

Cardiovascular Disease Screening

Limited to once every 5 years.

Rehabilitation

Limited to 35 combined visits per plan year

Limits do not apply for therapies for children with developmental delays, autism spectrum disorder, and mental health services.

Habilitation

Limited to 35 combined visits per plan year

Limits do not apply for therapies for children with developmental delays, autism spectrum disorder, and mental health services.

Hearing Aids

Limited to one device per ear every 3 years

Home Health Care

Limited to 60 visits per plan year

Skilled Nursing Facility

Limited to 25 days per plan year

Pediatric Prescription Eyewear

Limited to one pair of glasses or contact lenses per plan year. Refer to plan document for details.

Exclusions and Limitations

The benefits under the Policy shall not include or shall be limited by the following:

Abortions

Elective abortions, non-therapeutic termination of pregnancy, including any abortion-inducing medications are excluded except where the life of the mother would be endangered if the fetus were to be carried to term or a medical emergency that places the woman in danger of serious risk of substantial impairment of a major bodily function unless an abortion is performed.

Ambulance Transportation is excluded when another mode of transportation is clinically appropriate; for stable, non-emergency conditions, unless Preauthorized; when provided for the convenience of the Member, the Member's family, Ambulance provider, Hospital, or attending Physician, where no transportation of a Member occurs. Additionally, air or sea Ambulance transportation is excluded when ground Ambulance is clinically appropriate, and to locations other than an acute care Hospital. All forms of Medically Necessary ambulance transportation that are for non-emergency situations must be Preauthorized.

Assistant Surgeons are excluded unless determined to be Medically Necessary.

Breast Implants

Non-Medically Necessary implantation of breast augmentation devices, removal of breast implants, and replacement of breast implants are excluded.

Circumcision in any male other than a newborn, age 30 days or less, is excluded unless Medically Necessary.

Chiropractic Services other than those described in the Manipulative Therapy and Chiropractic Care provision is excluded.

Complications of non-covered procedures

Treatment related to complication of non-covered procedures are excluded.

Cosmetic or Reconstructive Procedures or Treatment

Cosmetic, plastic, medical or surgical procedures, and cosmetic therapy and related supplies, including, but not limited to Hospital confinement, Prescription Drugs, diagnostic laboratory tests and x-rays or surgery and other reconstructive procedures, including any related prostheses, except breast prostheses after mastectomy, are excluded, unless specifically covered in the **Medical Benefits** section of the Policy. Among the procedures that are excluded are:

- Excision or reformation of any skin on any part of the body, removal of port wine stains, removal of superficial veins, tattoos or tattoo removal, the enlargement, reduction implantation or change in the appearance of any portion of the body unless determined to be Medically Necessary.
- Removing or altering sagging skin.
- Changing the appearance of any part of the Member's body, such as enlargement, reduction, or implantation, except for breast construction following a mastectomy.
- Hair transplants or removal.
- Peeling or abrasion of the skin.
- Any procedure that does not repair a functional disorder; and
- Rhinoplasty as associated surgery except when Medically Necessary to treat craniofacial abnormalities as described in the **Medical Benefits** section of the Policy.

Court Ordered Care

Benefits provided solely because of the order of a court or administrative body, which benefits would otherwise not be covered under the Policy are excluded.

Cryotherapy devices such as PolarCare™ are excluded.

Custodial Care as follows is excluded:

- Any services, supply, care, or Treatment that the Medical Director determines to be incurred for rest, domiciliary, convalescent, or Custodial Care.
- Any assistance with activities of daily living which include activities such as walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking Prescription Drugs; and
- Any Care that can be performed safely and effectively by a person who does not require a license or certification or the presence of a supervisory nurse.

Such services will not be covered benefits no matter who provides, prescribes, recommends, or performs those services. The fact that certain benefits are provided while You or Your Covered Dependent are receiving Custodial Care does not require Us to cover Custodial Care.

Dental Care

All dental care or oral surgery is excluded, except for corrective Treatment of craniofacial abnormalities or an Accidental Injury to natural teeth, or any Treatment relating to the teeth, jaw, or adjacent structures, including but not limited to:

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

The only dental related coverage We provide is described in the **Medical Benefits** section of the Policy.

Disaster or Epidemic

In the event of a major disaster or epidemic, benefits shall be provided to the extent that is practical, according to the best judgment of Participating Providers and within the limitations of facilities and personnel available; but neither the Issuer, nor any Participating Providers shall have any liability for delay or failure to provide or to arrange for services due to a lack of available facilities or personnel.

Exceeding Medical Benefit Limits

Any services provided to a Member who has exceeded a Medical Benefit maximum are excluded from coverage, regardless of authorization status, as permitted by law.

Experimental or Investigational Treatment

A Prescription Drug, device, Treatment, or procedure that is Experimental or Investigational is excluded. We consider a Prescription Drug, device, Treatment, or procedure to be Experimental or Investigational if:

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

exclusion also applies if the informed consent form used with the Prescription Drug, device, Treatment, or procedure was or was requested by federal law to be reviewed and approved by that committee.

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

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

Additionally, any Prescription Drug, device, Treatment, or procedure that would not be used in the absence of an Experimental or Investigational drug, device, Treatment, or procedure is excluded.

Family Member (Service Provided by)

Treatments or services furnished by a Physician or provider who is related to You, or Your Covered Dependent, by blood or marriage, and who dwells in the Member's household, or any services or supplies for which the Member would have no legal obligation to pay in the absence of the Policy or any similar coverage; or for which no charge or different charge is usually made in the absence of healthcare coverage, are excluded.

Family Planning Treatment

The reversal of an elective sterilization procedure, and condoms for males are excluded.

Foot Care (Routine)

Treatment of weak, strained, or flat fee, corns, calluses, or medications for the Treatment of uncomplicated nail fungus are excluded. Corrective orthopedic shoes, arch supports, splints, or other foot care items are excluded, except as noted in the **Medical Benefits** section of the Policy. This will not apply to the removal of nail roots.

Genetic Testing

Genetic testing relating to pre-implantation of embryos for in-vitro fertilization is excluded, except for those required under applicable state or federal law and Medically Necessary prenatal genetic counseling. Genetic testing results or the refusal to submit to genetic testing will not be sued to reject, deny, limit, cancel, refuse to renew, increase Premiums for, or otherwise adversely affect eligibility for or coverage under this plan.

Hearing Devices

The following exclusions include hearing aid batteries or cords, temporary or disposable hearing aids, repair, or replacement of hearing aids due to normal wear, loss, or damage, a hearing aid that does not meet the specifications prescribed for correction of hearing loss.

Household Equipment

The following devices, equipment, and supplies are excluded:

- Corrective shoes, shoe inserts, arch supports, and Orthotic inserts, except as provided for in the **Medical Benefits** section of the Policy and for the Treatment of diabetes.
- Equipment and appliances considered disposable or convenient for use in the home, such as over-the counter bandages and dressings.

- Comfort or convenience items, such as bathtub chairs, whirlpool tubs, safety grab bars, stair gliders or elevators, over-the-bed tables, bed boards, saunas, and exercise equipment.
- Environmental control equipment, such as air conditioners, purifiers, humidifiers, dehumidifiers, electrostatic machines, and heat lamps.
- Consumable medical supplies, such as over-the-counter bandages, dressings, and other disposable supplies, skin preparations, surgical leggings, elastic stockings, TED stockings, stump socks and compression garments.
- Foam cervical collars.
- Stethoscopes, sphygmomanometers, and recording or hand-held pulse oximeters.
- Hygienic or self-help items or equipment; and
- Electric, deluxe, and custom wheelchairs or auto tilt chairs.

Illegal Acts

Charges for services received as a result of injury or sickness caused by or contributed to by the Member engaging in an illegal act or occupation or by committing or attempting to commit a crime, criminal act, assault, or other felonious behavior, regardless of whether charged, are excluded. For purposes of this exclusion, an act is “illegal” if it is contrary to or in violation of law, and includes, but is not limited to, operating a motor vehicle, recreational vehicle, or watercraft while intoxicated. Intoxication includes situations in which the Member has a blood alcohol content or concentration (BAC) which exceeds the applicable legal limit. This exclusion does not apply if the injury resulted from an act of domestic violence or medical condition (including both physical and mental health), or in case of emergency, the initial medical screening examination, Treatment and Stabilization of an emergency condition.

Infertility Treatment

The following Infertility services are excluded:

- in vitro fertilization.
- artificial insemination.
- gamete intrafallopian transfer, and similar procedures.
- zygote intrafallopian transfer, and similar procedures.
- drugs whose primary purpose is the Treatment of Infertility.
- reversal of voluntarily induced sterility.
- surrogate parent services and fertilization.
- donor egg or sperm.
- any costs related to surrogate parenting, sperm banking for future use, or any assisted reproductive technology or related Treatment that is not specified in the **Medical Benefits** section of the Policy.

Mental Health

Services for mental illness or disorders are limited to those services described in the “Mental Health Care” provision of the Policy including counseling and related services. Coverage for services for or in connection with a Court Order or condition of parole or probation are subject to the same limitation.

Non-Emergency Care when traveling outside the U.S.

Miscellaneous

Artificial aids, corrective appliances, other than those provided as Orthotic Devices. Non-prescribed medical supplies, such as take home and over the counter drugs, batteries, condoms, syringes (other than insulin syringes), dentures, eyeglasses, and corrective lenses, unless specified in the Plan, are excluded.

Non-Payment for Excess Charges

No payment will be made for any portion of the charge for a service or supply in excess of the Usual and Customary charges for such services or supply prevailing in the area in which the service or supply was received.

Orthotripsy and related procedures are excluded.

Personal Comfort Items

Personal items; comfort items; food products; guest meals; accommodations; telephone charges; travel expenses; private rooms, unless Medically Necessary; take home supplies; barber and beauty services; radio, television, or videos of procedures; vitamins, minerals, dietary supplements; and similar products except to the extent specifically listed as covered under the Policy, are excluded.

Pharmacy Benefit excludes the following:

- Covered drugs, devices, or other pharmacy services which a Member may properly obtain at no cost through a local, state, or federal government program, except if provided through Medicaid or this exclusion is specifically prohibited by law.
- “Over-the-counter” drugs which do not require a Participating Provider or Participating Health Professional's Prescription Order for dispensing. The exception is insulin and if the drug is listed on Our Formulary.
- Anything which is not specified as covered or not defined as a drug, such as therapeutic devices, appliances, support garments, glucometers, asthma spacers and machines, including syringes (except disposable syringes for insulin dependent Members) unless listed on Our Formulary.
- Experimental or Investigational drugs or other drugs which, in the opinion of the Pharmacy and Therapeutics Committee or Medical Director, have not been proven to be effective. NOTE: Denials based upon Experimental or Investigational use are considered Adverse Determinations and are subject to the Appeal of Adverse Determination and Independent Review provisions of the Policy.
- Drugs not approved by the Food and Drug Administration for use in humans.
- Drugs not recognized by the Food and Drug Administration, standard drug reference compendium, or substantially accepted peer-reviewed medical literature for the condition, dose, route, duration, or frequency prescribed.
- Drugs used for cosmetic purposes.
- Drugs used for Treatments or medical conditions not covered by the Policy.
- Drugs used primarily for the Treatment of Infertility.
- Vitamins except if drug is listed on Our Formulary.
- Any initial or refill prescription dispensed more than one (1) year after the date of the Participating Provider or Participating Health Professional's Prescription Order.
- Except for medical emergencies, drugs not obtained at a Participating Pharmacy.
- Drugs given or administered to a Member while at a Hospital, Skilled Nursing Facility, or other Facility.
- A prescription that has an over-the-counter alternative.
- Initial or refill prescriptions the supply of which would extend past the termination of the Policy, even if the Participating Provider or Participating Health Professional's Prescription Order was issued prior to termination.
- Drugs for the Treatment of sexual dysfunction, impotence, or inadequacy; or,
- High-cost drugs that are chemically similar drugs and share the same mechanism of action to an existing, approved chemical entity and offer no significant clinical benefit.
- Drugs used for treatment of obesity or weight reduction.

Physical and Mental Exams

Physical, psychiatric, psychological, other testing or examinations and reports for the following are excluded:

- obtaining or maintaining employment.
- obtaining or maintaining license of any type.
- obtaining or maintaining insurance.
- otherwise relating to insurance purposes and the like.
- educational purposes.
- services for non-Medically Necessary special education and developmental programs.

- premarital and pre-adoptive purposes by court order.
- relating to any judicial or administrative proceeding.
- medical research; and
- qualifying for participation in athletic activities, such as school sports.

Surgery for Refractive Keratotomy is excluded.

Reimbursement

We shall not pay any provider or reimburse Member for any Medical Benefit or Pharmacy Benefit for which a Member would have no obligation to pay in the absence of coverage under the Policy.

Speech and Hearing Loss

Services for the loss or impairment of speech or hearing are limited to those rehabilitation services described in the Rehabilitation Therapy provision.

Sports Rehabilitation refers to continued Treatment for sports related injuries to improve above and beyond normal ability to perform activities of daily living (ADLs). Sports-related rehabilitation or other similar avocational activities is excluded because it is not considered Treatment of disease. This includes, but is not limited to baseball, pitching/throwing, cheerleading, golfing, martial arts of all types, organized football, baseball, basketball, soccer, lacrosse, swimming, track, and field, etc. at a college, high school, or other school or community setting, professional and amateur tennis, professional and amateur/hobby/academic dance, and competitive weightlifting and similar activities.

Therapies and Treatments

The following therapies and Treatments are excluded: Equine therapy; cranial sacral therapy; recreational therapy; exercise programs; hypnotherapy, music therapy; reading therapy; sensory integration therapy; vision therapy; vision training; orthoptic therapy; orthoptic training; behavioral vision therapy; visual integration; vision therapy; orthotripsy; oral allergy therapy; acupuncture; naturopathy; hypnotherapy or hypnotic anesthesia; Christian Science Practitioner Services; Biofeedback services, except for the Treatment of Acquired Brain Injury and for rehabilitation of Acquired Brain Injury; massage therapy, unless associated with a physical therapy modality provided by a licensed physical therapist.

Transplants

Organ and bone marrow transplants and associated donor/procurement costs for You or Your Covered Dependent are excluded except to the extent specifically listed as covered in the Policy.

Treatment Received in State or Federal Facilities or Institutions

No payment will be made for services, except Emergency Care, received in Federal Facilities or for any items or services provided in any institutions operated by any state, government, or agency when Member has no legal obligation to pay for such items or services; except, however, payment will be made to the extent required by law provided such care is approved in advance by a Participating Provider and Preauthorized, if required, by Our Medical Director.

Unauthorized Services

Non-emergency Medical Benefits or Pharmacy Benefits which are not provided, ordered, prescribed, or authorized by a Participating Provider or Participating Health Professional are excluded.

Vision Care – Adult

Eye exercises, training, orthoptics, multiphase testing, eyeglasses, including eyeglasses and contact lenses prescribed following vision surgery, contact lenses for Members over the age of 18, except for Treatment of Keratoconus, and any other items or services for the correction of the Member's eyesight, including but not limited to orthoptics, vision training, vision therapy, radial keratotomy (RK), automated lamellar keratoplasty (ALK or LK), astigmatic keratotomy (AK), laser vision corrective surgery and photo refractive keratectomy (PRK-laser) are excluded unless specifically provided in the **Medical Benefits** section of the Policy, or provided by a Rider.

Vision Care – Pediatric

- Routine eye exams do not include professional services for contact lenses.
- Laser eye surgery (LASIK) is excluded.
- Any vision service, Treatment or materials not specifically listed as a covered Medical Benefit is excluded.
- Services and materials not meeting accepted standards of optometric practice are excluded.
- Telephone consultations are excluded.

War, Insurrection or Riot

Medical Benefits or Pharmacy Benefits provided as a result of any injury or illness caused by any act of declared or undeclared war, or Member's participation in a riot or insurrection are excluded.

If the rendition of a Medical Benefit or Pharmacy Benefit is delayed or rendered impractical due to circumstances beyond the reasonable control of the Issuer, such as complete or partial destruction of facilities due to war, riot, or civil insurrection; an act of terrorism; labor dispute; government order; national, state or local state of emergency; pandemic; or the like, neither We, nor any Participating Provider, Participating Health Professional, nor any Facility shall have any liability to Members.

Weight Reduction

Weight reduction programs, supplements, services, supplies, surgeries including but not limited to Gastric Bypass, gastric stapling, Vertical Banding, and gym memberships are excluded, even if the Member has medical condition or is prescribed by a Physician or Healthcare Professional.

Renewability

The Policy is guaranteed-renewable subject to the Issuer's right to change the applicable premium rates upon renewal or with sixty (60) days advance written notice. The Policy shall continue in effect for one (1) year from the effective date until terminated in accordance with the terms of the Termination of Coverage section of the Policy.

Termination of Coverage

We may terminate you or your covered dependent's coverage under the following circumstances:

- Thirty-one (31) days after written notice from us that you failed to pay any required payment when due; or
- In the event of fraud or intentional misrepresentation of material fact by you or your covered dependent (except as described under incontestability) or fraud in the use of services and facilities, coverage may be terminated retroactively upon thirty (30) days after written notice from us; or
- Member ceases to live, work, or reside in the service area upon thirty (30) days written notice. Coverage for a child who is the subject of a Qualified Medical Support Order cannot be canceled solely because the child does not reside, live, or work in the service area; or
- Our discontinuance of coverage in the service area. Coverage may be canceled after ninety (90) days written notice; in which case we must offer to each member on a guaranteed issue basis any other healthcare coverage offered by us in that service area. If we completely withdraw from the market in the service area, coverage under this plan may be canceled after one hundred eighty (180) days written notice to the state insurance commissioner and the members, in which case we may not re-enter the market in that service area for five (5) years beginning on the date of discontinuance of the last coverage not renewed.

If you or your covered dependent become totally disabled and you or your covered dependent's health benefits end, health expenses related to the injury or illness that caused the total disability may extend to

cover specific situations for a period not to exceed three (3) months. To be determined as totally disabled you or your covered dependent must not be able to be gainfully employed in a field for which either of you are specifically trained, unable to perform the regular duties of a job for which either of you are specifically trained, and not be able to perform the normal activities of a same gender healthy person within you or your covered dependents same age range.

If you or your covered dependent is determined to be pregnant at the time coverage cancels, pregnancy benefits will be covered at the same level they would normally be covered if the Policy continued in force.

Members may terminate their coverage in the plan for any reason upon giving written notice to us. Termination from the plan will be effective on the first day of the month following the month we receive the written request.

Upon termination of coverage as described above, we shall have no further liability or responsibility under the Agreement. Any required payments paid in advance by or on behalf of member will be refunded and any unpaid required payments to date of service will be due and payable. The subscriber is responsible for all required payments due but unpaid.

The effective date of termination will be the last day for which premiums were timely paid.

In the event a member has an open claim when the Agreement terminates, at the time of payment of a claim under the Agreement, any premium then due and unpaid or covered by any note or written order may be deducted from the payment.

Reinstatement of Coverage

You may request reinstatement of the Policy from the Issuer. If the Policy has lapsed for nonpayment of premium and we accept a later payment without requiring an Enrollment Application, the Policy shall be reinstated. If we require a written Enrollment Application, the Policy will be reinstated upon our approval of the Enrollment Application. If we do not notify you of our disapproval in writing within forty-five (45) days of the date of your Enrollment Application, the Policy shall be deemed reinstated. The reinstated Policy shall cover only expenses incurred after the date of reinstatement. In all other respects you and the Issuer shall have the same rights as provided under the Policy immediately before the due date of the defaulted premium, subject to any provisions added in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

Premium

Premium means the periodic amounts required to be paid to the Issuer as a condition of coverage under the Policy.

Grace Period and Cancellation of Coverage

The Issuer may cancel the Policy at any time by written notice delivered to the subscriber or mailed to the subscriber's last address on record with the Issuer, stating when the cancelation is effective, which may not be earlier than five (5) days after the date the notice is delivered or mailed. After the Policy has been continued beyond its original term, the subscriber may cancel the Policy at any time by written notice delivered or mailed to the Issuer, effective on receipt or on a later date specified in the notice. In the event of cancellation, the Issuer will promptly return the unearned portion of any premium paid. If the Issuer cancels, the earned premium shall be computed by the use of the short-rate table last filed with the State of Texas where the subscriber resided when the Policy was issued. If the Issuer cancels, the earned

premium shall be computed pro rata. Cancellation is without prejudice to any claim originating before the effective date of the cancellation.

If any premium is not received by us within thirty (30) days of the due date, we may terminate coverage under the Policy after the 30th day. During the 30-day grace period, coverage shall remain in force. However, if payment is not received, we shall have no obligation to pay for any benefits provided to the subscriber or covered dependents during the 30-day grace period or thereafter; and the subscriber shall be liable to the provider for the cost of those benefits.

Difference Between a Participating Provider and Non-Participating Provider

Participating Provider means any person employed by an entity that has contracted directly or indirectly with the Issuer to provide covered benefits to Members. Participating Provider includes but is not limited to Participating Hospitals, Participating Physicians, Participating Behavioral Health Providers, Participating Health Professionals, Participating Urgent Care Facilities, Participating Pharmacies and Participating Specialty Pharmacy Provider within the Service Area.

Non-Participating Provider means a Hospital, Physician, Behavioral Health Provider, Health Professional, Urgent Care Facility or Pharmacy who has not contracted with the Issuer to provide benefits to Members of the Plan. We strongly encourage Members to use Participating Providers to assure the highest quality and lowest cost. Use of a Non-Participating Provider may result in additional charges to the Member that are not covered under the Plan. Requests for benefits performed by a Non-Participating Provider may be denied if there is a Participating Provider in the Network who can provide the same or similar benefit.

Emergency Care

In the case of an emergency, Members may go to a Participating Provider or a Non-Participating Provider. The Plan will provide benefits for the Emergency Care received from a Non-Participating Provider to the same extent as would have been provided if care and Treatment were provided by a Participating Provider. However, follow-up care or Treatment by a Non-Participating Provider will be treated as Network coverage only to the extent it is Medically Necessary and appropriate care or Treatment rendered before the Member can return to Participating Provider in the Service Area. If a Member receives care and Treatment for an emergency from a Non-Participating Provider, the Member should notify Us as soon as reasonably possible to receive assistance transitioning care to a Participating Provider.

Medically Necessary Emergency Care received from a Non-Participating Provider will be reimbursed according to the terms of the Policy at the Usual and Customary or agreed upon rate, except for Copayments, and charges for non-covered benefits. The Member will be held harmless for any amounts beyond the Copayment or other Out-of-Pocket Expenses that the Member would have paid had the Network included Participating Providers from whom the Member could obtain care.

Medically Necessary Emergency Care is provided by the Policy and includes the following benefits:

- An initial medical screening examination or other evaluation required by Texas or federal law that takes place in a Hospital emergency Facility or comparable Facility, and that is necessary to determine whether an emergency medical condition exists.
- Treatment and Stabilization of an emergency medical condition; and
- Post-Stabilization care originating in a Hospital emergency room, Freestanding Emergency Medical Care Facility, or comparable emergency Facility, if approved by the Us, provided that We must approve or deny coverage within the time appropriate to the circumstances relating to the delivery

of care and the condition of the patient not to exceed one (1) hour of a request for approval by the treating Physician or the Hospital emergency room.

Examples of medical emergencies for which Emergency Care would be covered are:

- Heart attacks.
- Cardiovascular accidents.
- Poisoning.
- Loss of consciousness or breathing.
- Convulsions.
- Severe bleeding; and
- Broken bones.

Once a Member's condition is stabilized and as medically appropriate, We, upon authorization of Our Medical Director, may facilitate transportation to a Participating Facility. Where Stabilization of an emergency medical condition originates in a Hospital emergency Facility or comparable Facility, further Treatment following such Stabilization will require approval by Us.

Plan Network

Members are entitled to the covered benefits specified and subject to the conditions and limitations stated in the Schedule of Benefits and the Policy that are Medically Necessary. Except for Emergency Care, approved referrals to Non-Participating Providers or care provided to a Covered Dependent child under a Qualified Medical Support Order who is outside the Service Area, covered benefits are available only through Participating Providers. We have no liability or obligation for any care needed or received by any Member from any other provider, Hospital, extended care Facility, or other person, institution, or organization, unless Preauthorization for referral has been obtained by a Medical Director. Members can access up-to-date lists of Participating Providers and other Plan Network information by visiting Our website at BSWHealthPlan.com.

Required Payments

You are entitled to coverage under the Policy provided the required Premium is paid to the Issuer. In addition to the payment of Premiums, You will be responsible for expenses incurred that are limited or not a covered benefit under the Plan, Deductibles, and Copayment amounts.

Deductible means the dollar amount, if any, shown in the Schedule of Benefits payable by the member for covered benefits before the plan provides payment for those benefits under the Policy.

Copayment means the dollar amount of the cost of covered benefits, if any, shown in the Schedule of Benefits payable by the member to a Participating Provider, when those benefits are obtained from that Participating Provider.

Coinsurance means the percentage of covered expenses you are responsible for paying (after the applicable deductibles are satisfied). Coinsurance does not include charges for services that are not covered benefits or charges in excess of covered expenses. These charges are your responsibility and are not included in the coinsurance calculation.

Maximum Out-of-Pocket means the total dollar amount of out-of-pocket expenses which a member is required to pay for covered benefits during a plan year. Maximum Out-of-Pocket does not apply to any treatments which are not medically necessary or not a covered benefit.

Utilization Review

The Plan includes a Utilization Review program to evaluate inpatient and outpatient Hospital and Ambulatory Surgical Center admissions and specified non-emergency outpatient surgeries, diagnostic procedures, and other services. This program ensures that Hospital and Ambulatory Surgical Center care is received in the most appropriate setting, and that any other specified surgery or services are Medically Necessary. Utilization Review includes all review activities and may be undertaken by:

- Preauthorization review which takes place before a service is provided that requires Preauthorization.
- Admission review which takes place before a Hospital admission or after an emergency admission.
- Continued stay review which takes place during a Hospital stay.
- Retrospective review which takes place following discharge from a Hospital or after any services are performed.

Certain benefits require Preauthorization in order to be covered. For a complete list of benefits that require Preauthorization, visit Our website at BSWHealthPlan.com.

We will accept requests for renewal of an existing Preauthorization beginning sixty (60) days from the date that the existing Preauthorization is set to expire. Upon receipt of a request for renewal of an existing Preauthorization, We will, to the extent possible, review the request and issue a determination indicating whether the benefit is Preauthorized before the existing authorization expires.

Preauthorization Review

To satisfy Preauthorization review requirements, the Member or Participating Provider should contact Us at the authorization phone number listed on the Member ID Card on business days 6:00 AM – 6:00 PM CT and on Saturdays, Sundays, and Holidays 9:00 AM – 12:00 PM CT at least three (3) calendar days prior to any admission or scheduled date of a proposed benefit that requires Preauthorization. Participating Providers may Preauthorize benefits for Members, when required, but it is the Member's responsibility to ensure Preauthorization requirements are satisfied.

The Preauthorization process for health care services may not require a Physician or Participating Provider to obtain Preauthorization for a particular health care service if the Physician or Participating Provider meets exemption criteria for certain health care services.

Subject to the notice requirements and prior to the issuance of an Adverse Determination, if We question the Medical Necessity or appropriateness of a service, We will give the Participating Provider who ordered it a reasonable opportunity to discuss with Our Medical Director the Member's Treatment plan and the clinical basis of Our determination. If We determine the proposed benefit is not Medically Necessary, the Member or Participating Provider will be notified in writing within three (3) days. The written notice will include:

- the principal reason(s) for the Adverse Determination.
- the clinical basis for the Adverse Determination.
- a description of the source of the screening criteria used as guidelines in making the Adverse Determination; and
- description of the procedure for the Complaint and Appeal process, including the Member's rights and the procedure to Appeal to an Independent Review Organization.

For an Emergency admission or procedure, We must be notified within forty-eight (48) hours of the admission or procedure or as soon as reasonably possible. We may consider whether the Member's condition was severe enough to prevent the Member from notifying Us, or whether a family member was available to notify Us for the Member.

If the Member has a Life-Threatening Disease or Condition, including emergency Treatment or continued hospitalization, or in circumstances involving Prescription Drugs or intravenous infusions, the Member has the right to an immediate review by an Independent Review Organization and the Member is not required to first request an internal review by Us.

Admission Review

If Preauthorization review is not performed, We will determine at the time of admission if the Hospital admission or specified non-emergency outpatient surgery or diagnostic procedure is Medically Necessary.

Continued Stay Review

We also will determine if a continued Hospital or Skilled Nursing Facility stay is Medically Necessary. We will provide notice of Our determination within twenty-four (24) hours by either telephone or electronic transmission to the provider of record followed by written notice within three (3) working days to the Member or provider of record. If We are approving or denying Post Stabilization care subsequent to Emergency Care related to a Life-Threatening Disease or Condition, We will notify the treating Physician or other provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the Member, but in no case to exceed one (1) hour after the request for approval is made.

Retrospective Review

In the event services are determined to be Medically Necessary, benefits will be provided as described in the Plan. If it is determined that a Hospital stay or any other service was not Medically Necessary, You are responsible for payment of the charges for those services. We will provide notice of Our Adverse Determination in writing to the Member and the provider of record within a reasonable period, but not later than thirty (30) days after the date on which the Claim is received, provided We may extend the 30-day period for up to fifteen (15) days if:

- We determine that an extension is necessary due to matters beyond Our control; and
- We notify You and the provider of record within the initial 30-day period of circumstances requiring the extension and the date by which We expect to provide a determination.

If the period is extended because of Your failure or the failure of the provider of record to submit the information necessary to make the determination, the period for making the determination is tolled from the date We send Our notice of the extension to You or the provider until the earlier of the date You or the provider responds to Our request, or the date by which the specified information was to have been submitted.

Failure to Preauthorize

If any benefit requiring Preauthorization is not Preauthorized and it is determined that the benefit was not Medically Necessary, the benefit may be reduced or denied. The Member may also be charged additional amounts which will not count toward the Member's Deductible or Maximum Out-of-Pocket.

Prescription Drugs and Intravenous Infusions

We will determine if the use of Prescription Drugs or intravenous infusions is Medically Necessary.

Appeal of an Adverse Determination

Internal Appeal

Our determination that the care the Member requested or received was not Medically Necessary or appropriate or was Experimental or Investigational based on Our Utilization Review standards is an Adverse Determination, which means the Member's request for coverage of the care is denied. Once We have all the information to provide a determination, Our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an Adverse Determination subject to an internal Appeal.

The Member, a person acting on the Member's behalf, or the Member's Physician may request an internal Appeal of an Adverse Determination to Us orally or in writing in accordance with Our internal Appeal procedures. Members will have one hundred eighty (180) days following receipt of a notification of an Adverse Determination within which to Appeal the determination. We will acknowledge the Member's request for an internal Appeal within five (5) working days of receipt. This acknowledgment will, if necessary, inform the Member of any additional information needed before a decision can be made. A clinical peer reviewer who is a Physician or a Health Professional in the same or similar specialty as the provider, who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial Adverse Determination will perform the Appeal.

If the Member's Appeal is denied, Our notice will include a clean and concise statement of the clinical basis for the denial and the Member's right to seek review of the denial from an Independent Review Organization and the procedures for obtaining that review.

If the Member has a Life-Threatening Disease or Condition or in circumstances involving Prescription Drugs or intravenous infusions, the Member has the right to an immediate review by an Independent Review Organization and the Member is not required to first request an internal review by Us.

If the Member's Appeal relates to an Adverse Determination, We will decide the Appeal within thirty (30) calendar days of receipt of the Appeal request. Written notice of the determination will be provided to the Member, or the Member's designee, and where appropriate, the Member's Provider, within two (2) business days after the determination is made, but no later than thirty (30) calendar days after receipt of the Appeal request.

An Appeal regarding continued or extended benefits, additional benefits provided in the course of continued Treatment, Home Health Care benefits following discharge from an inpatient Hospital admission, benefits in which a provider requests an immediate review, or any other urgent matter will be handled on an expedited basis.

The Member can additionally request an expedited Appeal for the denial of Emergency Care, continued hospitalization, Prescription Drugs for which the Member is receiving benefits through the Plan and a step therapy exception request. For an expedited Appeal, the Member's provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. The Member's provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or one (1) business day of receipt of the information necessary to conduct the Appeal.

If a Member has any questions about the Appeals procedures or the review procedure, contact Us at **844.633.5325**.

[Independent Review Organization](#)

An Adverse Determination means a determination by Us or Our designated Utilization Review organization that the benefits provided or proposed to be provided are not Medically Necessary or are Experimental or Investigational.

A Final Internal Adverse Determination means an Adverse Determination that has been upheld by Us at the completion of Our internal review and Appeal process. This procedure pertains only to Appeals of Adverse Determinations.

The Member or an individual acting on the Member's behalf or the Member's provider has the right to request an immediate review of Our Appeal decision by an IRO by submitting a request to Our HHS administered external review contractor, MAXIMUS, within four (4) months after receipt of the notice of the determination of the Member's Appeal. There is no cost to the Member for the independent review.

The Member will not be required to exhaust Our Appeal process before requesting an IRO if:

- the Appeal process timelines are not met; or
- in an Urgent Care situation.

Under non-urgent circumstances, the Member may request a standard external review. For Urgent Care, the Member may request an expedited external review.

The IRO examiner will contact Us upon receipt of the request for external review. For a standard external review, We will provide the examiner all documents and information used to make the final internal Adverse Determination within three (3) business days. For an expedited external review, We will provide the examiner all documents and information used to make the final internal Adverse Determination as soon as possible.

The IRO examiner will give the Member and Us written notice of the final external review decision as soon as possible, but no later than twenty (20) days after the examiner receives the request for a standard external review. For an expedited external review, the examiner will give the Member and Us the external review decision as quickly as medical circumstances require, but no later than within seventy-two (72) hours of receiving the request.

The Member may request an external review for an Adverse Determination for Prescription Drug exception requests. The IRO will issue a response to the Member or the Member's legal representative no later than seventy-two (72) hours from receipt of the Member's request. For an expedited Appeal for Prescription Drug exception requests, the IRO will issue a response to the Member or the Member's legal representative no later than twenty-four (24) hours from receipt.

Continuity of Care

During the course of medical care, a Member qualifies as a continuing care patient if he or she is receiving care from a Participating Provider for:

- a Serious and Complex Condition,
- a course of institutional or inpatient care from a Participating Provider or Facility,
- a nonelective surgery from a Participating Provider or Facility, including receipt of post-operative care with respect to a surgery,
- pregnancy and is undergoing a course of treatment for the pregnancy, or
- if past the 24th week of pregnancy at the time of termination, we will reimburse the terminated provider, and the Member is covered through delivery and postpartum care within the six-week period after deliver.
- a determined terminal illness and is receiving treatment for such illness from a Participating Provider or Facility, and such Participating Provider or Facility's contract to be a network provider terminates or expires for any reason other than fraud by such Participating Provider or Facility, then the Issuer is required to meet all of the following requirements:
 - We will notify each Member under the Plan who is a continuing care patient that he or she is protected for continuing care at the time the Participating Provider or Facility's contract terminates and tell such Member of his or her right to elect continued transitional care from such Participating Provider or Facility.

- We will provide the Member with an opportunity to notify Us of the Member's need for transitional care.
- We will permit the Member to elect to continue to have the benefits provided under the Plan or such coverage under the same terms and conditions as would have applied and with respect to such items and services as would have been covered under the Plan had the Participating Provider or Facility's contract not terminated.

The transitional coverage shall continue beginning on the date the Member receives notice of the contract termination and shall continue until the earlier of ninety (90) days after the Member's receipt of the notice, or the date the Member is no longer qualified as a continuing care patient with respect to that Participating Provider or Facility. The Participating Provider caring for the continuing care patient agrees to accept payment from the Issuer for services and items furnished to the continuing care patient as payment in full for such items and services and to maintain compliance with all policies, procedures, and quality standards imposed by the Issuer.

Complaint Procedure

We recognize that a Member, Physician, provider, or other person designated to act on behalf of a Member may encounter an event in which performance under the Policy does not meet expectations. It is important that such an event be brought to the attention of Issuer. We are dedicated to addressing problems quickly, managing the delivery of benefits effectively, and preventing future Complaints and Appeals. We will not retaliate against a Member because the Member, the Member's provider, or a person acting on the Member's behalf files a Complaint or appeals a decision made by Us.

We offer Members the opportunity to file a Complaint within one hundred eighty (180) days to dispute the benefit/Claim processing. Members are required to file a Complaint in writing and can call Customer Service to begin the process. If Our resolution of the Complaint is unsatisfactory Member, the Member will be afforded the opportunity to Appeal that Complaint.

In some cases, We may ask for additional time to process a Member's Complaint. If a Member does not wish to allow additional time, We will decide a Member's Complaint based on the information We have. This may result in a denial of a Member's Complaint.

We will send an acknowledgment letter upon receipt of oral or written Complaints no later than five (5) business days after the date of the receipt. The acknowledgment letter will include a description of Our Complaint procedures and time frames. If the Complaint is received orally, We will also enclose a one-page Complaint form, which must be returned for prompt resolution of the Complaint.

We will acknowledge, investigate, and resolve all Complaints within thirty (30) calendar days after the date of receipt of the written Complaint or one-page Complaint form.

The Complaint resolution letter will include the specific reason(s) for Our determination. The response letter will also contain a full description of the process for Appeal, including the time frames for the Appeals process and the time frames for the final decision on the Appeal.

Appeal of Complaints

If the Complainant is not satisfied with Our resolution of the Complaint, the Complainant will be given the opportunity to appear in person before an Appeal panel at the site of which the Member normally receives benefits or at another site agreed to by the Complainant or address a written Appeal to an Appeal panel.

We will send an acknowledgment letter of the receipt of oral or written Appeal from Complainants no later than five (5) business days after the date of the receipt of the Appeal. The acknowledgment letter will include a description of Our Appeal procedures and time frames. If the Appeal is received orally, We will also enclose a one-page Appeal form, which must be returned for prompt resolution of the Appeal.

We will appoint members to the Complaint Appeal panel, which shall advise Us on the resolution of the Complaint. The Complaint Appeal panel shall be composed of one Issuer staff member, one Participating Provider, and one Member. No member of the Complaint Appeal panel may have been previously involved in the disputed decision. The Participating Provider must have experience in the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the Treatment in the area of care that is in dispute and must be independent of any Physician or provider who made any prior determination. If specialty care is in dispute, the Participating Provider serving on the Appeal panel must be a specialist in the field of care to which the Appeal relates. The Member may not be an employee of Issuer.

No later than five (5) business days before the scheduled meeting of the panel, unless the Complainant agrees otherwise, We will provide to the Complainant or the Complainant's designated representative:

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

The Complainant, or designated representative if the Member is a minor or disabled, is entitled to:

- appear before the Complaint Appeal panel in person or by other appropriate means.
- present alternative expert testimony; and
- request the presence of and question any person responsible for making the prior determination that resulted in the Appeal.

Notice of the final decision of the Issuer on the Appeal will include a statement of:

- The specific medical determination.
- The clinical basis for the Appeal's denial.
- The contractual criteria used to reach the final decision.
- The notice will also include the toll-free telephone number and the address of the Texas Department of Insurance.

We will complete the Appeals Process no later than the thirty (30) calendar days after the date of receipt of the written request for Appeal or one-page Appeal form.

Service Area

Your network service is Austin, Bell, Blanco, Bosque, Brazos, Burleson, Burnet, Caldwell, Coke, Coleman, Collin, Concho, Coryell, Crockett, Dallas, Denton, Ellis, Erath, Falls, Fayette, Freestone, Grimes, Hamilton, Hill, Hood, Irion, Johnson, Kimble, Lampasas, Lee, Leon, Limestone, Llano, Madison, Mason, McCulloch, McLennan, Menard, Milam, Mills, Reagan, Robertson, Rockwall, Runnels, San Saba, Schleicher, Somervell, Sterling, Sutton, Tarrant, Tom Green, Travis, Waller, Washington, Williamson.

Network Demographics

The number of members in the Issuer's service area is 128.

The numbers of available Participating Providers in the Issuer's service area for the following provider areas of practice are indicated below:

- Internal medicine – 2,356

- Family/general practice – 3,351
- Pediatric practitioner practice – 2,887
- Obstetrics and gynecology – 1,072
- Anesthesiology – 5,894
- Psychiatry – 731
- General surgery – 502
- There are 212 Participating Hospitals in the Issuer's service area.

Waivers and Local Market Access Plan

A waiver and local market access plan apply to the services furnished by internal medicine, family/general practice, pediatric practitioner practice, obstetrics, gynecology, anesthesiology, psychiatry, general surgery, and hospital services. This access plan may be obtained by contacting the Issuer at **844.633.5325** or through our website, **BSWHealthPlan.com**.

Texas Department of Insurance Notice

- An exclusive provider benefit plan provides no benefits for services you receive from out-of-network providers, with specific exceptions as described in your policy and below.
- You have the right to an adequate network of preferred providers (known as "network providers").
 - If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.
- If your insurer approves a referral for out-of-network services because no preferred provider is available, or if you have received out-of-network emergency care, your insurer must, in most cases, resolve the nonpreferred provider's bill so that you only have to pay any applicable coinsurance, copay, and deductible amounts.
- You may obtain a current directory of preferred providers at the following website: **BSWHealthPlan.com** or by calling **844.633.5325** for assistance in finding available preferred providers. If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.