Access to Care Health Plan (ACHP)

Evidence of Coverage

State Mandated Plan

Off Exchange Health Benefit Plan

THIS IS NOT A CONTRACT OF WORKERS' COMPENSATION PLAN. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS PLAN, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS, WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

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

Within this agreement, the contract holder may be referenced as “You”, “Member” and/ or “Enrollee”.

[Access to Care Health Plan (ACHP)]
[address]
[city, state ZIP]
Toll Free Phone Number: [1-800-xxx-xxxx]
[Website]

Figure: 28 TAC §1.601(a)(2)(B)

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.

[Access to Care Health Plan]

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

Call Member Services at: [1-800-xxxs-xxxx]
Toll-free: [1-800-xxxs-xxxx]
Online: [website]
Email: [complaints email]
Mail: [address]

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Physical Address: 1601 Congress Avenue, Austin, Texas, 78701
PO Box: Consumer Protection, MC: CO-CP P.O. Box 12030, Austin, Texas 78711-2030

¿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.

[Access to Care Health Plan]

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

Llame a: Member Services at: [1-800-xxxs-xxxx]
Teléfono gratuito:[1-800-xxx-xxxx]
En línea: [Website]
Correo electrónico: [Complaints email]
Dirección postal: [address]

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 con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección: 1601 Congress Avenue, Austin, Texas, 78701

Dirección postal: Consumer Protection, MC: CO-CP P.O. Box 12030, Austin, Texas 78711-2030

Figure: 28 TAC §11.1612(c)

Your rights with a Health Maintenance Organization (HMO) plan

Notice from the Texas Department of Insurance

Your plan

Your HMO plan contracts with doctors, facilities, and other health care providers to treat its members. Providers that contract with your health plan are called "contracted providers" (also known as "in-network providers"). Contracted providers make up a plan's network. Your plan will only pay for health care you get from doctors and facilities in its network.

However, there are some exceptions, including for emergencies, when you didn't pick the doctor, and for ambulance services.

Your plan's network

Your health plan must have enough doctors and facilities within its network to provide every service the plan covers. You shouldn't have to travel too far or wait too long to get care. This is called "network adequacy." If you can't find the care you need, ask your health plan for help. You have the right to receive the care you need under your in-network benefit.
If you don't think the network is adequate, you can file a complaint with the Texas Department of Insurance at www.tdi.texas.gov or by calling 800-252-3439.

List of doctors

You can get a directory of health care providers that are in your plan's network.
You can get the directory online at [enter website] or by calling [enter phone number].
If you used your health plan's directory to pick an in-network health care provider and they turn out to be out-of-network, you might not have to pay the extra cost that out-of- network providers charge.

Bills for health care

If you got health care from a doctor that was out-of-network when you were at an in- network facility, and you didn't pick the doctor, you won't have to pay more than your regular copay, coinsurance, and deductible. Protections also apply if you got emergency care at an out-of-network facility or lab work or imaging in connection with in-network care.

If you get a bill for more than you're expecting, contact your health plan. Learn more about how you're protected from surprise medical bills at tdi.texas.gov.

EVIDENCE OF COVERAGE

[Access to Care Health Plan, LLC.]
(Herein called "[Access to Care Health Plan]" or "ACHP")

Hereby certifies that it has issued an Individual Off-Exchange Managed Health Care and Pharmacy Benefits Contract (herein called the "Plan) for qualified Members. Subject to the provisions of the Plan, each Member to whom a [Access to Care Health Plan] Identification Card is issued, shall have coverage under the Plan, beginning on the Effective Date shown on the Identification Card, if timely payment of the total premium due is paid. Issuance of this Evidence of Coverage by [ACHP] does not waive the eligibility and Effective Date provisions stated in the Plan.

Sharon Alvis
Chief Executive Officer,
[Access to Care Health Plan, LLC]

[ACHP] CONTACT INFORMATION

[Access to Care Health Plan]
[2028 E. Ben White Blvd.,
Suite 400
Austin, TX 78741]
Toll Free Phone Number: [1-844-800-4693]

Resource	Contact Information	Accessible Hours
Customer Service	[1-844-800-4693]	Monday-Friday 8:00 a.m. – 5:00 p.m.
Website	[www.ACHP.com]	24 hours /7 days a week
Medical Preauthorizations	[1-855-297-9191]	Monday-Friday, 6:00 a.m. – 6:00 p.m. Weekends and Holidays, 9:00 a.m. - Noon
Suicide & Crisis Lifeline	9-8-8	24 hours /7 days a week

The Schedule of Benefits and Coverage included with this Evidence of Coverage indicates benefits, copayment and amounts, maximums, and other benefits and payment issues that apply to the Plan. [Access to Care Health Plan] provides Managed Health Care Pharmacy Benefit Coverage.

This contract can be returned within 10 days (about 1 and a half weeks) of receiving it, and to have the premium paid refunded if, after examination of the contract the contract holder is not satisfied with it for any reason. If you return the contract to [ACHP] within 10 days (about 1 and a half weeks) it will be considered void from the beginning, and the relation would be as if no contract had been issued. If services are rendered or [ACHP] has paid claims during the 10 days for your services rendered to you, you will be responsible for repaying [ACHP] or the rendering provider for such services or claims.

EVIDENCE OF COVERAGE ENCLOSURE

IMPORTANT NOTICE ENCLOSURE

SCHEDULE OF BENEFITS AND COVERAGE ENCLOSURE

INTRODUCTION

Welcome to [Access to Care Health Plan], a Health Maintenance Organization (HMO) Off Exchange plan. Texas has a standardized set of benefits that are compliant with the Affordable Care Act (ACA) requirements as well as several Texas-mandated benefits.

Coverage is limited to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury and within the scope of coverage described below. The benefits provided are intended to assist you with many of your health care expenses for Medically Necessary services and supplies. There are provisions throughout this Evidence of Coverage (EOC)/ Contract that affect your health care coverage.

The terms "you" and "your" as used in the EOC refer to [ACHP] Members. Use of the masculine pronoun "his," "he," or "him" will be considered to include the feminine unless the context clearly indicates otherwise.

IN-NETWORK BENEFITS

To receive benefits as indicated in your EOC/Contract you must choose in-network providers for all care (other than for Emergency Care and Emergency Transportation). You have elected to enroll in [Access to Care Health Plan (ACHP)]'s Plan. This plan has a special network of Independent Practice Associations (IPA's) and Medical Groups, which includes only a limited number of Plan providers. The [ACHP] Plan's special network is a subset of the entire [ACHP] network. Members enrolled in [ACHP] Plan may only select Personal Physicians and Medical Group/IPAs designated as providers in the special network's directory, which includes general practitioners, family practitioners, internists, obstetricians/gynecologist, and pediatricians. You may access and verify this information on [ACHP]'s website at [Website], or by calling Member Services at [1-800-xxx-xxxx], the telephone number provided on the back of your Member ID card. Please note, a Plan Provider's status may change. It is your obligation to verify whether the provider you choose is a [ACHP] Plan provider; in case there have been any changes since your directory was published. Each eligible Covered Dependent / Family Member may select a different Personal Physicians as long as they are designated as [ACHP] Plan providers in the directory.

You are responsible for paying any copayment amounts (based on the Provider's contracted rate or fee). With a few exceptions, you should not be balanced billed. You may be required to pay for limited or excluded services.

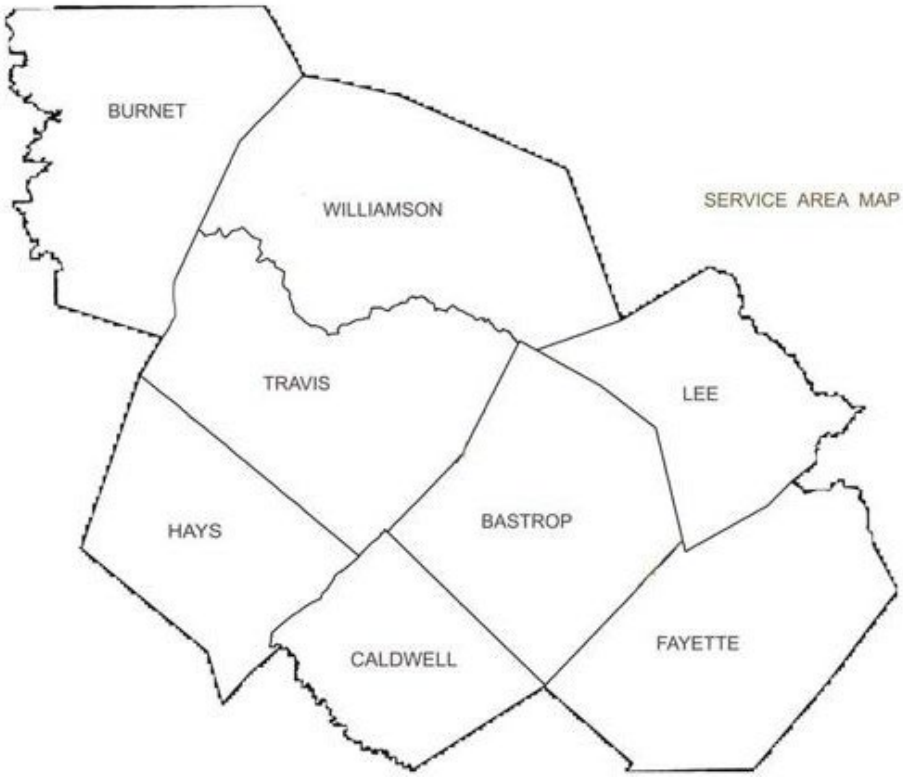
[ACHP] will fully reimburse non-participating providers at the usual and customary rate or at the agreed-upon rate: when services are rendered to an enrollee by a non-network facility-based physician in a network facility, or in circumstances where an enrollee is not given the choice of a network physician or provider for emergency services performed in a non-network facility, and for preapproved (and preauthorized when required) non-emergency services that are not available through an in-network provider.

If you are billed (balance-billed) in these instances, you should contact the plan. The enrollee's responsibility is limited to required copayments.

If you receive Emergency Services at an In-Network Facility and receive a bill from a non-network facility-based physician, or other health care practitioner for Emergency Services, contact [ACHP] at

[1-800-xxx-xxxx]. You should not be balance billed for Emergency Services received at an In-Network Facility. You may be required to submit a copy of the itemized billing statement for investigation purposes.

Copayment amounts may not exceed 50 percent of the total cost of services provided. [ACHP] may not impose copayment charges on any Covered Person in a calendar year when the copayments made by the Covered Person in that calendar year total 200 percent of the total annual premium cost.



Participating Providers (In-Network Providers)

In most instances, there are participating Providers available to provide Medically Necessary services within your [ACHP] Plan. Participating Providers have agreed to accept discounted or negotiated fees. You are responsible for paying the participating Provider for any applicable 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 this EOC/Contract.

When receiving services, you must make sure the Provider is a participating Physician or Participating Provider to avoid any additional out-of-pocket expenses.

Participating Providers are neither agents nor employees of [ACHP] but are independent contractors. [ACHP] conducts a process of credentialing and certification of all Providers who participate in the [ACHP] Plan. However, in no instance shall [ACHP] be liable for the negligence, wrongful acts, or omissions of any person receiving or providing services, including any Physician, Hospital, other provider, or employees of such.

Out-of-Network Services

Unless pre-approved by [ACHP] or rendered as a part of covered Emergency Care, Out-of-Network Benefits are Excluded Services and are not Covered Services by [ACHP]. You are responsible for the full cost of Excluded Services. [ACHP] will approve use of an out-of-network provider if the covered services are not available within the [ACHP] network. Excluded Services do not count toward your copayment or Maximum Out of Pocket amounts.

Approval from [ACHP] to receive services from an out-of-network provider is a benefit coverage decision and is different from a medical necessity Preauthorization. If Medically Necessary Covered Services are not available through an In-Network Provider, your Primary Care Provider (PCP) may ask [ACHP] to allow you to see an Out-of-Network Provider. Some services will also require a separate review for medical necessity Preauthorization (unless your provider holds a preauthorization exemption from [ACHP] for the service). If you receive [ACHP]'s approval to see an Out-of-Network Provider (and, if the service(s) require Preauthorization, [ACHP]'s medical necessity approval), then [ACHP] will fully reimburse the Out-of- Network Provider at the usual and customary rate or at an agreed-upon rate.

When using an Out-Of-Network Provider in the circumstances described above, you are responsible for the Copayment(s) as if the Provider were an In-Network Provider.

[ACHP] mails or otherwise transmits to the requesting Provider a written decision no later than the third calendar day after receipt of a medical necessity Preauthorization request. If the request is for a current hospitalization or inpatient facility care, [ACHP] will communicate whether service (s) are approved within 24 hours after the request is received from the physician or provider. If the preauthorization request is for post- stabilization treatment or a life-threatening condition, [ACHP] will communicate whether services are preauthorized as quickly as possible based on the appropriate delivery of services and the health condition of the member, but not later than one hour after the request is received. [ACHP] follows up within three working days with a decision letter to the member and provider.

Selecting a Primary Care Physician or Provider (PCP)
To ensure access to Services, each Member must select a Primary Care Physician (PCP). Selecting a PCP will provide you with a Medical Home and is important to your overall health. We provide you many options for PCP services. The following Participating Provider types may serve as your PCP:

- General Practice,
- Family Practice,
- Internal Medicine,
- Pediatrics,
- Obstetrical/Gynecology Physicians who notify [ACHP] that they are willing to serve as PCP for selected Members,
- Other Specialty Care Physicians who notify [ACHP] that they are willing to 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, or
- Advanced Practice Nurses (APNs) and Physician Assistants (PAs) when practicing under the supervision of a Physician designated as a PCP, as defined here.

ATTENTION FEMALE ENROLLEES**:** You have the right to select and visit an obstetrician-gynecologist (OB-GYN) without first obtaining a referral from your PCP that is within your health benefits plan network. However, you are not required to select an OB-GYN. You may elect to receive OB-GYN services from your PCP. You may also select an OB-GYN other than your PCP.

If you have a chronic, disabling, or Life-Threatening Illness, you may submit a request to [ACHP] to use a Specialty Care Physician as your PCP. You may make this request by calling [ACHP]'s Member Services telephone number on your Member Identification Card. If your request is denied you have the right to seek a review of the denial through the complaints process. *Refer to the Appeals, Complaints and External Review Rights provision in this Contract for more information*.

Your designated PCP is listed on your member identification card. You may change your PCP online through the Member Portal or by calling [ACHP]'s Member Services at [1-800-xxx-xxxx]. The effective date of the PCP change will be one business day from the date of the request. Depending on the circumstance, [ACHP] can make your PCP change effective immediately if requested by you or your provider's office. In the meantime, your current PCP will continue to coordinate your care. You must arrange to have your/your Dependent's medical files transferred to the new PCP.

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.

When a PCP is Not Available

When your PCP is unavailable, you may need to obtain services from the back- up or on call Participating Provider designated by your PCP. You must make sure that your PCP's on-call physician is a Participating Physician or Participating Provider in [ACHP]'s network to avoid additional out-of-pocket expenses. Please be sure to discuss care arrangements or the process with your PCP for when he or she is out of the office.

Seeing a Specialist

All medical needs should be discussed with your PCP. Wide ranges of Specialty Care Physicians are included in [ACHP]'s network. Some Specialty Care Physicians will require a referral from your PCP. If a member and his or her PCP determine that there is a need to see a Specialty Care Physician, the PCP should refer you to [ACHP]'s Participating Providers only. Be sure to confirm with [ACHP] that the Provider you are referred to is In-Network.

We do require Preauthorization of certain services unless your Provider has been issued a preauthorization exemption from [ACHP]. Visit [ACHP]'s website at [Website], or call Customer Service for a list of services that require Preauthorization.

Seeking Emergency Care Services

If you need Emergency Care:

1. Go to the nearest Participating Hospital Emergency Room in your Plan's network: or
2. Find the nearest Hospital Emergency Room if your condition does not allow you to go to a Participating Hospital in your Plan's network.

[ACHP] will pay for emergency care performed by out-of-network physicians, and/or transportation services in an emergency, at the usual and customary rate or at the agreed-upon rate. Transportation for non-emergency situations must be preauthorized by [ACHP]. In case of an emergency, [ACHP] will provide coverage for the following emergency care:

1. a medical screening examination or other evaluation required by the state or federal law necessary to determine whether an emergency medical condition exists shall be provided to covered enrollees in a hospital emergency facility or comparable facility;

2. necessary emergency care, including the treatment and stabilization of an emergency medical condition; and

3. services originated in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility following treatment or stabilization of an emergency medical condition.

You, or someone on your behalf must call [ACHP] within 48 hours (about 2 days) after your admission to a Non-Participating Hospital/Out-of-Network hospital for Emergency Care. If your condition does not allow you to call us within 48 hours (about 2 days) after your admission, please contact us as soon as your condition allows. We may transfer you to a Participating Hospital in your [ACHP] Plan network when you reach a stable condition. You must see a Participating Provider for any follow-up care. For emergency services provided at a Non-Participating Hospital, we will pay for those services at the usual and customary rate or at an agreed-upon rate.

[ACHP] will fully reimburse non-participating providers at the usual and customary rate or at the agreed-upon rate: when services are rendered to an enrollee by a non-network facility-based physician in a network facility, or in circumstances where an enrollee in not given the choice of a network physician or provider for emergency services performed in a non-network facility, or for pre-approved (and preauthorized where required) non-emergency services that are not available through an in-network provider.

[ACHP] will not impose cost-sharing for such services that are greater than the cost-sharing requirement that would apply if such services had been provided in-network; and shall count such cost sharing toward any in-network out-of-pocket maximum.

If you are balance-billed in these instances, you should contact the Plan. The enrollee's responsibility is limited to required copayments.

If you receive Emergency Services at an In-Network Facility and receive a bill from a non-network facility-based Physician, or other health care practitioner for Emergency Services, contact [ACHP] at [1-800-xxx-xxxx]. You should not be balance billed for Emergency Services received at an In-Network Facility. You may be required to submit a copy of the itemized billing statement for investigation purposes.

Seeking Urgent Care Services

The steps for seeking Urgent Care services are as follow:

1. Contact your PCP or their back-up or on-call physician.

2. If the Primary Care Physician is unavailable, you may go to any Urgent Care Center within the [ACHP] network. You can obtain the names of Participating Provider Urgent Care Centers in your [ACHP] Plan by calling Customer Service or by accessing the Provider directory at [Website].

3. [You can also contact [ACHP]'s Customer Service Department to access 24/7 Virtual Urgent Care through NormanMD. This benefit offers a quick and convenient way to communicate with a doctor 24/7/365 for immediate medical issues. 24/7 Virtual Urgent Care through NormanMD doctors can answer questions, treat common ailments, diagnose minor illnesses, and write prescriptions, if appropriate.]

4. You must receive follow-up services from your Urgent Care Center visit by your PCP or a participating Provider.

5. You must pay any copayment required for Urgent Care Services.

Use of Non-Participating Providers

When an Out-Of-Network Provider receives a Preauthorization as described above, you are responsible for copayments as if the Provider was an In-Network Provider.

Except for emergencies, you must obtain [ACHP]'s pre-approval for out-of-network services when (covered) services are not available within your plan's provider network. For services requiring a medical necessity review and listed on the [ACHP] Prior Authorization list, you must also obtain a medical necessity preauthorization approval from [ACHP] unless your Provider has been issued a preauthorization exemption from [ACHP] for the service(s).

[ACHP] will fully reimburse non-participating Providers at the usual and customary rate or the agreed-upon rate:

1) when services are rendered to an enrollee by a non-network facility-based physician in a network facility, or in circumstances where an enrollee is not given the choice of a network Physician or Provider, and for
2) emergency services performed in a non-network facility, and for
3) preapproved non-emergency services not requiring medical necessity review that are not available from an in-network Provider, and for
4) preauthorized non-emergency services requiring medical necessity review that are not available with an in-network Provider.

If you are balance-billed in these instances, you should contact Customer Service. The enrollee's responsibility is limited to required copayments.

If you receive Emergency Services at an In-Network Facility and receive a bill from a non-network facility-based physician or other health care practitioner for Emergency Services, contact [ACHP] at [1-

800-xxx-xxxx]. You should not be balance billed for Emergency Services received at an In-Network Facility. You may be required to submit a copy of the itemized billing statement for investigational purposes

Not all Healthcare Practitioners who provide services at Participating Hospitals Are Participating Providers. If you receive services from a Non-Participating Provider, we will pay for those services at the usual and customary rate or an agreed-upon rate. This includes, but is not limited to, non-network diagnostic imaging providers, laboratory services, pathologists, anesthesiologists, radiologists and emergency room physicians (facility-based physicians) at a Participating Hospital.

It is your responsibility to verify the network participation status of all Providers prior to receiving all Non-Emergency care. You should verify your [ACHP] Plan's network / provider participation status only with [ACHP] by either calling Customer Service or by accessing [ACHP]'s website at [Website]. We are not responsible for the accuracy, inaccuracy, or miscommunication of network participation representations made by any PCP, Specialty Care Physician, Hospital, or other Provider whether contracted with us or not. For example, if the In-Network Primary Care Physician, Specialty Care Physician, or other Provider recommends services from or at another entity, it is your responsibility to verify the network participation status of that entity before receiving such services. If you do not, and the entity is not a Participating Provider (regardless of what the referring provider may have told you), you will be responsible for all costs incurred unless we have pre-approved and (when required) preauthorized the services provided.

Case Management

Under certain circumstances, the Contract allows [ACHP] the flexibility to offer benefits for certain care or services at its discretion. [ACHP] has in place Care Management Programs for Members with chronic conditions or complex care needs that are appropriate for ongoing education, coaching, or care coordination. [ACHP]'s Care Management team works with You, your family or significant other, and Your Physician or Provider to support and coordinate the services needed to meet your care needs, and to optimize outcomes and value for your health care benefits.

[ACHP], at its discretion, may contact You to offer such benefits, and offer the opportunity to participate in Care Management. Any decision by [ACHP] to provide such benefits shall be made on a case-by-case basis. [ACHP]'s Health Services will initiate case management in appropriate situations. You may also request help from a Health Services team member by calling [ACHP] Customer Service.

Medical Necessity

All services and supplies for which benefits are available under the Contract must be Medically Necessary as determined by [ACHP]. Charges for services and supplies which [ACHP] determines are not Medically Necessary will not be eligible for benefit consideration and may not be used to satisfy or apply to the Out-of-Pocket Maximum.

Preauthorization

Preauthorization establishes in advance the Medical Necessity or Experimental/Investigational nature of certain care and services covered under this contract. It ensures that the preauthorized care and services described below will not be denied on the basis of Medical Necessity or Experimental/Investigational. However, Preauthorization does not guarantee payment of benefits, nor does it guarantee coverage for the service or procedure. Actual availability of benefits is always subject to other requirements of the Contract, such as, limits on the number or type of services covered, limitations and exclusions, payment

of premium, and eligibility at the time care and services are provided.

For Prescription Drugs, Preauthorization is a confirmation of the dosage, quantity, and duration as appropriate for the Member's age, diagnosis and gender. [ACHP] preauthorizes a service(s) or Prescription Drug(s). [ACHP] may not deny or reduce payment to the Healthcare Practitioner based upon medical necessity or appropriateness of care. However, if the proposed service(s) or Prescription Drug(s) requested by the Healthcare Practitioner has materially been misrepresented, or if the Practitioner has substantially failed to perform the proposed services, the services will not be covered and [ACHP] may deny or reduce payment to the Healthcare Practitioner accordingly.

With some exceptions, Preauthorization approvals for certain prescription drugs with a treatment period of more than 12 months, such as for autoimmune diseases, hemophilia, or Von Willebrand disease will be issued once a year.

All benefits payable under this Contract must be for services, including preventive services, or Prescription Drugs that are Medically Necessary. Preauthorization is required for certain services and Prescription Drugs (unless your Provider has been issued a preauthorization exemption from [ACHP]). The list of services and Prescription Drugs that require Preauthorization is subject to change. Visit our Web site at [Website], or call Customer Service to obtain a current list of services that require Preauthorization or the Prescription Drug Formulary that indicates when Preauthorization is required for Prescription Drugs. Coverage provided in the past for services or Prescription Drugs that did not receive or require Preauthorization is not a guarantee of future coverage of the same service or Prescription Drug.

Your Physician or Provider must contact [ACHP] by telephone, electronically or in writing to request the appropriate preauthorization. [ACHP] allows a renewal of an existing preauthorization to be requested by your Physician or Provider at least 60 days before the date the preauthorization expires. If [ACHP] received a preauthorization renewal request before the existing preauthorization expires, [ACHP], if practicable, will review the request and issue a determination indicating whether the requested renewal is preauthorized before the existing preauthorization expires. [ACHP] may not require a physician or provider to obtain preauthorization for a particular health care service if the physician or provider has been issued a preauthorization exemption for certain health care services.

The telephone number to call to request a preauthorization is on your member identification card and on [ACHP]'s Preauthorization Form located on the [ACHP] website.

Facilities are required to Notify [ACHP] for the following:

1. All urgent Inpatient Hospital admissions, including behavioral health, except for maternity and breast cancer minimum stays listed below

Preauthorization is not required in these situations for In-Network Maternity Care and Treatment of Breast Cancer unless extension of minimum length of stay is requested and medically necessary, as follows:

Maternity Care

1. 48 hours (about 2 days) following an uncomplicated vaginal delivery
2. 96 hours (about 4 days) following an uncomplicated delivery by caesarean section

Treatment of Breast Cancer

1. 48 hours (about 2 days) following a mastectomy
2. 24 hours following a lymph node dissection

Preauthorization will not be required in these situations for a length of stay less than those listed above or if your provider has been issued a preauthorization exemption for these services from [ACHP]. If you require a longer stay, your Provider must seek an extension for the additional days by obtaining Preauthorization from [ACHP].

Failure to Preauthorize

If you or your provider fails to obtain Preauthorization as described in this EOC and the current Prior Authorization List, then [ACHP] will deny payment for these services.

A current Prior Authorization List containing notification timeframes can be found on the [ACHP] website at https://[Website]/providers. Click the "Prior Authorizations" tab, then click the "Quick Reference Guide". You can also request a current Prior Authorization List by contacting [ACHP] at [1-800-xxx-xxxx], Monday – Friday, between 8:00 AM -5:00 PM, or sending an email request to [Customer Service email address].

ELIGIBLE EXPENSES, PAYMENT OBLIGATIONS, AND BENEFITS

Benefits and Eligible Expenses

The Plan provides coverage for the following categories of Benefits, which are detailed in subsequent sections:

- Essential Health Benefits
- Prescription Drug Benefits
- Ambulance and Emergency Services
- Maternity Care and Newborn Services
- Preventive Services and Wellness Care
- Special Provisions Benefits
    - Acquired Brain Injury
    - Pediatric Dental Services
    - Diabetes Services Benefits
- Durable Medical Equipment/Orthotics/Prosthetic Devices
- Fertility preservation services related to cancer treatment, including collection an preservation of sperm, unfertilized oocytes, and ovarian tissue, not including storage of genetic materials.
- Healthcare Treatment Facility Service Benefits
- HealthCare Practitioner Medical-Surgical Service Benefits
- Extended Care Benefits
    - Home Health Care

    - Skilled Nursing Facility
    - Hospice Care (Home and Facility)
- Home Infusion Therapy Benefits
- Behavioral Health and Substance Use Disorder Benefits
- Rehabilitative and Habilitative Therapy Benefits
- Inpatient Hospital Benefits
- Other Medical-Surgical Benefits

Your benefits are calculated on a calendar year benefit period basis unless otherwise stated. At the end of a calendar year, a new benefit period starts for each Member.

Refer to the General Exclusions and Prescription Drug Exclusions sections in this Contract for further details on exclusions. All terms and provisions of this Contract, including the Preauthorization requirements specified in this Contract, are applicable to Covered Services. Cost sharing and limitations depend on type and site of service.

COVERED MEDICAL SERVICES

Essential Health Benefits and Basic Health Care Services
You and Your Covered Dependents are entitled to the following medically necessary Essential Health Benefits and Basic Health Care Services without being subject to Annual or Lifetime limitations:

- Ambulatory patient services, including:
    - Primary care and specialist physician services;
    - Outpatient services by other providers;
    - Home health services;

- Emergency services
    - Emergency services as required by Texas Insurance Code §1271.155

- Hospitalization

    - Inpatient hospital services, including room and board, general nursing care, meals and special diets when medically necessary, use of operation room and related facilities, use of intensive care unit and services, x-ray services, laboratory and other diagnostic tests, drugs, medications, biologicals, anesthesia and oxygen services, private duty nursing when medically necessary, radiation therapy, inhalation therapy, whole blood including administration and cost of blood, blood plasma, and blood plasma expanders, that are not replaced by or for You or Your Covered Dependents, and short-term rehabilitation therapy services in the acute hospital setting.

    - Inpatient physician care services, including services performed, prescribed, or supervised by physicians or other health professionals including diagnostic, therapeutic, medical, surgical, preventive, referral, and consultative health care services.

- Outpatient hospital services, including treatment services; ambulatory surgery services; diagnostic services, including laboratory, radiology, and imaging services; rehabilitation therapy; and radiation therapy.

- Maternity and newborn care, including prenatal services, breastfeeding services, and birth control services.

- Mental health and substance use disorder services, including behavioral health treatment

- Prescription drugs

- Rehabilitative and habilitative services and devices, including:
  - Outpatient rehabilitation therapies including physical therapy, speech therapy, manipulative, and occupational therapy

- Laboratory services
- Diagnostic and Therapeutic Radiology Services including:
  - Diagnostic services, including laboratory imaging and radiologic services
  - Therapeutic radiology services
  - Evidence-based Biomarker testing for diagnosis, treatment, management, and/or monitoring of a covered disease or condition. This testing must inform a member's outcome or guide treatment decisions. In addition, [ACHP] will provide coverage in a manner that limits disruption in care, including limiting the number of biopsies and biospecimen samples.

- Preventive and wellness services and chronic disease management, including:
  - Periodic health examinations for adults as required in the Insurance Code §1271.153
    - Annual physical coverage is set as once per calendar year.
  - Immunizations for children as required in the Insurance Code §1367.053
  - Cancer screening as required in the Insurance Code Chapter 1356 relating to mammography
  - Cancer screening as required in the Insurance Code Chapter 1362 relating to screening for prostate cancer
  - Immunization for adults in accordance with the United States Department of Health and Human Services Center for Disease Control Recommended Adult Immunization Schedule by Age Group and Medical Conditions, or its successor

- Pediatric services, including
  - Oral and vision care, consisting of screenings and examinations (as detailed below);
  - Well-child care from birth as required in the Insurance Code §1271.154;
  - Eye and ear examinations for children through age 21, to determine the need for vision and hearing corrections in accordance with established medical guidelines

If a Covered Service is an Essential Health Benefit, [ACHP] will not apply annual or lifetime dollar limits to that service.
The remainder of this Agreement describes the Covered Services We will provide, which may or may not

be considered Essential Health Benefits.

Prescription Drug Benefits

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

[ACHP] prohibits step therapy for prescription drugs used to treat stage four-advanced metastatic cancer. This prohibition only applies to an FDA approved drug when its use is consistent with best practices for the treatment of stage four-advanced metastatic cancer or an associated condition and is supported by peer-reviewed, evidence-based literature.

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

The amount paid by [ACHP] to the dispensing Pharmacy may not reflect the ultimate cost to [ACHP] for the drug. Prescription Drug Copayments are made on a Prescription or refill basis and will not be adjusted if we receive any retrospective volume discounts or Prescription Drug rebates. This reference applies to the amount paid by and on behalf of Sendero, this does not pertain to the member's cost share amounts, nor to statutory requirements as it relates to member cost-shares.

We must be notified of any Cost Share that is applicable to a Member's claim that is waived or reduced by the Pharmacy. For covered drugs, ACHP must apply any third-party payment, financial assistance, discount, product voucher, or other reduction in out-of-pocket expenses made by or on behalf of an enrollee for a prescription drug to the enrollee's deductible, copayment, cost-sharing responsibility, or out-of-pocket maximum applicable to health benefits under the enrollee's plan.

Members requesting higher tier 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. This cost difference does not apply to any Out-of-Pocket Maximum.

The Specialty Pharmacy program is part of your pharmacy benefit and is mandatory after your first fill of a specialty drug at a retail pharmacy. [PBM] Specialty Rx works with a specialty pharmacy to offer services with the highest standard of care. Should you wish to use an alternative Specialty Pharmacy, verify if Your Prescription Drug meets the Rx Specialty requirements by contacting [PBM Specific toll number].

With [PBM Specialty Rx], delivery of your specialty medications is free, either right to your door or to the prescriber's office via FedEx. Local courier service is available for emergencies, same-day medication needs. To start using [PBM] Specialty Rx, call toll-free [PBM Specialty RX toll free number]. We will work with your prescriber for current or new specialty prescriptions.

Covered Prescription Drugs available with a prescription from a health care practitioner are:

1. Drugs prescribed to treat a chronic, disabling, or life-threatening illness that:

    a) have been approved by the United States Food and Drug Administration (FDA) for at least one indication; and

b) are recognized by the following for the treatment of the indication for which the drug is prescribed
    a. (1) a prescription drug reference compendium approved by the Department of Insurance, or
    b. (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 Diabetes Supplies that are included on the Drug Formulary;
5. Hypodermic needles or syringes for use with insulin of Self-Administered Injectable Drugs that are included on the Drug Formulary.
6. Hypodermic needles, syringes or other methods of delivery necessary for administration of a Specialty Drug, if included with the charge for the Specialty Drug.
7. Hypodermic needles and syringes used in conjunction with covered drugs may be available at no cost to the Member;
8. Specialty drugs and Self-Administered Injectable Drugs that are included on the Drug Formulary approved by [ACHP] limited to a 30-day supply, unless otherwise determined by [ACHP];
9. Drugs, medicines or medications required under the Affordable Care Act;
10. Enteral formulas and nutritional supplements necessary for the treatment of phenylketonuria (PKU) or other inherited metabolic diseases that are included on the Drug Formulary.
    a) PKU or a heritable disease is provided to the same extent that coverage is provided for drugs that are available only on the order(s) of a physician.
11. Prescribed, orally administered anticancer medication that is used to kill or slow the growth of cancerous cells;
12. Amino acid-based elemental formulas, regardless of delivery method, when Medically Necessary for the treatment of:

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

13. Pacers and/or peak flow meters for the treatment of asthma.

The most prescribed drugs covered by [ACHP] are specified on [ACHP]'s Drug Formulary. The Drug Formulary identifies drugs by category. It also indicates Dispensing Limits and any applicable Preauthorization or Step Therapy requirements for pharmacy benefits. A Pharmacy and Therapeutics committee made up of Physicians and Pharmacists reviews this information on a regular basis. 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 or substance use disorder or condition.

You can obtain a copy of [ACHP]'s Drug Formulary by visiting [Website] or calling [PBM]' Member Services telephone number on your member identification card. If a specific prescription drug is not listed on the Drug Formulary, you may contact [ACHP] orally or in writing to request a Standard Exception

Request to determine whether a specific drug is included in our Drug Formulary. We will respond to your request within 72 hours (about 3 days) of receiving the request. If we do not approve coverage for a prescription drug because it is not on the Drug Formulary, you have the right to appeal that decision.

You may request an Expedited Exception Request. The Expedited Exception Request can be requested by a Member, a Member Representative or a Member's Prescribing Provider, due to an exigent circumstance. An exigent circumstance exists when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug. [ACHP] will decide to an Expedited Exception Review based on exigent circumstances and notify the Member, Member Representative or the Member's Prescribing Provider of its coverage determination no later than 24 hours following receipt of the request. When [ACHP] grants an exception based on exigent circumstances, [ACHP] must provide coverage of the non-formulary drug for the duration of the exigency.

If [ACHP] denies the Standard Exception Request or denied the Expedited Exception request, you may request an External Exception Request Review. *Please refer to the External Review Rights process in the General Provisions section.*

[ACHP] will assist with synchronizing refills for maintenance of prescription drugs and allow for prorated cost sharing amounts for partial supplies of certain prescription drugs. If you have any questions, contact [ACHP]'s Customer Service department. As a Covered Person, you are only required to make a payment that is the lesser of your copayment, the allowable claim amount, or the amount you would pay if purchasing the prescription drug without health benefits or discounts.

[ACHP] will review your or your prescribing physician's request to expedite an exception request due to exigent circumstances. [ACHP] will review these cases on an urgent timeline and provide a determination no later than 24 hours following receipt of the request.

[ACHP] will not impose a copayment or other cost-sharing provision applicable to benefits for prescription contraceptive drugs, outpatient contraceptive services, or devices. Covered contraceptive drugs may be obtained as a 3-month supply for the first fill; then may be obtained as a 12 month supply thereafter.

In urgent situations for chronic, complex, rare or life-threatening conditions, [ACHP] will not limit to specific pharmacies for dispensing associated medications, require administration of such medication in any particular setting, nor require higher member cost-share based on choice of pharmacies.

Chronic Eye Disease eye drops are dispensed at a 30/60/90-day supply. For more information, please contact the Customer Service Pharmacy Line at [1-866-333-2757]. Mail order is available for [ACHP] members.

Prescription Drug coverage is subject to change. Any prescription drug that was approved or covered under the plan for a medical condition or mental illness, regardless of whether the drug has been removed from the health benefit plan's drug formulary before the plan renewal date, will continue to be offered at the contracted benefit level and until the plan's renewal date, with the exception of when a medication is taken off the market due to safety issues.

Based on State law, advanced written notice to you is required for the following modifications that affect Prescription Drug coverage:

1. Removal of a drug from the Drug Formulary;
2. Requirement that You receive Preauthorization 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.

The examples above will be implemented at the renewal of the EOC/Contract. We will provide written notice no later than 60 days (about 2 months) prior to the Effective Date of the change.

The Utilization Review shall provide notice of an adverse determination for a concurrent review of the provision of prescription drugs, or intravenous infusions for which the patient is receiving health benefits under the Evidence of Coverage, no later than the 30th day before the date on which the provision of prescription drugs or intravenous infusions will be discontinued.

This section does not prohibit a physician or other health professional who is authorized to prescribe a drug from prescribing an alternative to a drug for which continuation of coverage is required under Subsection

(a) if the alternative drug is:

(1) covered under the health benefit plan; and

(2) medically appropriate for the enrollee.

Office, Clinic, or Home-Administered Injectable or Infusible Drugs

Prescription drugs which are dispensed and/or administered to a member in the office of an In-Network Physician or Provider or in another Outpatient setting, will be covered as part of Your Medical Services benefit. These are often infusion or injectable medications. No additional Copayments are required for outpatient prescription drugs so dispensed and administered. These drugs may require Preauthorization by a Medical Director, and may require step therapy, to be covered as part of Your Medical Services benefit. Because they are not available at an outpatient pharmacy, these drugs are not listed in our Drug Formulary.

Ambulance Transportation Services

Non-emergency ground ambulance transportation is a covered benefit when Preauthorized and determined to be Medically Necessary by [ACHP] for transporting a member who is unable to be transported by alternative means (e.g., Member is unable to sit upright independently), between facilities and from facility-to-home.

Specific Transportation Services

Air ambulance transportation is covered when **all** the following apply:
1. The member is being transported to the nearest acute care hospital equipped to treat the member's condition, including non-emergency air ambulance services;
2. The member's destination is an acute care hospital, and the sending facility does not have the required services to treat the member.
3. The transport is to an appropriate contracted facility unless there is no appropriate contracted facility available to treat the member's condition.
4. Ground transport would not be clinically appropriate for the severity or urgency of the member's condition.

Emergency Services

Covered Services are 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-upon rate when you receive care due to a medical emergency.

If you receive Emergency Services at an In-Network Facility and receive a bill from a non-network facility-based physician, or other health care practitioner for Emergency Services, contact [ACHP] at [1-800-xxx-xxxx]. You should not be balance billed for Emergency Services received at an In-Network Facility. You may be required to submit a copy of the itemized billing statement for investigation purposes.

Maternity Care and Newborn Services

Prenatal, delivery and inpatient services for Maternity Care and postnatal Care are Covered Services. Covered Services for a Dependent newborn child include but are not limited to, the following:

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

Maternity services include prenatal care, delivery, and postnatal treatment and pregnancy complications.

Prenatal and postnatal care are covered benefits. You may have a copayment for the initial prenatal visit. Laboratory, ultrasound, genetic testing and/or other medical service requested or provided by your Provider are subject to a copay.

Delivery benefits for vaginal deliveries include the first 48 hours (about 2 days) for the mother and newborn. For cesarean section delivery, the first 96 hours (about 4 days) for the mother and newborn are covered. Delivery and all inpatient services, are covered benefits and are subject to a copayment.

[ACHP] provides coverage for post-delivery care:

a. If a decision is made to discharge a woman who has given birth to a child or the newborn child from inpatient care before the expiration of the minimum hours of coverage, [ACHP] must provide coverage to the woman and child for timely post-delivery care.
b. The timeliness of the post-delivery care shall be determined in accordance with recognized medical standards for that care.
c. The post-delivery care may be provided by a physician, registered nurse, or another appropriate licensed health care provider.

The post-delivery care may be provided at:

1. The woman's home;
2. A health care provider's office;
3. A health care facility; or
4. Another location determined to be appropriate under rules adopted by the commissioner.

Out of network prenatal care, postnatal care, delivery and all inpatient services are not covered benefits without pre-approval from [ACHP] for services rendered outside of the network.

Preventive Services and Wellness

Preventive Services for adults, women, and children are covered as recommended by the U.S. Department of Health and Human Services (HHS) or as mandated by the State of Texas. This does not include Routine Nursery Care.

Preventive care services will be provided for the following covered services, and In-Network Preventive Care will not be subject to Copayment or Cost share:

a. 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 (USPSTF);
b. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention (CDC) with respect to the individual involved;
c. Evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents; and
d. With respect to women, such additional preventive care and screening, not included or described in item (a) above, as provided for in comprehensive guidelines supported by HRSA.

For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009).

The preventive services described in items (a) through (d) above may change as USPSTF, CDC, and HRSA guidelines are modified.

For questions on which Preventive Services are covered under Your Contract, refer to HHS at www.HHS.gov or call [ACHP]'s Customer Service telephone number on the back of Your Member Identification Card.

Covered services not included in items (a) through (d) above, and not included in the detailed lists below, will be subject to Copayment and Cost-share.

The determination of whether a service is a Preventive Service may be influenced by the type of service for which your Physician or Provider bills [ACHP]. Specifically: (1) if a recommended preventive service is billed separately from an office visit, then [ACHP] may impose cost-sharing requirements with respect to the office visit, (2) if a recommended preventive service is not billed separately from an office visit and the primary purpose of the office visit is the delivery of the preventive service, then a plan may not impose cost-sharing requirements with respect to the office visit, and (3) if a recommended preventive service is not billed separately from an office visit and the primary purpose of the office visit is not the delivery of a preventive service, then Health Plan may impose cost-sharing requirements with respect to the office visit.

Coverage of Counseling, or Screening, for a particular condition or disease as a Preventive Service does not mean treatment of that particular condition or disease.

While the Counseling or Screening visit may be a Preventive Service and thus not subject to Copayments, the treatment of such condition or disease will be subject to appropriate Copayments, and to the Exclusions and Limitations provisions of the Health Plan.

Preventive care benefits for adults

The following services are provided under the preventive benefit at zero copay.

1. Falls prevention (with exercise intervention) for adults 65 years and over who are at increased risk of falls.
2. Health Risk assessment every three years.
3. PrEP (pre-exposure prophylaxis) HIV prevention medication for persons who are at increased risk of HIV acquisition to decrease risk of acquiring HIV
4. Immunizations for adults (doses, recommended ages, and recommended specific populations vary), per the current ACIP and CDC-recommended immunization schedule for adults (ages 19 and older):
    a. COVID-19
    b. Haemophilus influenza type b
    c. Hepatitis A
    d. Hepatitis B
    e. Human Papillomavirus (HPV)
    f. Measles, Mumps, Rubella
    g. Meningococcal A, C, W, Y
    h. MPox (Poxvirus)
    i. Pneumococcal
    j. Respiratory Syncytial virus
    k. Tetanus, diphtheria, pertussis
    l. Varicella (Chickenpox)
    m. Zoster Recombinant
5. Screenings
    a. Abdominal aortic aneurysm one-time screening for men of specified ages (age 65 to 75) who have ever smoked
    b. Atherosclerosis screening: For males age 45 to 75 years and females age 55 to 76 years with diabetes or risk of developing coronary heart disease: coverage up to $200 for one (1) of the following screenings every five (5) years:
        i. A computed tomography (CT) scanning measuring coronary artery calcification; or
        ii. An ultrasonography measuring carotid intima-media thickness and plaque;
    c. Blood Pressure screening with office blood pressure measurement.

d. Colorectal cancer screening for adults of certain ages or higher risk adult members aged of 45 years and older who are at normal risk of colorectal cancer are eligible for medically recognized screening examinations for the detection of colorectal cancer, including all colorectal cancer examinations assigned a grade of "A" or "B" by the United States Preventive Services Task Force for average-risk individuals, including the services that may be assigned a grade of "A" or "B" in the future; and an initial colonoscopy or other medical test or procedure for colorectal cancer screening and a follow-up colonoscopy if the results of the initial colonoscopy, test, or procedure are abnormal.
    i. an annual colorectal cancer screening test with fecal occult blood test (i.e., high-sensitivity guaiac fecal occult blood test, or gFOBT), or fecal immunochemical test (FIT); or
    ii. An sDNA-FIT test performed every 3 years; or
    iii. a flexible sigmoidoscopy performed every 5 years; or
    iv. a CT colonography every 5 years
    v. a colonoscopy every 10 years. [ACHP] may impose a cost-sharing requirement for coverage described by this section only if the enrollee obtains the covered benefit or service outside the plan's network.
e. Depression screening for adults, including pregnant and postpartum persons, as well as older adults.
f. Diabetes (Type 2) and prediabetes screening for adults aged 35 to 70 years who are overweight or obese;
g. Prostate Specific Antigen test (PSA) annual test for a male aged 50 years and over and for a male aged 40 or older with a family history of prostate cancer or another prostate risk factor.
h. Syphilis screening for adults at increased risk
i. Tobacco use screening for all adults and behavioral and pharmacotherapy cessation interventions for tobacco users;
j. Tuberculosis screening for latent tuberculosis for certain adults, without symptoms, at high risk including those who:
k. Were born in or have lived in a country where TB is common
l. Live or have lived in a high risk congregate setting such as homeless shelter or correctional facility.
m. Hepatitis B screening for Adults at increased risk of infection
n. Hepatitis C screening for adults aged 18 to 79 year
o. Human Immunodeficiency Virus (HIV) screening for everyone ages 15 to 65, and older adults at increased risk
p. Lung cancer screening for adults aged 50-80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years
q. Behavioral counseling for adults who are at increased risk for sexually-transmitted infections
r. Unhealthy alcohol use screening and brief behavioral counseling
s. Unhealthy drug use screening assessment questions

6. Skin cancer prevention behavioral counseling for those aged 18 to 24 years with fair skin
7. Statin preventive medication for adults 40 to 75 with one or more risk factor for cardiovascular disease.

Preventive care benefits for women

8. Breast cancer risk assessment, genetic counseling (BRCA) and genetic testing for women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or an ancestry associated with brca ½ gene mutation Breast cancer mammography screenings every 1 to 2 years for women over 35
9. Contraception - Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for adolescent and adult women with reproductive capacity (not including abortifacient drugs)
10. Pregnancy related benefits
    a. Breastfeeding comprehensive support and counseling from trained providers (only covered under the mother), as well as access to breastfeeding supplies, for pregnant and nursing women during pregnancy and after birth, including but not limited to:
        i. Lactation support services (including consultation, counseling, education by clinicians and peer support services, and breastfeeding equipment and supplies) during the antenatal, perinatal, and postpartum periods. Breast pump limitation is one per birth.
    b. Folic Acid supplements for women who may become pregnant
    c. During pregnancy screenings:
        i. Blood pressure screening for pregnant women throughout pregnancy.
        ii. Gestational diabetes screening for women at 24 weeks of pregnancy or after for those pregnant
        iii. Hepatitis B screening for pregnant women at their first prenatal visit
        iv. HIV Screening during pregnancy, or at delivery if HIV status is unknown
        v. Rh incompatibility screening for all pregnant women during their first pregnancy-related visit and follow-up testing during weeks 24 to 28 for those at higher risk
        vi. Syphilis screening early in each pregnancy.
        vii. Unhealthy alcohol use screening and brief behavioral counseling
11. Screenings for all women
    a. Breast cancer mammography screenings annually for women age 35 and over
    b. Cervical cancer screening
        i. Cervical cancer screening with cervical cytology alone (Pap test, a Pap smear) every 3 years for women ages 21 to 29
        ii. Cervical cancer screening with cervical cytology alone every 3 years for women aged 30 to 65 years or every 5 years with high-risk human papillomavirus (hrHPV) testing alone or every 5 years with hrHPV testing in combination with cytology (cotesting).
    c. Domestic and interpersonal violence screening and counseling for all women: Intimate Partner Violence, Screening: women of reproductive age for all sexually

active women 24 years or younger and in women 25 years or older who are at increased risk for infection.

d. Osteoporosis screening with bone density testing for women 65 years and older to prevent osteoporotic fractures, and for postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool
e. Tobacco use screening, counseling and behavioral intervention for pregnant tobacco users

12. Annual Well Woman Exam – including detection of human papillomavirus, cervical cancer and ovarian cancer screening for woman ages 18 years and over. This includes any other test or screening approved by the United States Food and Drug Administration for the detection of human papillomavirus and ovarian cancer. Well-women visits also include pre-pregnancy, prenatal, postpartum, and interpregnancy visits.

Preventive care benefits for children and adolescents

13. Counseling
    a. Behavioral counseling for all sexually active adolescents regarding risk of sexually-transmitted infections.
    b. Skin cancer prevention behavioral counseling for those aged 6 months and older with fair skin.
    c. Tobacco use prevention education or counseling, school-aged children and adolescents
    d. Unhealthy alcohol use and brief behavioral counseling.

14. Immunizations for children from birth to age 18 (doses, recommended ages, and recommended specific populations vary), per the appropriate, current ACIP and CDC-recommended immunization schedule:
    a. COVID-19
    b. Dengue
    c. Diphtheria, Tetanus, Pertussis (Whooping Cough)
    d. Haemophilus influenza type b
    e. Hepatitis A
    f. Hepatitis B
    g. Human Papillomavirus (HPV)
    h. Inactivated Poliovirus (IPV)
    i. Measles, Mumps, Rubella
    j. Meningococcal
    k. Mpox (Poxvirus)
    l. Pneumococcal conjugate
    m. Respiratory syncytial virus (RSV)
    n. Rotavirus
    o. Tetanus, diphtheria & acellular pertussis (Tdap >= 7 years)
    p. Varicella (Chickenpox)

q. Age-appropriate routine and catch-up immunizations for children from birth to age 18 years old, per the current childhood immunization schedule of the U.S. CDC and ACIP

15. Ocular prophylaxis (eye infection prevention medication) for all newborns
16. PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adolescents at high risk for getting HIV through sex or injection drug use.
17. Screenings
    a. Cervical dysplasia screening for sexually active females
    b. Chlamydia and Gonorrhea screening, sexually active females
    c. Lead screening for children at risk of exposure
    d. Hepatitis B screening for Adolescents at increased risk of infection
    e. Major depressive disorder screening in adolescents aged 12 to 18 years
    f. Newborn screening test for heritable conditions, including the cost of a test kit in the amount required by Texas Health and Safety Code § 33.019
    g. Newborn Hearing Screening up to 30 days of age, and necessary diagnostic follow-up care related to the screening test through 24 months of age
    h. Obesity screening and counseling children and adolescents age 6 years and older
    i. Regular screenings for children and adolescents as recommended by their provider
    j. Sexually transmitted infection (STI) prevention counseling and screening for active adolescents
    k. Syphilis screening for adolescents at increased risk
    l. Vision screening at least once in children ages 3 to 5 years to detect amblyopia or its risk factors

Your Contract Benefits Management

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

If you obtain services that are **not** covered, 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.

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. There are no Copayments for Preventive Services.

A Member 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.

A Member 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:

1. If the provider was terminated due to reason of medical competence or professional behavior;
2. After the 90th day after the Effective Date of the provider 's termination; or
3. After the expiration of the nine-month period after the effective date of the provider 's termination if the Member was diagnosed as having a terminal Illness at the time of the termination.

Continuity of care is available for a Member who:

1. is undergoing a course of treatment for a serious and complex condition from the provider or facility;
2. is undergoing a course of institutional or inpatient care from the provider or facility;
3. is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
4. is pregnant and undergoing a course of treatment for the pregnancy including through delivery, immediate postpartum care and a check-up within the six-week period after delivery; or
5. is or was determined to be terminally ill and is receiving treatment for such illness from such provider or facility.

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

Acquired Brain Injury

Rehabilitative and habilitative therapy services that are Medically Necessary for the treatment of an Acquired Brain Injury are Covered Services. These services include, but are not limited to, Cognitive Rehabilitation Therapy, Cognitive Communication Therapy, Neurocognitive Therapy and Rehabilitation, Neurobehavioral, Neuropsychological, Neuropsychological and Psychophysiological Testing and Treatment, Neurofeedback Therapy, Remediation required for and related to treatment of an Acquired Brain Injury and Post-Acute Transition Services, and Community Integration Services. In addition, services may also include outpatient day treatment services or other Post-Acute Treatment Services if such services are necessary as they relate to an Acquired Brain Injury. Reasonable expenses related to periodic reevaluation of the care of an individual who:

a. has incurred an Acquired Brain Injury;
b. has been unresponsive to treatment; and
c. 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, the home, or in 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, 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 Brian Injury; service means the work of testing, treatment, and providing therapies to an individual with an Acquired Brain Injury.

Dental Services

Routine dental services, including an annual dental exam, are covered benefits, only for:

a. Pediatric Members up to the age of 19 (coverage will end on the last day of the month in which the Member turns 19).

Except as specified immediately above, Dental services are not provided except for:

a. Care or treatment due to an external, accidental injury to sound natural teeth and supporting tissue;
b. dental care or treatment provided to a newborn child which are necessary to correct or treat a congenital defect, disease or anomaly was deleted
c. or [ACHP] 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.

Diabetes Services Benefits

Benefits are available and will be determined on the same basis as any other sickness for those Medically Necessary items for Diabetes Equipment and Diabetes Supplies (for which a Physician or Provider has written an order) and Diabetic Management Services/Diabetes Self-Management Training. Such items, when obtained for a Member, shall include but not be limited to the following:

Prescription Drugs for the treatment of diabetes are covered under the Prescription Drug provision.

1. Blood Glucose Monitors (including, when medically necessary, noninvasive glucose monitors, continuous glucose monitors, and monitors for visually impaired);

2. Insulin pumps (both external and implantable) and associated equipment, which include:
   a. Insulin infusion devices
   a. Batteries
   b. Skin preparation items
   c. Adhesive supplies
   d. Infusion sets
   e. Insulin cartridges
   f. Durable and disposable devices to assist in the injection of insulin and
   g. Other required disposable supplies

3. Podiatric appliances, including up to two pairs of therapeutic footwear per Calendar Year, for the prevention of complications associated with diabetes.

b. Diabetes Supplies and Services

1. Test strips specified for use with a corresponding blood glucose monitor
2. Lancets and lancet devices
3. Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein

4. Insulin and insulin analog preparations
5. Injection aids, including devices used to assist with insulin injection and needleless systems
6. Insulin syringes
7. Biohazard disposable containers
8. Prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and
9. Glucagon emergency kits.

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

d. As new or improved treatment and monitoring equipment or supplies become available and are approved by the U. S. Food and Drug Administration (FDA), such equipment or supplies may be covered if determined to be Medically Necessary and appropriate by the treating Physician or Professional Other Provider who issues the written order for the supplies or equipment.

e. Retinal eye exam for all members with Diabetes are covered with no Co-Pay (as listed above in Preventive Services). The exam is to screen for diabetic retinal disease and is covered annually, when provided by an Eye Care Professional.

f. Medical-Surgical Expense provided for the nutritional, educational, and psychosocial treatment of the Qualified Participant. Such Diabetic Management Services/Diabetes Self-Management Training for which a Physician or Professional Other Provider has written an order to the Participant or caretaker of the Participant is limited to the following:
    a. when rendered by or under the direction of a Physician.

g. Initial and follow-up instruction concerning:
    1. The physical cause and process of diabetes;
    2. Nutrition, exercise, medications, monitoring of laboratory values and the interaction of these in the effective self-management of diabetes;
    3. Prevention and treatment of special health problems for the diabetic patient;
    4. Adjustment to lifestyle modifications; and
    5. Family involvement in the care and treatment of diabetic patients. The family will be included in certain sessions of instruction for the patient.

Diabetes Self-Management Training for the Qualified Participant will include the development of an individualized management plan that is created for and in collaboration with the Qualified Participant (and/or his or her family) to understand the care and management of diabetes, including nutritional counseling and proper use of Diabetes Equipment and Diabetes Supplies.

A Qualified Participant means an individual eligible for coverage under this Contract who has been diagnosed with (a) insulin dependent or non-insulin dependent diabetes, (b) elevated blood glucose levels induced by pregnancy, or (c) another medical condition associated with elevated blood glucose level (e.g., metabolic syndrome).

[ACHP] will provide coverage for emergency refills of diabetes equipment or diabetes supplies dispensed to each eligible member in accordance with Section 562.0541, Occupations Code, in the same manner as

for a nonemergency refill of diabetes equipment or diabetes supplies. [ACHP] may require a copayment for coverage provided under this section. The amount of the copayment may not exceed the amount of copayment required for treatment of other analogous chronic medical conditions.

Cost-sharing for insulin that is on the formulary will not exceed $25 per prescription for a 30-day supply, including at least one insulin from each therapeutic call.

Durable Medical Equipment/Orthotics/Prosthetic Devices

Medically Necessary Durable Medical Equipment, Orthotic Devices, and/or Prosthetic Devices are covered under this Contract when medically necessary, taking into account certain conditions. The conditions include, but are not limited to, the following: the length of time covered; the equipment covered; the supplier; and the basis of coverage, i.e., rental, purchase, or loan.

Durable Medical Equipment refers to devices specifically designed and intended for the care and treatment of a Bodily Injury or illness, and include the following:

1. Wheelchair, non-motorized or power/motorized according to medical necessity; (a motorized scooter may be substituted for a power/motorized wheelchair if approved by [ACHP])
2. Hospital bed;
3. Blood pressure monitoring device;
4. Ventilator (rental only);
5. Hospital-type equipment;
6. Oxygen and rental of equipment for its administration;
7. Services related to the fitting and use of prosthetic devices and orthotic devices.
8. Casts, splints (other than dental), trusses, braces, and crutches, except as otherwise expressly provided in this Contract
9. Standard wigs following cancer treatment that causes loss of hair ($350 dollar limit, not to exceed one per lifetime);

Consumable Supplies are non-durable medical supplies that:

- Are usually disposable in nature;
- Cannot withstand repeated use by more than one individual;
- Are primarily and customarily used to serve a medical purpose;
- Generally, are not useful to a person in the absence of illness or injury; and
- May be ordered/prescribed by a physician. Consumable supplies are covered only if the supply is required in order to use a covered Durable Medical Equipment, Orthotic Device, or Prosthetic Device. Repair, maintenance and cleaning due to abnormal wear and tear or abuse are Your responsibility.

Examples of covered **consumable supplies** include but are not limited to:

1. Oxygen tubing

The following special supplies up to a 30-day supply, when prescribed to the Member by the Physician or Provider:

a) Surgical Dressings;
b) Catheters;
c) Colostomy bags, rings, and belts;
d) Flotation pads;
e) Diabetes equipment and supplies; and
f) Other Durable Medical Equipment.

Examples of non-covered equipment include but are not limited to air conditioners, air purifiers, humidifiers, physical fitness equipment, and whirlpool bath equipment.

Visit [Website] or call the [ACHP] Member Services Department to verify preauthorization requirements or if you need more information about durable medical equipment.

Durable Medical Equipment may be covered under this Contract if determined as Medically Necessary by [ACHP]. DME may be covered as a purchased or rented item at the discretion of the Plan. Costs for these items will be limited to the lesser of the rental cost or the purchase price, unless stated otherwise in this EOC. If [ACHP] determines the lesser cost is the purchase option, any amount paid as rent for such Durable Medical Equipment shall be credited toward the purchase price. Rented or loaned equipment must be returned in satisfactory condition, and You are responsible for cleaning and repair required due to abnormal wear and tear or abuse. Coverage for rented or loaned equipment is limited to the amount such equipment would cost if purchased by Health Plan from a Participating DME provider. Health Plan shall have no liability for installation, maintenance or operation of such equipment for home-based use.

If the equipment and device includes comfort or convenience items or features that exceed what is Medically Necessary, [ACHP] 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 deemed by the Medical Director to be all that is Medically Necessary. If you choose to upgrade the equipment or device for a non-Medically Necessary reason, you will be responsible for the price difference between the cost of the standard item and the cost of the upgraded item.

Hearing Aids and Cochlear Implants

[ACHP] provides coverage for audiology exams and the cost of one hearing aid or cochlear implant per hearing impaired ear every 36 months (about 3 years) for all covered individuals including 18 years of age and younger. This coverage also includes services related to a covered hearing aid device or cochlear implant prescribed by a licensed audiologist, hearing instrument specialist, or an ear, nose and throat (ENT) Physician, including:

- fitting and dispensing services;
- the provision of ear molds as necessary to maintain optimal fit of hearing aids;
- any treatment related to hearing aids and cochlear implants, including coverage for habilitation and rehabilitation as necessary for educational gains; and,
- specific to a cochlear implant, an external speech processor and controller with necessary components replacement every three years, as medically or audiologically necessary.

Coverage is subject to all the requirements of the health plan and does not include replacement hearing aid batteries.

If the equipment and device include comfort or convenience items or features that exceed what is Medically Necessary, [ACHP] will not pay more than is Medically Necessary. If you choose to upgrade the equipment or device, you will be responsible for the price difference between the cost of the standard item and the cost of the upgraded item.

[ACHP] will not deny a covered individual's claim for a hearing aid solely on the basis that the price of the hearing aid is more than the benefit available under the health benefit plan.

Please contact [ACHP] Customer Service Department at [1-800-xxx-xxxx] for more details on the covered cost of a hearing aid or cochlear implant.

Prosthetic Device or Appliance benefits may include the following when they meet the conditions determined by [ACHP] to be Medically Necessary to replace defective parts of the body following illness or injury:

- Initial device;
- replacement of the device when not due to misuse or loss of the device;
- and normal repairs, not due to misuse or loss;
- Prosthetic device coverage is limited to the most appropriate model of prosthetic device that adequately meets the medical needs of the Member as determined by the Member's treating physician, podiatrist and prosthetist or orthotist;
- Services related to the fitting and use of prosthetic devices;
- Prosthetics are subject to applicable Copayments specified in the Schedule of Coverage.

Orthotic Devices (i.e. an orthopedic appliance used to support, align or hold bodily parts in a correct position) and crutches, including rigid back, leg or neck braces, casts for treatment of an part of the legs, arms, shoulders, hips or back; special surgical and back corsets; Physician-prescribed, directed or applied dressings, bandages, trusses and splints which are custom designed for the purpose of assisting the function of a joint.

Orthotic Benefits may include the following when they are considered Medically Necessary by [ACHP]:

1. Initial device;
2. Replacement of the device if replacement is not due to misuse or loss;
3. Normal repairs, not due to misuse or loss;
4. Orthotic coverage is limited to the most appropriate model of orthotic device that adequately meets the medical needs of the Member as determined by the Member's treating physician, podiatrist and prosthetist or orthotist;.
5. Services related to the fitting and use of orthotic devices;
6. Prosthetics are subject to applicable Copayments, specified in the Schedule of Coverage.

Healthcare Treatment Facility Service Benefits include:

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 these services as ordered by the Member's health care practitioner:

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 determine a shorter period is appropriate;
b. Not less than 48 hours (about 2 days) after an uncomplicated vaginal delivery and 96 hours (about 4 days) after an uncomplicated delivery by cesarean section;
c. Confinement in a critical care unit or intensive care unit and related services;
d. Operating room and related facilities;
e. Ancillary services;
f. Administration of blood and blood products including blood extracts or derivatives;
    - The administration of whole blood including costs of blood, blood plasma, and blood plasma expanders that are not replaced by or for the enrollee are covered services.
g. Other Healthcare Treatment Facility charges;
h. Drugs, medicines and biologics that are provided or administered to the Member while Confined in a Facility;
i. 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;
j. Outpatient services in a Hospital or Free-Standing Surgical Facility;
k. Short-term rehabilitation therapy services in an acute care, long-term acute care, inpatient rehabilitation Hospital or Skilled Nursing Facility setting;
l. Laboratory and other diagnostic tests;
m. Meals and special diets when Medically Necessary;
n. Special duty nursing when Medically Necessary; and
o. X-ray services.

Healthcare Practitioner Medical-Surgical Services Benefits include:

- Services of Physicians and other Healthcare Practitioners;
- Consultation services of a Physician and other Healthcare Practitioner.
- Services of a surgical assistant and/or assistant;
- Services of a physician assistant (P.A.), registered Nurse (R.N.), Nurse Practitioner (N.P), midwife (CNM), or a certified operating room technician when Medically Necessary;
- Anesthesia administered by a Healthcare Practitioner;
- Services of a pathologist;
- Services of a radiologist; Second surgical opinions;
- Surgery;

Assessments and Examinations

- Drug use assessments for adolescents
- Behavioral assessments for children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- General examinations to support diagnosis, treatment, and monitoring of covered conditions

- Height, weight and body mass index (BMI) measurements for children taken regularly
- Oral Health risk assessment for young children ages: 6 months to 6 years

Counseling
- Breast cancer chemoprevention counseling for women at elevated risk
- Diet counseling for adults at higher risk for chronic disease
- Healthy weight and weight gain in pregnancy counseling
- Nutritional counseling;

Diagnosis/diagnostics:
- Diagnostic laboratory and radiology tests;
- Diagnosis of infertility
- Diagnostic follow-up care related to the hearing impairment for a Dependent child from birth through 24 months (about 2 years) of age;

Screenings
- Bilirubin concentration screening for newborns
- Blood Pressure screening for children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- Cervical dysplasia screening for sexually active females
- Chlamydia and Gonorrhea screening, sexually active females
- Developmental screening for children under age three, and surveillance throughout childhood;
- Dyslipidemia screening for all children once between 9 and 11 years and once between 17 and 21 years, and for children at higher risk of lipid disorders
- Hematocrit or hemoglobin screening for all children
- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening for adolescents at higher risk
- Lead screening for children at risk of exposure
- Obesity screening and counseling
- Regular screenings for children and adolescents as recommended by their provider
- Tuberculin testing for children at higher risk of tuberculosis ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- Urinary tract bacteria or other infection screening for pregnant women
- Urinary incontinence screening for women, yearly

Treatments
- Allergy injections, therapy, testing, and serum. Therapy and testing for treatment of allergies must be approved by the American Academy of Allergy and Immunology or the Department of Health and Human Services or any of its offices or agencies;
- Fluoride chemoprevention supplements, starting at 6 months, for children without fluoride in their water source;
- Fluoride varnish for all infants and children as soon as teeth are present;
- Injections other than allergy injections;
- Radiation therapy; Services related to the administration of:
- Dietary formulas necessary for the treatment of phenylketonuria (PKU) or other heritable diseases as provided under the Prescription Drugs provision
- Amino acid-based elemental formulas as provided under the Prescription Drugs provision;

- Telemedicine Medical Services or Telehealth Medical Services.

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

- Taking a history;
- Performing an examination;
- Making a diagnosis or medical decision and associated treatment

Covered expense during a Healthcare Practitioner's office visit does not include charges incurred for Advanced Imaging, pulmonary function studies, cardiac catheterization, electrocardiogram (EKG), or electroencephalogram (EEG).

Extended Care Benefits

Extended Care Expenses are a Benefit for Members under this Contract. Refer to Preauthorization Requirements of [ACHP] as listed above for relevant preauthorization requirements.

Any drug (including antibiotic therapy) and laboratory service charges incurred as Home Health Care or home Hospice Care will not be an Extended Care Expense but will be considered a Medical-Surgical Expense.

Services and supplies for Extended Care Expenses include:

1. **For Skilled Nursing Facilities and Subacute Rehabilitation Facilities:**

    1. Daily room and board and all routine services, supplies, and equipment provided by the Facility;
    2. All usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N), or by a Licensed Vocational Nurse (L.V.N), to provide general nursing services for each day of Confinement;
    3. Physical, occupational, speech and respiratory therapy services by licensed therapists; and
    4. The evaluation of the need for the services listed here.
    5. Limited to 25 days a year.

The Member may enter the Subacute Rehabilitation Facility or Skilled Nursing Facility directly from a discharging Hospital, an emergency department, or directly from the home.

Coverage for Subacute Rehabilitation Facility or Skilled Nursing Facility includes services that are temporary and lead to rehabilitation and an increased ability to function. Coverage will cease when any of the following occurs:

1. The Member has achieved the goals of the plan of care; or
2. The Member has reached a point in functioning where daily skilled services are no longer necessary to continue improving toward goals, e.g., the member is expected to be able to continue making progress with skilled services in the home setting; or
3. The Member has plateaued and is not able to continue improving; or
4. The Member declines to or is unable to participate in the plan of care.

2. **For Home Healthcare**

1. Services provided by a Home Healthcare Agency at the Covered Person's home. Home Healthcare Services are subject to authorization guidelines. Home health services will be reimbursed when the attending physician certifies that hospitalization or confinement in a skilled nursing facility would be required if a home health care treatment plan were not provided. Home health care benefits are limited to 60 visits per calendar year for the covered member. As listed under item e. above, this limit does not include home visits to deliver home infusion therapy of medications, which are categorized separately from other skilled home visits.

2. Each of the following is considered to be one visit for home health services:
    a. a single visit by a representative of a home health agency
        i. Part-time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse, (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.); or
        ii. Part-time or intermittent home health aide services which consist primarily of caring for the patient for up to four hours of time; or
        iii. Physical, occupational, speech, and respiratory therapy services by licensed therapists).
    b. if home health aide service extends beyond four hours, each additional four hours or portion of that four-hour period.

3. No benefits will be provided for, or on account of:
    a. Services provided by an individual who:
        i. resides in the covered member's home; or
        ii. is a member of the covered member's family.
    b. Services provided to a covered member who is eligible for Medicare coverage;
    c. Annual cost share provisions for home health services coverage that are not less favorable than the cost share provisions applicable to hospital services coverage;
    d. Custodial care.

3. Hospice Care:

Services provided under a Hospice Care Program furnished in a Hospice Facility or in the Member's home by a Hospice Care Agency. A Healthcare Practitioner must certify that the Member is terminally ill and with a life expectancy of six months or less in order for the Member to qualify for Hospice Care services.

For Home Hospice Care:

1. Part-time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse for up to eight hours a day
2. (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
3. Part-time or intermittent home health aide services which consist primarily of caring for the patient;
4. Medical social services for the terminally ill Member and/or the Member's immediate Family Members, including:
    a. medical supplies, drugs and medicines prescribed by a Healthcare Practitioner for Palliative Care for the Member;
    b. Physical, speech, and respiratory therapy services by licensed therapists for the Member; and

c. Homemaker, assessment, and counseling services routinely provided by the Hospice agency, including bereavement, psychological, and dietary counseling.

For Facility Hospice Care:

1. All usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
2. Room and board and all routine services, supplies, and equipment provided by the Hospice facility, including:
   a. medical supplies, drugs and medicines prescribed by a Healthcare Practitioner for Palliative Care;
   b. Physical, speech, and respiratory therapy services by licensed therapists; and
   c. Assessment and counseling services routinely provided by the Hospice agency, including bereavement, psychological, and dietary counseling.

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. Services of a social worker other than a licensed clinical social worker;
4. 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
5. Respite care.

Home Infusion Therapy Benefits

As recommended by an In-Network Physician and approved by [ACHP] as Medically Necessary, Home Infusion Services are available for "high technology" services, including but not limited to: line care, chemotherapy, pain management infusion, parenteral nutrition and antibiotic, antiviral or antifungal therapy. Home Infusion Therapy thus refers to the administration of fluids, nutrition, or medication (including all additives and chemotherapy) by intravenous or gastrointestinal (enteral) infusion, or by intravenous injection in the home setting.
Home Infusion Therapy shall include:

1. Drugs and IV solutions;
2. Pharmacy compounding and dispensing services;
3. All equipment and ancillary supplies necessitated by the defined therapy;
4. Delivery Services;
5. Patient and family education; and
6. Nursing Services.

Not included in the Home Infusion Therapy Benefit are:

- Medical professional services (physician, nursing, etc.) other than those required for items 1-6 above
- Over-the-Counter products which do not require a Physician's or Provider's prescription, including but not limited to standard nutritional formulations used for enteral nutrition therapy ("enteral formula")
- Covered durable medical equipment, not related to the home infusion therapy – some of which may be covered under other provisions of this Contract, and subject to additional Copayments.

Subject to any limits on the maximum number of days for which a Copayment is required, you are

required to pay a Copayment for each day of Home Infusion Therapy as stated in Your schedule of benefits.

Behavioral Health and Substance Use Disorder Benefits

Covered Services provided by a:

- Healthcare Practitioner;
- Hospital; or
- Healthcare Treatment Facility.

Covered Inpatient Behavioral Health Services for:

1. Inpatient services including room and board;
2. Partial hospitalization program; and
3. Healthcare practitioner visits.

Covered outpatient Behavioral Health care and office services for Behavioral Health incurred for:

1. Diagnostic evaluation and treatment or crisis intervention;
2. Office exams or consultations;
3. Intensive Outpatient Program; and
4. Cognitive-Behavioral Therapy.

Additional covered services for Behavioral Health and Substance Use Disorder:

1. A partial Hospitalization program;
2. A Residential Treatment Center.

No benefits will be provided for, or on account of a halfway house. Prior authorization is required for some outpatient mental health, behavioral health and / or substance abuse services. Visit our website at [Website] or call Customer Service for a list of services that require Prior Authorization.

[ACHP] provides benefits and coverage for Behavioral Health conditions and substance use disorders under the same terms and conditions applicable to the plan's medical and surgical benefits and coverage. [ACHP] does not impose quantitative or non-quantitative treatment limitations on benefits for a Behavioral Health condition or substance use disorder that are generally more restrictive than quantitative or non-quantitative treatment limitations imposed on coverage of benefits for medical or surgical expenses.

1. Neurocognitive Disorders

Generally recognized services in relation to neurocognitive disorders and conditions, such as but not limited to Alzheimer's disease or Multiple Sclerosis. Generally recognized services for the purposes of this section include but are not limited to:

- Diagnostic, evaluation and assessment services;
- Medically necessary testing, treatment, and provision of therapy to an individual with a Neurocognitive Disorder

Treatment for a Neurocognitive Disorder may be provided at a hospital, an acute or post-acute rehabilitation hospital, an assisted living facility, in the home, or at any other facility at which appropriate services or therapies may be provided.

Treatment goals for services may include the maintenance of functioning or the prevention of or slowing

of further deterioration.

2. Autism Spectrum Disorder:

(a) Autism screening for children at 18 and 24 months (about 2 years) is included above in preventive services for children, as described above.

Benefits for treatment of Autism Spectrum Disorder:

Generally recognized treatment services prescribed in relation to Autism Spectrum Disorder by the Participant's Physician or Behavioral Health Practitioner in a treatment plan recommended by that Physician or Behavioral Health Practitioner are available for a Member whose Autism Spectrum Disorder diagnosis was in place prior to the child's 10th birthday.

[ACHP] will provide coverage for treatment of autism spectrum disorder as provided by this section to a Member who is diagnosed with autism spectrum disorder from the date of diagnosis

(b) [ACHP] will provide coverage to a Member for all *generally recognized services* prescribed in relation to autism spectrum disorder by the Member's PCP in the treatment plan recommended by that physician. An individual providing treatment prescribed under this subsection must be:

(1) A health care practitioner:

(A) who is licensed, certified, or registered by an appropriate agency of this state;

(B) whose professional credential is recognized and accepted by an appropriate agency of the United States;

(C) who is as a provider under the TRICARE military health system; or

(2) An individual acting under the supervision of a health care practitioner.

(c) For purposes of Subsection (b) "*generally recognized services*" may include services such as:

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

(d) Coverage under Subsection (b) may be subject to annual benefit limits that are consistent with annual copayments required for other coverage under the health benefit plan.

Covered Services include therapies that result in a practical improvement in the level of functioning within a reasonable period of time and therapy that is not considered Maintenance Care. When determined to be Medically Necessary by the Healthcare Practitioner, therapy services for a Member who has a physical disability will not be considered Maintenance Care. Habilitative services are provided to help Members learn, maintain, or improve skills for everyday life activities.

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.

ABA treatment will not be authorized for any of the following, as they do not meet the medical necessity guidelines for ABA:

- ABA when measurable functional improvement is not expected or progress has plateaued
- Services that are primarily educational in nature
- Services that duplicate services under an individualized family service plan or an Individualized Education Program (IEP), as required under the federal Individuals with Disabilities Education Act (IDEA) or the provision of services to an individual under any other federal or state law
- Speech-Language, Occupational or Physical therapy
- Supportive respite care
- Services that are not medically necessary
- Treatment whose purpose is vocational or recreational based
- Treatment that is investigational or unproven
- Services that are provided for developmental purposes
- Cognitive Therapy or retraining
- Personal training or life coaching
- Counseling, psychotherapy, or family therapy
- Any services that are educational, custodial, or vocational in nature
- Any service, supply or procedure performed in a non-conventional setting

Inpatient Hospital Expenses

Benefits include coverage for Inpatient Hospital Expenses for the Member(s). Each inpatient Hospital Admission requires preauthorization. Refer to the Preauthorization sections of this Contract for additional information.

Reconstructive Surgery

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

- To restore function for conditions resulting from a Bodily Injury provided the Bodily Injury 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 or has its onset while the Member is covered under this Contract;
- 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; and
- Because of a congenital illness or anomaly that resulted in a functional defect to improve the function of or attempt to create a normal appearance of the abnormal body structure.

- For children under 19 years of age: Craniofacial abnormalities to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections or disease.

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 Member was covered under this Contract or under any prior coverage.

Rehabilitative and Habilitative Therapy Benefits

As recommended by an In-Network Provider or Physician as Medically Necessary, outpatient rehabilitative and habilitative therapy services are available for the following services:

- Physical therapy;
- Speech therapy or speech pathology;
- Audiology (hearing) therapy;
- Occupational therapy services;
- Dietary or nutritional evaluations

Other than specified in this Contract, rehabilitation and services that are Medically Necessary, shall not be otherwise denied, limited or terminated as long as they result in the member meeting or exceeding Treatment goals in accordance with an Individual Treatment Plan.

You are required to pay Copayments for outpatient rehabilitative and habilitative therapy visits as indicated in the Schedule of Coverage.

Manipulative Therapy / Chiropractic Services

A Member is eligible for outpatient manipulative therapy from providers licensed to perform that therapy, including Chiropractors. Manipulative therapy services are those within the scope of rehabilitative care, including those services provided by a Chiropractor or other provider licensed to provide the service, which are supportive or necessary to help Members achieve the same physical state as before an injury or illness, and that are determined to be Medically Necessary. The services are generally furnished for the diagnosis and/or treatment of neuromusculoskeletal conditions associated with an injury or illness, including the following:

- Examinations
- Manipulations
- Conjunctive Physiotherapy

Routine Care during Clinical Trials

We will pay for Covered Services that are Routine Patient Care Costs furnished to a Member 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.

Surgeries/Procedures- Inpatient or Outpatient

Covered services include but are not limited to:

Cataracts:
1. Laser Cataract Surgery
2. Monofocal lens

Sleep Apnea:
1. Surgery for Obstructive Sleep Apnea
2. Sleep studies
3. Durable Medical Equipment for Sleep Apnea

Teledentistry (pediatric only), Telemedicine Medical Services and Telehealth Services

If a Member receives Covered Services as teledentistry (pediatric only), telemedicine medical services or telehealth from an in-network Healthcare Practitioner, coverage for these services is the same as seeing a Healthcare Practitioner in an in-person setting. There is not a separate deductible, annual maximum, or lifetime maximum for Covered Services delivered as teledentistry (pediatric only), telemedicine medical services or telehealth services.

Transplant Service

Covered transplants, using human tissue, and FDA approved artificial devices only, if determined Medically Necessary and approved by the Medical Director as not Experimental or not Investigational for the Member's condition, may include:

a. Auto-islet cell;
b. Bone or Bone marrow;
c. Cornea
d. Fecal transplant (e.g., for *C. difficile*)
e. Heart or Heart valve
f. Intestine
g. Kidney
h. Lung(s);
i. Liver;
j. Middle ear
k. Multivisceral
l. Pancreas;
m. Any combination of the above listed organs;
n. Any organ not listed above, if required by state or federal law
o. FDA approved artificial devices.

Covered services and supplies considered related to a transplant include:
- Donor/procurement costs for covered transplants for matching, removal, and transportation of the transplant tissue or organ;
- Other services related to the transplant, such as radiology, laboratory testing, chemotherapy, radiation therapy, prescription drugs (subject to medical-surgical policies and benefits detailed elsewhere in this contract);

- Post-discharge services;
- Treatment of complications arising from the covered transplant

Preauthorization is required for all transplant and transplant services, including for pre-transplant evaluation. Review the Preauthorization Requirements section of this Contract for more specific information.

Donor costs will not exceed the Transplant Treatment Period. After the benefits of a Member who is a recipient have been paid, [ACHP] 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.

No benefits are available for a Member for the following services or supplies:

- Living and/or travel expenses of the recipient or a live donor;
- Expenses related to maintenance of life of a donor for purposes of organ or tissue donation;
- Purchase of the organ or tissue; or
- Transplanted organs that came from China, and surgeries that were carried out in China or other country known to harvest organs.
- Organs or tissue (xenograft) obtained from another species.
- 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;
- Expenses related to a transplant for which We do not approve coverage based on Our established guidelines/criteria;
- Expenses related to the transplantation of any non-human organ or tissue except as expressly provided in this Contract;
- 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;
- Expenses related to the storage of cord blood and stem cells unless it is an integral part of a transplant approved by [ACHP]; or
- Expenses related to a transplant performed outside of the United States and any care resulting from that transplant.

Transplant Transportation and Lodging

Direct non-medical costs for:
The Member receiving the transplant when the Hospital performing the Covered Organ Transplant is more than 100 miles away from the Member's residence; and
One designated caregiver or support person (two, if the Member receiving the Covered Transplant is under 18 years of age), if that individual lives more than 100 miles from the Hospital performing the Covered Transplant.
Direct non-medical costs include:

- Transportation Covered Services to and from the Hospital where the Covered Transplant is performed limited to two round trips per Covered Transplant; and
- Temporary lodging at a prearranged location when requested by the Hospital performing the Covered Transplant and approved by [ACHP].

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

Urgent Care Services

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

Vision Services

Covered services include:

- One routine pediatric eye exam on an annual basis, for Members up to the age of 21
- One pair of select frames and standard lenses per year, or contact lenses per year, for children up to the age of 21.

Wellness Program

[ACHP]'s Wellness Programs

The mission of [Access to Care Health Plan] ([ACHP]) is to improve the health and wellbeing of our Members. As such, [ACHP] offers member health promotion, education and rewards programs. Our most comprehensive program offering is known as Passport to Health. Other related initiatives do even more to help to promote healthy decisions and behaviors. Passport to Health and related initiatives are included in your Contract. Members will have access to these programs and an opportunity to earn non-insurance benefits like rewards and incentives.

Overall, [ACHP]'s Wellness Program is designed to promote disease prevention, wellness and health. The Program will assist you to develop and maintain a relationship with your doctor. You and your doctor can determine which services are best to maximize your health. You will be provided a reward for participation after you have completed the wellness service offered, such as a scan, test or diagnostic service. The reward or incentive is not based upon the outcome of the test or service.

You may receive one or more documents that will further outline, explain or summarize [ACHP]'s wellness programs.

The rewards may include gift cards for completing the preventive services, test, or screening; a waiver of copays; or discounts or support for the disease or activity-focused discussion groups in which you may participate.

[ACHP]'s Wellness program offerings may be terminated or modified with prior notification to you and is subject to state and federal law and regulation.

The decision to participate in [ACHP]'s Wellness programs are voluntary and available to all members. If this Contract terminates, you will no longer be eligible for the [ACHP] Wellness programs. To resolve any issue or ask any questions, you may call [1-800-xxx-xxxx].

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 External Review. 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. Pre-authorized by [ACHP]; or
    b. delivered in an emergency situation:
        - Services in a hospital emergency room, freestanding emergency medical care facility or comparable emergency facility
        - Services delivered when the Member, in connection with a medical emergency, is being transported to the nearest acute care hospital equipped to treat the member's condition.
2. Services incurred before the effective date or after the termination date of this Contract;
3. Services not Medically Necessary to prevent, diagnose or treat Bodily Injury or Illness;
4. 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.
5. Services or supplies provided in connection with an occupational sickness, or an injury sustained in the scope of and in the course of any employment whether benefits are, or could upon proper claim, be provided, under the Worker's Compensation law.
6. Any services or supplies provided for injuries sustained:
    a. As a result of war, declared or undeclared, or any act of war; or
    b. while engaging in an illegal activity;
    c. while in the custody of police or confined as a result of a crime;

d. while engaging in any act of armed conflict, or any conflict involving armed forces or any authority;
e. while on active or reserve duty in the armed forces of any country or international authority.

7. Services received for any injury caused by a Member's commission of, or attempt to commit an illegal act, are excluded from coverage.
8. Any services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical assistance (Medicaid); provided, however, that this exclusion shall not be applicable to any coverage held by the Participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
9. Any charges resulting from the failure to keep a scheduled visit with a Healthcare Practitioner or other Provider; or for completion of any insurance forms; or for acquisition of medical records.
10. Complications directly related to a service that is not an EOC/Covered Service under this Contract because it was determined by [ACHP] to be Experimental or Investigational or not Medically Necessary, except as expressly provided in this Contract. "Directly related" means 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;
11. Services exceeding the amount of benefits available for a particular service or any plan annual or aggregate limits;
12. Services for, or the treatment of, complications of, non-covered procedures or services;
13. Services, except for Emergency Care, relating to an Illness or Bodily Injury incurred: .
    a. For which no charge is made, or for which the Member 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;
    b. Furnished by or payable under any plan or law through a government or any political subdivision, except Medicaid, unless prohibited by law which the Member is not legally obligated to pay;
    c. Furnished while a Member 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;
    d. Which are not rendered or not substantiated in the medical records;
    e. Provided by a Family Member or person who resides with the Member;
    f. Performed in association with a non-covered service.
    g. Hospital Inpatient Services when the Member is in Observation Status;
    h. Except as otherwise provided in this Contract, cosmetic services, or any complication there from;
    i. Custodial care and Maintenance Care;

14. Private duty nursing, except for covered Extended Care Expenses, except as explicitly provided elsewhere in this Contract.
15. Non-ambulance transport, such as wheelchair van, except as explicitly provided elsewhere in this Contract or at the discretion of [ACHP] through a discretionary program
16. Ambulance services used because they are more convenient for the patient than another mode of transportation, whether or not recommended by a Physician or Other Professional Provider

17. Elective medical or surgical abortion unless:
    a. An abortion is performed due to a 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 woman in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed.
18. Any services or supplies provided for, in preparation for, or in conjunction with: Infertility Treatment, except for fertility preservation services related to a diagnosis of cancer, the following infertility treatments are excluded
    a. Sterilization reversal (male or female);
    b. Transsexual surgery or sex change services, regardless of any diagnosis of gender role or psychosexual orientation problems;
    c. Sexual dysfunctions;
    d. In vitro fertilization;
    e. 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
    f. insemination, gamete intra-fallopian transfer (GIFT), pronuclear oocyte stage transfer, zygote intra-fallopian transfer, tubal ovum transfer, tubal embryo transfer; and Embryo freezing or transfer;
    g. Sperm storage or banking;
    h. Ovum storage or banking;
    i. Embryo or zygote banking;
    j. And any other assisted reproductive techniques or cloning methods.
19. Genetic testing that is non-diagnostic or that will not impact your care plan or that is not required by law, unless explicitly stated as covered elsewhere in this document.
20. Any services or supplies provided for reduction mammoplasty;
21. Adult 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;
22. Child (under 21) radial keratotomy; refractive keratoplasty; or any other Surgery or procedure to correct myopia, hyperopia or stigmatic error; orthoptic treatment (eye exercises);
23. Non-pediatric dental services, including 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, 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;
24. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
25. Any items of Medical-Surgical Expense incurred for dental care and treatments, Covered Oral Surgery, or dental appliances, except as provided for in the Benefits for Dental Services provision in this Benefit Booklet
26. Pre-surgical/procedural testing duplicated during a Hospital Confinement;
27. Any treatment for obesity, regardless of any potential benefits for co-morbid conditions, including but not limited to:
    a. Bariatric surgery, procedures, or treatment(s);
    b. Other surgical procedures for Morbid Obesity;

c. Services or procedures for the purpose of treating an Illness or Bodily Injury caused by, complicated by, or exacerbated by the obesity; or
d. Complications related to any services rendered for weight reduction;
e. Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or a weight loss Surgery;

28. Routine eye care for adults, other than what is covered under "Diabetes Services" above, or otherwise expressly provided in this Contract.
29. 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. Shock wave therapy of the feet;
    b. Treatment of Weak, strained, flat, unstable or unbalanced feet;
    c. Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses or hyperkeratosis;
    d. Tarsalgia, metatarsalgia or bunion treatment, except Surgery which involves exposure of bones, tendons or ligaments;
    e. Cutting of toenails, except removal of nail matrix; and
    f. Arch supports, heel wedges, lifts, shoe inserts, the fitting or provision of foot orthotics or orthopedic shoes, unless Medically Necessary because of diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, chronic arterial or venous insufficiency, or hammertoe;
30. Hair prosthesis, hair transplants or implants (except for wigs after cancer treatment, as expressly provided in this Contract under Durable Medical Equipment/Prosthetics/Orthotics);
31. Any items that include, but are not limited to, an orthodontic or other dental appliance; splints or bandages provided by a Physician or Provider in a non-facility setting or purchased "over the counter" for support of strains and sprains; orthopedic shoes which are a separable part of a covered brace; specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or affect changes in the foot or foot alignment, arch supports, elastic stockings and garter belts.
    a. Note: this exclusion does not apply to podiatric appliances when provided as Diabetic
32. Replacement Prosthetic Appliances except those necessitated by growth due to maturity of the Participant.
33. Hearing care that is routine, including but not limited to exams and tests, any artificial hearing device, auditory prostheses or other electrical, digital, mechanical or surgical means of enhancing, creating or restoring auditory comprehension, except as expressly provided in this Contract;
34. Transplant services except as expressly provided in this Contract;
35. Payment for transplanted organs that came from China, and surgeries that were carried out in China or other country known to harvest organs.
36. "Over the counter" medical items or supplies that are available without a written order or Prescription, except for those Benefits expressly provided in this Contract as Preventive Services;
37. Immunizations including those required for foreign travel for Members of any age except as expressly provided in this Contract;
38. Expense for employment, school, sports or camp physical examinations or, for the purpose of obtaining insurance, premarital tests/examinations; Physical Therapy or other expenses for the purpose of improving sports performance.
39. Any occupational therapy services which do not consist of traditional physical therapy modalities, and which are not part of an active multi-disciplinary physical rehabilitation program designed to restore lost or impaired body function, except as may be provided under benefits for Autism expressly provided in this Contract. See Autism section on page 42.
40. Services received in an emergency room other than Emergency Care;

41. Observation Status stays longer than 48 hours
42. Room and board charges incurred during a Hospital Admission for diagnostic or evaluation purposes unless the test(s) could not have been performed on an outpatient basis without adversely affecting the Member's physical condition or the quality of medical care provided
43. Any Expense Incurred for services received outside of the United States except for Emergency Care services;
44. Any Expenses for complications of services received outside of the United States, except for Emergency Services
45. Any services or supplies provided for treatment of adolescent behavior disorders, including conduct disorders and opposition disorders
46. 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 or for intellectual disability; and
47. For the purpose of medical social services, bereavement counseling, vocational counseling, or marriage and family therapy, except as specifically included in covered expenses Immunotherapy for recurrent miscarriage;
48. Sleep therapy;
49. Immunotherapy for food allergy;
50. Prolotherapy;
51. Cranial banding;
52. Hyperhidrosis Surgery; and
53. Sensory integration therapy;
54. Charges for alternative medicine, including medical diagnosis, treatment and therapy.
55. 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 diet prescriptions;
    m. Massage therapy;
    n. Naturopathy;
    o. Ozone therapy;
    p. Reflexology;
    q. Relaxation response;
    r. Rolfing;
    s. Shiatsu; and
    t. Yoga;
56. Living expenses; travel; transportation, except as expressly provided in the Emergency and Ambulance services provision or Transplants provision in the Your Contract Benefits section of this Contract; and

57. 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 (except as a substitute for a medically necessary motorized wheelchair) or motorized transportation equipment escalators, elevators, ramps, modifications or additions to living/working quarters or transportation vehicles;
    c. Personal hygiene equipment including bath/shower chairs, transfer equipment or supplies or bed side commodes;
    d. Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools or spas or saunas;
    e. Medical equipment that does not require a prescription, including blood pressure monitoring devices, PUVA lights and stethoscopes;
    f. Charges for any membership fees or program fees paid by a Member, 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.
    i. Legal Medicine Specialist or Services: The specialty areas of medicine concerned with matters of, and relations with, substantive law and legal institutions; such as the conduct of medical examinations at crime scenes, performance of autopsies, giving of expert medical testimony in judicial proceedings, medical treatment of inmates of penal institutions, and the practice of trauma medicine in law enforcement settings, and other clinical practice and medical science applications in the fields of law, law enforcement, and corrections.
58. Any treatment or service received by the Member:
    a. Before becoming covered under this benefit; or
    b. After the date the Member 's coverage under this Contract has ended.

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. Dietary supplements except enteral formulas and nutritional supplements for the treatment of phenylketonuria (PKU) or certain other inherited metabolic diseases and amino acid-based elemental formulas as expressly provided in this Contract;
3. Nutritional products;
4. Fluoride supplements except when prescribed to preschool children older than 6 months of age whose primary water source is deficient in fluoride;
5. Minerals;
6. Herbs and vitamins
7. Legend (prescription) drugs which are not deemed Medically Necessary by [ACHP];
8. Any drug prescribed for any Illness or Bodily Injury for which services are not covered under this Contract;
9. 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;

10. 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 Member;
11. Allergen extracts;
12. The administration of covered medication(s);
13. 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 [ACHP];
    b. Support garments;
    c. Other non-medical substances;
14. Anorectic or any drug used for the purpose of Weight control;
15. Abortifacients (drugs used to induce abortions);
16. 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.;
17. 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;
18. 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;
19. Compounded estrogen, progesterone, and testosterone hormone replacement therapy;
20. Infertility Treatment, including medications;
21. Any drug prescribed for impotence and/or sexual dysfunction, e.g., Viagra;
22. Drug delivery implants;
23. Prescriptions that are to be taken by 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. Inpatient facilities include, but are not limited to:
    a. Hospital;
    b. Skilled nursing facility; or
    c. Hospice facility;
24. Injectable drugs, including, but not limited to:
    a. Immunizing agents; or
    b. Self-administered injectable drugs or Specialty Drugs for which coverage is not approved by us
25. 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;
26. 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 [ACHP]'s program which allows a Covered Person to receive a 90-day supply of a Prescription or refill;
27. Any portion of a Prescription or refill that exceeds a 30-day supply when received from a retail

Pharmacy that does not participate in [ACHP]'s program which allows a Covered Person to receive a 30-day supply of a Prescription or refill;

28. Any portion of a Specialty Drug or Self-Administered Injectable Drug that exceeds a 30- day supply;
29. Any portion of a drug for which Prior Authorization or Step Therapy is required and not obtained;
30. Any drug for which a charge is customarily not made;
31. Any portion of a Prescription or refill that:
    a. Exceeds [ACHP]'s drug specific Dispensing Limit (e.g., IMITREX);
    b. Is dispensed to a Covered Person whose age is outside the drug specific age limits defined by [ACHP];
    c. Is refilled early, as defined by [ACHP]; or
    d. Exceeds the duration-specific Dispensing Limit;
32. 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;
33. Any costs related to the mailing, sending or delivery of Prescription Drugs;
34. Any intentional misuse of this benefit, including Prescriptions purchased for consumption by someone other than the Covered Person;
35. Any Prescription or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled or damaged;
36. 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;

If a claim is denied as being Experimental Investigation, you have the right to seek review of the denial by an Independent Federal External Review. *Refer to the Appeal Complaints and External Review provision in the General Provisions section in this EOC/Contract for more information*.

Premium Payment

Your Duty to Pay Premium

You must pay the required premium to [ACHP] as it becomes due. If you do not pay your premium on time, subject to the grace period, we will terminate coverage. During the grace period, the coverage will stay in force; if your coverage is terminated, however, all claims paid after your termination date will be recouped and you will be responsible for payment.

The first premium is due on the date specified by [ACHP]. Subsequent premiums are due on the date we assign. You can pay your premium at a payment center, by calling 1-877-817-4636, or online at [Website]. You can also mail your payment to [ACHP] at:

[Access to Care Health Plan]
[Payment address]

Grace Period

Grace Period is a time period in which an overdue premium can be paid after the due date and the member is able to retain ongoing coverage. During the grace period, the plan will stay in force;

however, if your coverage is terminated, all claims paid after your termination date will be recouped and you will be responsible for payment.

The one-month grace period starts the first day of the month that you fail to make a payment. For Example:

- You don't make your June payment by June 1st.
- You are now considered in Grace Period.
- Your Grace Period ends June 30th. (The last day of the month)
- If you do not pay your entire premium amount due, by the last day of the month you will lose coverage.
- Your last day of coverage will be May 31st.

Failure to pay outstanding monthly premiums during a grace period may result in your coverage terminating.

Changes to Your Premium
Your Premium may change annually when:

1) Family members are added or deleted;
2) Coverage is increased or decreased;
3) Premium payment method is changed;
4) A new rate table applies;
5) Any Member's age increases;
6) Any Member's rating classification changes;
7) The Member moves to a different zip code or county; or
8) There is a misstatement on the application resulting in the proper amount due not being charged.

A 60-day notice will be provided prior to premium rate change for items 3, 4, 5, 6 and 8. Your continued payment of premium will constitute your agreement to the change.

Return of Premium

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

- The Contract Holder returns the Contract as described in the Right to Return Contract provision;
- Rescission of coverage as described in the Incontestability provision in the General Provisions section; or
- 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 at a prorate.
Cancellation of this Contract will not affect claims incurred prior to the cancellation.

Enrollment Effective Dates
Off Exchange Member coverage will begin on the first day of the month following the enrollment if completed between the 1st and 15th of the previous month.

For example, if you enroll with [ACHP] between February 1st and February 15th, your coverage will become effective on March 1st.

If you enroll with [ACHP] between February 16th and the 28th your coverage will become effective April 1st.

Third Party Payment

Payment of premiums for individual plans are a personal expense to be paid for directly by Individual and family plan subscribers. In compliance with federal guidance, [ACHP] will accept third-party payment for premium from the following entities:

1) the Ryan White HIV/AIDS Program under title XXVI of the Public Health Services Act;
2) Indian tribes, tribal organizations, or urban Indian organizations; and
3) State and federal Government programs.

In addition, [ACHP] will accept third party payments from the Travis County Healthcare District. [ACHP] may accept third party payments from other non-profit entities, as approved for such purpose at the sole discretion of the [ACHP] Board of Directors. Except as provided above, [ACHP] will not accept payment, either directly or indirectly from third-party entities for any or all of a member's premium or other costs. In the event that this Contract is cancelled, the premium shall be computed pro rata. Cancellation of this EOC/Contract will not affect claims incurred prior to the cancellation.

Your Rights to Make Changes to the Contract

You have several rights to make changes to your Contract.

Changes in Benefits

You may call or write us to request additional, increased or decreased benefits.
If the change in benefits you request is available, as determined and approved by us, the benefit will become effective on the date we assign.

Change in Residence

If you are enrolled off exchange, you must contact [ACHP] directly to change your residence and/ or mailing address by calling [1-800-xxx-xxxx].

Changes to Members

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

Removing Dependents

If you wish to remove a Member from your Contract, simply call or write us at the address on your Member Identification Card.

Adding Dependents

If a child is born to a Contract Holder, or any Member, a Contract Holder adopts a child, or a grand/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 grand/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 Member under this Contract.

If a Dependent grand/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 Member and be accepted by [ACHP] during the annual open enrollment period. A Dependent child is eligible to apply if they are under age 26. If accepted, the Member will be covered on the date we specify.

Dependents 25 years of age and younger may be added to a Subscriber's plan either during open enrollment or during a Special Enrollment Period. Newborn children may be added to a Subscriber's plan by notifying [ACHP] and/ or the Marketplace Exchange within 60 days (about 2 months) from the child's birth. The newborn child will be covered for the first 31 days (about 1 month) from birth.

Effective Date of Dependent Changes

1. Coverage for a newborn or adopted child will be effective for the first 31 days (about 1 month) 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 [ACHP] and remit the premium within 31 days of the child's date of birth or adoption;
2. Coverage of a Dependent child who is the subject of a medical support order will be effective for the first 31 days (about 1 month) after receipt of the medical support order or notice of the medical support order;
3. If We receive the application or notification as applicable, and any required premium more than 31 days (about 1 month) 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;
4. Changes for other Dependents will be effective upon acceptance by [ACHP], and receipt of premium.

Our Rights to Make Changes to the Contract

We have the right to make certain changes to your EOC/Contract. [ACHP] can make changes to this EOC/Contract at any time without prior consent when the changes are required by State or Federal law.

Continuation of Coverage for Surviving Dependents

If this EOC/Contract has been in-force for at least 90 days (about 3 months) and the Contract Holder dies while Dependent coverage is in-force, the surviving Dependents that are covered under this EOC/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 EOC/Contract Holder if covered under this EOC/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 EOC/Contract will continue to apply.

Continuation of Coverage Due to Marital Change

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

Continuation of Coverage Due to Change of Insurance Carrier during an Inpatient Stay

When [ACHP] coverage begins during an inpatient hospital stay, [ACHP] is responsible for the inpatient hospital and physician claim charges starting on the date you become eligible with [ACHP].

[ACHP] is not responsible for inpatient hospital stay or physician claim charges incurred on dates you were not eligible during your inpatient hospital stay.

Renewability and Termination

Reasons We Will Terminate Your Contract

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

- The required premium was due to [ACHP] and was not received, including any grace period.
- Termination will be effective on the last day for which the premium was paid.
- The Contract Holder commits fraud or makes an intentional misrepresentation of a material fact, in which case, we will provide 30-days' notice of [ACHP]'s intent to rescind this EOC/Contract. The Contract Holder will have the right to Appeal the rescission.
- The Contract Holder requests termination of the Contract in writing.
- Contract Holder moves outside of [ACHP]'s approved service area.

Termination will be effective on the later of the date requested by you or the date [ACHP] receives your notice to cancel; or we cease to offer a particular type of coverage or cease to do business in the individual basic health care market, as allowed by federal or state law.

If we decide to discontinue offering a type of EOC/Contract, 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 Hospital, medical or surgical Contract providing medical benefits that are being offered by [ACHP] at such time.

If we decide to cease doing business in the individual Hospital, medical or surgical market, the EOC/Contract Holders covered by such contract and the Commissioner of Insurance will be notified of

such discontinuation at least 180-days prior to the date of discontinuation of such coverage.

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

1. When the Covered Person no longer qualifies as defined in the Definitions section of this Contract or no longer meets eligibility criteria;
2. The Covered Person commits fraud or makes an intentional misrepresentation of a material fact, in which case, we will provide 30-days' notice of [ACHP]'s intent to rescind this Contract with regard to the Covered Person. The Covered Person will have the right to Appeal the Rescission.
3. Failure to pay the monthly premium;
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.

Your Duty to Notify Us

You are responsible for notifying us of any of the events stated above which would result in termination of this EOC/Contract or a Covered Member.

Reinstatement

If this Contract is terminated due to lack of premium payment, other than your initial premium payment, you may request reinstatement. [ACHP] will review your account and determine if you qualify for reinstatement, provided all of the following are met:

1. Coverage has not been terminated for more than 30 days; and
2. You agree to pay all current and past due premiums.

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

Fraud

You commit fraud against us or make an intentional misrepresentation of a material fact by intentionally not telling us the correct facts or by withholding information which is 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 [ACHP] by filing a claim or form that contains a false or deceptive statement may be committing insurance fraud.

If you or the Member commits fraud against [ACHP], as determined by a court of law, coverage will be terminated. We will provide at least 30 days (about 4 and a half weeks)' advance written notice of [ACHP]'s intent to terminate or cancel your coverage. 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.

Reasons You May Terminate Your Contract

If you enrolled directly with [ACHP], you can request same-day contract terminations by emailing your request to [ACHP]IDCCustomerService@[ACHP]Health.com.You can also fax your written termination to (512) 901-9724 or mail your termination request to:

[Access to Care Health Plan]
[P.O. Box Address]

General Provisions, Appeals, Complaints and External Review Rights

You have a right to Appeal any decision we make that denies payment on your claim or your request for coverage of a health care service or treatment. Included in your rights are the right to appeal an Adverse Determination to [ACHP] and to External Review, the right to appeal a Contractual Denial, and the right 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.

[ACHP] will not discriminate or take punitive action against a member or a member's representative for making a complaint, an Appeal, or requesting an Expedited Appeal. [ACHP] will not engage in retaliatory action, including refusal to renew or cancel coverage because the member or a person acting on behalf of the member has filed a complaint against [ACHP] or appealed a decision of [ACHP]. Furthermore, [ACHP] is prohibited from retaliating against a physician or providers because the physician or provider has filed a complaint or appealed a decision on behalf of the member.

Appeal from an Adverse Determination
If we determine that health care services provided or proposed to be provided are not Medically Necessary or not covered because the services are considered experimental or investigational,, 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. If your case involves a life-threatening condition or if we do not meet timeframes, you will be entitled to an immediate appeal to an Independent Federal External Review.

If your Adverse Determination is not related to you being in the hospital at the time of the review, [ACHP] will provide a written notice of Adverse Determination to the patient and the Provider of record within mandated timeframes.

If [ACHP] transmits an Adverse Determination for a retrospective utilization review, the notice of Adverse Determination will be transmitted to the Provider of record and the patient within mandated and customary timeframes.

The Utilization Review shall provide notice of an adverse determination for a concurrent review of the provision of prescription drugs or intravenous infusions for which the patient is receiving health benefits under the Evidence of Coverage within mandated and customary timeframes

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, intravenous infusion, prescription drugs, and denials of continued stays for a hospitalization. The expedited review, if granted, 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. All information necessary to complete the appeal must be received. A determination may be provided by telephone or electronic transmission, but will be followed with a letter, within mandated and customary timeframes.

When we receive an Appeal, we will, within mandated and customary timeframes, 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 time frames 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 to the appealing party.

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, within mandated and customary timeframes. If the Appeal is for Emergency Care, or denial of a continued stay for a Hospitalized Member, the time frame for resolution will be based on the medical or dental immediacy of the condition, procedure or treatment, within mandated and customary timeframes. The resolution letter will contain the clinical basis for the Appeal determination, the specialty of the Healthcare Practitioner making the denial, and notice of the appealing party's right to seek review of the denial by an Independent Federal External Review.

[ACHP] will review your or your prescribing physician's request to expedite an exception request due to exigent circumstances when the request involves a medication on the formulary or non-formulary drugs. [ACHP] will review these specific cases on an urgent timeline, within mandated and customary timeframes for such. If [ACHP] grants an exception based on exigent circumstances, we will provide coverage of the non-formulary drug for the duration of the treatment or care plan.

If the Appeal of Adverse Determination is denied and Your provider, within mandated and customary timeframes, the Appeal denial shall be reviewed by a Participating Provider in the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment under discussion for review in the Appeal Such specialty review will be completed within mandated and customary timeframes.

Independent Federal External Review

In a circumstance involving a life-threatening condition, exigent denial of prescription drugs or intravenous infusions for which the patient is receiving benefits under the Evidence of Coverage, you are entitled to an immediate appeal to an Independent Federal External Review and are not required to comply with [ACHP]'s procedures for an Appeal of the Adverse Determination. Any member whose Appeal of an Adverse Determination is denied by [ACHP] may seek review of that determination by submitting an appeal request through the Federal External Review Process. To find out about the process to request a Federal External Review, you may call [ACHP]'s Health Services Department at 1-855-297-9191 for more information. You may also visit http://www.externalappeal.com/Forms.aspx to download and complete an HHS Federal External Review Request Form and return it to:

MAXIMUS Federal Services, Inc.
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534

Toll-Free phone: 888-866-6205
Fax: 888-866-6190

Upon request and free of charge, you or your designee may have reasonable access to, and copies of, all documents, records and other information relevant to the claim or appeal, including:

- Information relied upon to make the decision;
- Information submitted, considered or generated in the course of making the decision, whether or not it was relied upon to make the decision;
- Descriptions of the administrative process and safeguards used to make the decision;
- Records of any independent reviews conducted by [ACHP];
- Medical judgments, including whether a particular service is Experimental/Investigational or not Medically Necessary or appropriate; and
- Expert advice and consultation obtained by [ACHP] in connection with the denied claim, whether or not the advice was relied upon to make the decision.

The Appeal process does not prohibit you from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment or other relief available under law.

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:

1. Do not understand the reason for the denial;
2. Do not understand why the health care service or treatment was not fully covered;
3. Do not understand why a request for coverage of a health care service or treatment was denied;
4. Cannot find the applicable provision in Your Evidence of Coverage;
5. Want a copy (free of charge) of the guideline, criteria or clinical rationale that [ACHP] used to make the decision; or
6. 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 Member 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 Member's health in serious jeopardy.

For questions on appeal and external review rights, a Covered Person can call [ACHP]'s Customer Service Department.

Complaint Process

If you notify us orally or in writing of a Complaint, we will notify you in writing no later than the fifth business day after the date of the receipt of the complaint. We will send you a letter acknowledging the date we received the complaint. This letter will also include [ACHP]'s 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 [ACHP]'s resolution. We will notify You of [ACHP]'s determination within 30 calendar days after the date we received the complaint. If your complaint is related to emergency or denial of a continued hospitalization, we will investigate and resolve the complaint within one business day.

[ACHP] will not discriminate or take punitive action against a member or a member's representative for making a complaint, an Appeal, or for requesting an Expedited Appeal. [ACHP] will not engage in retaliatory action including refusal to renew or cancel coverage because the member or a person acting on behalf of the member has filed a complaint against [ACHP] or appealed a decision of [ACHP]. Furthermore, [ACHP] is prohibited from retaliating against a physician or providers because the physician or provider has filed a complaint or appealed a decision on behalf of the enrollee.

Appeals from a Complaint to the Plan

If the complaint is not resolved to the Member's satisfaction, the Member has the right either to appear in person before a complaint appeal panel where the Member normally receives healthcare services, unless another site is agreed to by the Member, 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.

- We shall send an acknowledgment letter to the Member not later than the fifth business day after the date of receipt of the request for appeal.
- 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 [ACHP] staff, Healthcare Practitioners, and other persons covered under a health plan provided by us. A member of the complaint appeal panel may not have been previously involved in the disputed decision.
- Not later than the fifth business day before the scheduled meeting of the panel, unless the Member agrees otherwise, we shall provide to the Covered Person or Covered Person's designated representative:
  - Any documentation to be presented to the panel by [ACHP] staff;
  - The specialization of any Healthcare Practitioner consulted during the investigation; and
  - The name and affiliation of each of [ACHP] representatives on the panel.
- The Member or the Member's designated representative if the Member is a minor or disabled, are entitled to:
  - Appear in person before the complaint appeal panel;
  - Present alternative expert testimony; and
  - Request the presence of and question any person responsible for making prior determination that resulted in the appeal

Where to Send Appeals and Complaints

All Appeals and Complaints must be sent to:

[Access to Care Health Plan]
[Complaints Address]

Filing Complaints with the Texas Department of Insurance

Any Member, including persons who have attempted to resolve complaints through [ACHP] complaint and appeal process and who are dissatisfied with the resolution, may report the information to Texas Department of Insurance. To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Physical Address: 1601 Congress Avenue, Austin, Texas, 78701
Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance, PO Box 12030, Austin, TX 78711-2030

The Commissioner will investigate a complaint against us to determine compliance within 60 days (about 2 months) after TDI's receipt of the compliant and all information necessary for the department to determine compliance. The Commissioner may extend the time necessary to complete an investigation in the event any of the following circumstances occur:

- Additional information is needed;
- An on-site review is necessary;
- We, the Healthcare Practitioner, or the Member does not provide all documentation necessary to complete the investigation; or
- Other circumstances beyond the control of the department occur.

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.

Assignment of Benefits
Assignment of benefits may be made only with [ACHP]'s 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.

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.

Cost of Legal Representation
The costs of [ACHP] legal representation in matters related to [ACHP] rights under this Contract shall be borne solely by us. The costs of legal representation incurred by or on behalf of a Member shall be borne solely by you or the Member unless we were given timely notice of the claim and an opportunity to protect [ACHP]'s own interests and we failed or declined to do so.

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.

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

No modification or amendment to this Contract will be valid unless approved by the President, Secretary or a Vice-President of [ACHP]. The approval must be endorsed on or attached to this EOC/Contract. No agent has authority to modify this EOC/Contract, waive any of the Contract provisions, extend the time for premium payment, or bind us by making any promise or representation.

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.

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

- 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
- 180 days (about 6 months) after a final determination of a timely filed appeal.

Premium Adjustment
If it is determined that information about the age or smoking status of a Member was omitted or misstated, we will make an equitable premium adjustment. This provision applies equally to the Member and to us.

Notice of Claim
Generally, any services the Member receives will be billed to us by the Physician or Provider.

If the Member receives a service, which will not be billed to us by the Physician or Provider, the Member must send [ACHP] a completed Medical Claim Form with the required documents. The Medical Claim Form can be found in the Member Portal, or you can go to https://[ACHP]health.com.

The Member should mail the Medical Claim Form to the address indicated on the form. Please be advised that Medical Claim Forms cannot be emailed or faxed. We must receive the Medical Claim Form within 30 days (about 4 and a half weeks) from the date the service was received or as soon as reasonably possible, but no later than 95 days from the date of service.
For Emergency Care received and provided outside the United States, the information to be submitted by a Member along with their complete claim includes but is not limited to:

- Proof of payment to the foreign provider for the services provided;
- Complete medical information and/or records;
- Proof of travel to the foreign country such as airline tickets or passport stamps; and
- The foreign provider's fee schedule if the provider uses a billing agency.

Not later than the 15th day after which we receive the claim, we will acknowledge receipt of the claim and investigate the claim. We may need to obtain additional information we reasonably believe will be required, including, but is not limited to:

- Authorizations for the release of medical information including the names of all providers from whom the Covered Person received services;
- Medical information and/or records from any provider;
- Information about other insurance coverage; and
- Any information we need to administer the terms of this Contract.

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 [ACHP]'s notice.

If we notify you, we will pay the claim or part of the claim, we will pay no later than the 5th business day after [ACHP] 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 [ACHP] 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, nor will this Contract be terminated if it was not reasonably possible to give such proof.

Our Relationship with Providers

Participating Providers are not [ACHP] agents, employees or partners. Participating Providers are independent contractors. We do not endorse or control the clinical judgment or treatment recommendation made by Participating Physicians 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, call Customer Service at the telephone number on your member identification card.

Rights That Affect [ACHP]'s Obligation to Pay
Your obligation to assist in the recovery process

The Member is obligated to cooperate and assist us and [ACHP] agents in order to protect [ACHP] recovery rights by:

- Promptly notifying us that you may have a claim;
- Obtaining [ACHP]'s consent before releasing any party from liability for payment of medical expenses;
- Providing us with a copy of any legal notices arising from the Covered Person's injury and its treatment;
- Taking all action to assist [ACHP] enforcement of recovery rights and doing nothing after the Illness, Bodily Injury or accident to prejudice [ACHP] recovery rights; and
- 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.

Right to Request Information
The Member must cooperate with us, and when asked, assist us by:

- Authorizing the release of medical information including the names of all providers from whom medical attention was received;
- Obtaining medical information, or records from any Physician or Provider as requested by [ACHP];
- Providing information regarding the circumstances of the Illness, Bodily Injury or accident;
- 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
- 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.

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.

Coordination of Benefits
This Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one plan. You should not have other health plan coverage per the ACA regulations. The Plan is defined below.

Following are definitions applicable to this COB provision, Section 9.3, Coordination of Benefits

“Plan” is any of the following that provides benefits or services for medical or dental or vision care or treatment.

Plan includes: group, blanket, or franchise accident and health insurance policies,; 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; a vision benefit plan that provides coverage for vision or eye care expenses; 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.

Plan does not include: disability income protection coverage; 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 contract that is designed to fully integrate with other policies.

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.

"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.

"Allowable expense" is a health care expense, including copayments that are 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 member 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.

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:

- The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.
- Except as provided in Section 8(2)(h), a plan that does not contain a COB provision that is consistent with this contract is always primary unless the provisions of both plans state that the complying plan is primary.
- 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.
- 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.
- 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 member uses a non-contracted health care provider or physician, except for emergency services or authorized referrals that are paid or provided by the primary plan.
- When multiple contracts providing coordinated coverage are treated as a single plan for the purpose of COB , 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.
- If a person is covered by more than one secondary plan, the order of benefit determination rules of this subchapter decides 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.
- Each plan determines its order of benefits using the first of the following rules that apply.
    - **Nondependent or Dependent**. The plan that covers the Member other than as a dependent, for example as an employee, member, contract holder, 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, contract holder, subscriber, or retiree is the secondary plan and the other plan is the primary plan.
    - **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.

- For a dependent child whose parents are married or are living together, whether or not they have ever been married:
    a. the plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
    b. if both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

- For a dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:
    a. 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.
    b. 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.
    c. 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 (h)(2)(A) or (h)(2)(B) must determine the order of benefits.
    d. if there is no court order allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the childcare as follows:
        - the plan covering the custodial parent;
        - the plan covering the spouse of the custodial parent;
        - the plan covering the noncustodial parent; then
        - the plan covering the spouse of the noncustodial parent.
- 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. (h)(5) must determine the order of benefits as if those individuals were the parents of the child.
- For a dependent child who has coverage under either or both parents' plans and has their coverage as a dependent under a spouse's plan, Section 8.v. applies.
- 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(h)(2)(A)to the dependent child's parent(s) and the dependent's spouse.

- **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 Section (h)(1) can determine the order of benefits.

- **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 Section (h)(1) 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, contract holder, subscriber, or retiree longer is the primary plan, and the plan that has covered the person the shorter period is the secondary plan.

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

Effect on the Benefits of This Plan
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 any amounts it would have credited in the absence of other health care coverage.

Facility of Payment
A payment made under another plan may include an amount that should have been paid under this Plan. If it does, [ACHP] 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. [ACHP] 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.

Release of Information
For purposes of this Evidence of Coverage, [ACHP] 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 [ACHP] all information deemed necessary to implement these Coordination of Benefits provisions.

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 (about 1 month) of any benefit payment, settlement, compromise or judgment. If you waive or impair [ACHP]'s 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.

[ACHP] Right of Subrogation
To the extent allowed by Texas law, we have the right to recover payments acquired by You against any third party 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 the [ACHP] right of subrogation we may exercise [ACHP]'s right of reimbursement.

Assignment of Recovery Rights
If your claim against the 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 [ACHP] on behalf of you, you agree that any right you have against the other insurer for medical expenses we pay will be assigned to us.

Right to Request Overpayments
We reserve the right to recover any payments made by [ACHP] that were:

- Made in error;
- 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;
- Made to You and/or any party on Your behalf, based on fraudulent or intentional misrepresentation of a material fact; or
- 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 Out-of-Pocket Maximum.

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 [ACHP]'s expense.

State Public Medical Assistance
If a Member 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.

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.

Unpaid Premium
If any premium is due or unpaid and a payment of a claim is made under this Contract, the due or unpaid premium may be deducted from the payment due on the claim.

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

Definitions

The following are definitions of terms as they are used in this Contract.

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 [ACHP] or a designee that the healthcare services furnished or proposed to be furnished to a Member 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 Member, an individual acting on behalf of a Member Person or a Member's provider of record may request reconsideration of an Adverse Determination or Denial of Benefits.

Basic Health Care Services means health care services that the Texas Insurance Commissioner determines an enrolled population might reasonably need to be maintained in good health.

Balance Billing means when a provider bills you for the difference between the provider's charge and the allowed amount. A preferred provider may not balance bill you for covered services.

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 which are administered to a patient following high-dose, ablative or myelosuppressive 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 by [ACHP].

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 Member on the date benefits under this Contract first become effective for that Member 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 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:

- The Centers for Disease Control (CDC) and Prevention of the U.S. Department of Health and Human Services;
- The National Institutes of Health (NIH);
- The U.S. Food and Drug Administration (FDA);
- The U.S. Department of Defense (DOD);
- The U.S. Department of Veterans Affairs (VA); or

- An Institutional review board of an institution in this state that has an agreement with the Office for Human Research Protection (OHRP) of the
- U.S. Department of Health and Human Services (HHS);
- The Agency for Health Care Research and Quality;
- The Centers for Medicare and Medicaid Services;
- 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 which have licensed and/or certified personnel and equipment to provide Advanced Cardiac Life Support (ACLS) consistent with American Heart Association (AHA) and American Trauma Society (ATS) standards of care: (ii) for purposes of emergency care related to mental illness, behavioral 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 defend 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 Behavioral Healthcare; 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 Member; or a Provider's or Member's oral or written expression of dissatisfaction or disagreement with an adverse determination.

Complainant means a Member, or a Physician, Provider, or other person designated to act on behalf of a Member who files a complaint.

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:

- Due to the same Bodily Injury or Illness; and
- 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 contract agreement, 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 which describe the agreement between you and [ACHP].

Contract Holder means the person to whom this Contract is issued.

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 [ACHP] 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.

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 copayment that must be paid by the Member for Prescription Drugs.

Covered Service means a service or supply that is covered under this Contract and 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.

Covered Oral Surgery means maxillofacial surgical procedures 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. Surgical treatment of the temporomandibular joing, and
5. Removal of complete bony impacted teeth.

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 [ACHP] 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.

Member means anyone eligible to receive Contract benefits under this plan as a Member.

Custodial Care means services given to a Member if:

a. The Member needs services that include, but are not limited to, assistance with dressing, bathing, preparation and feeding of special diets, walking, supervision of medication, which is ordinarily self-administered, getting in and out of bed and maintaining continence; or
b. The services are required to primarily maintain and not likely to improve the Member's condition.
c. Services may still be considered Custodial Care by [ACHP] even if:
The Member is under the care of a Healthcare Practitioner,

- The services are prescribed by a Healthcare Practitioner to support or maintain the Member's condition;
- Services are being provided by a Nurse; or
- The services involve the use of skills which can be taught to a layperson and do not require the technical skills of a Nurse.

Denial of Benefits means any of the following: a denial, reduction, or termination of, or a failure to provide health care benefit.

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 [ACHP] or administrative order to provide coverage until such [ACHP] 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:

a. Is beyond the limiting age of a child;
b. Is unmarried;
c. Is permanently mentally or physically handicapped; and
d. 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 [ACHP] or administrative order, must meet all of the qualifications of a Dependent as determined by us.

You must furnish satisfactory proof to us upon [ACHP] 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:

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

b. Insulin pumps and associated appurtenances;
c. Insulin infusion devices; and
d. Podiatric appliances for the prevention of complications associated with diabetes.

Diabetic Supplies means:

a. Test strips for blood glucose monitors;
b. Visual reading and urine test strips;
c. Lancets and lancet devices;
d. Insulin and insulin analogs;
e. Injection aids;
f. Syringes;
g. Prescriptive and non-prescription oral agents for controlling blood sugar levels;
h. Glucagon emergency kits; and
i. Alcohol swabs.

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 [ACHP] and indicates applicable Dispensing Limits and/or any Prior Authorization or Step Therapy requirements. Visit [ACHP] Website at [Website] or call [ACHP] Member Services Department at the telephone number on Your [ACHP] Member Identification Card to obtain the Drug Formulary. The Drug Formulary is subject to change. We will provide written notice no later than 60 days prior to the Effective Date of the change

Drug Tiers allow plans the ability to group different drug types together (i.e., Generic, Brand, Preferred Brand).

Durable Medical Equipment means equipment that:

1. can withstand repeated use;
2. is primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience;
3. generally, is not useful to a person in the absence of an injury or illness;
4. is appropriate for use in the home;
5. is Medically Necessary for the Member's Injury or Illness;
6. is prescribed by a Healthcare Practitioner.

Effective Date means the first date all the terms and provisions of this Contract apply. It is the date that appears on your [ACHP] 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:

a. Placing the health of that individual in serious jeopardy;
b. Serious impairment of bodily functions;
c. Serious disfigurement; or
d. Serious dysfunction of any bodily organ or part; or
e. 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 Member or the provider of treatment or services.

Experimental or Investigational means any procedure, treatment, supply, device, equipment, facility or drug (all services) determined by [ACHP]'s Medical Director or his/her designee to:

a. Not be a benefit for diagnosis or treatment of an Illness or a Bodily Injury;
b. Not be as beneficial as any established alternative; or
c. 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:

- 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:
    - Found to be accepted for that use in the most recently published edition of the United States Pharmacopoeia-Drug Information for Healthcare Professional (USP-DI) or in the most recently published edition of the American Hospital Formulary Service (AHFS) Drug Information;
    - 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
    - Is mandated by state law;
- Is a device required to receive Premarket Approval (PMA) or 510K approval by the FDA, but has not received a PMA or 510K approval;
- 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;
- 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;
- Is identified as not covered by the Centers for Medicare and Medicaid Services (CMS) Medicare Coverage Issues Manual, a CMS Operational Contract Letter or a CMS National Coverage Decision except as required by state or federal law;

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

1. The treatment, services or supplies are:

- Not as effective in improving health outcomes and not as cost effective as established technology; or
- 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 Federal External Review. See the Appeals Process to Independent Federal External Review provision in the General Provisions section of this Contract.

Extended Care Expenses means the Allowable Amount of charges incurred for those Medically Necessary services and supplies provided by a Skilled Nursing Facility, a Home Health Agency, or a Hospice as described in the Extended Care Expenses portion 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 Member 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 Member 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.

Free-Standing Surgical Facility means any licensed public or private establishment which 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 [ACHP].

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 Member's home or is a Family Member.

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

Heritable Disease means an inherited disease that may result in intellectual or physical disability or death.

Home Healthcare Agency means a Home Healthcare Agency or Hospital which meets all 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/or 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 and is measured in 15-minute increments.

Hospice Care Agency means an agency which:

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; and
3. Meets the following requirements:

    - Has obtained any required certificate of need;
    - Provides 24-hours-a-day, seven-days-a-week service, supervised by a Healthcare Practitioner,
    - Has a full-time administrator;
    - Keeps written records of services provided to each patient; and
    - Has a coordinator who:
        a. Is a Nurse; and
        b. Has clinical experience, of which at least two were involved in caring for terminally ill patients; and
        c. 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 Member 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.

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

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

1. Principally provides hospice care;
    a. Keeps medical records of each patient;
    b. Has an ongoing quality assurance program;
2. Has a Healthcare Practitioner on call at all times;
3. Provides 24 hours -a-day skilled nursing services under the direction of a Nurse; and
4. 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; and
5. It must be operated as a Hospital as defined by those laws; and
6. It must not be primarily a convalescent, rest or nursing home; or
7. Facility providing custodial, educational or rehabilitative care. The Hospital must be accredited by one of the following:
    - The Joint Commission on the Accreditation of Hospitals;
    - The American Osteopathic Hospital Association;
    - The Commission on the Accreditation of Rehabilitative Facilities; or
    - DNV (Det Norske Veritas).

Identification or ID Cards means cards each Member receives which contain [ACHP] address and telephone number.

Intensive Outpatient Program means a freestanding or Hospital-based program that provides services for at least three hours per day, two or more days per week, to treat mental illness, drug addiction, substance abuse or alcoholism, or specializes in the treatment of co-occurring mental illness with drug addiction, substance abuse or alcoholism. These programs offer integrated and aligned assessment, treatment and discharge planning services for treatment of severe or complex co-occurring conditions which make it unlikely that the Participants will benefit from programs that focus solely on mental illness conditions.

Illness means disturbance in function or structure of the Member's body which causes physical signs or symptoms which if left untreated, will result in a deterioration of the health state of the structure or system(s) of the Member'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.

Inpatient Physician Care Services means Inpatient care by non-primary care physician while the enrollee is in an inpatient facility, for example, hospital or skilled nursing facility, a provision that on admission to the inpatient facility a physician other than the primary care physician may direct and oversee the Member's care. Inpatient Physician Care Services include services performed, prescribed, or supervised by physicians or other health professionals including diagnostic, therapeutic, medical, surgical, preventive, referral, and consultative health care services

Inpatient Hospital Expense means the Allowable Amount incurred for the Medically Necessary items of service or supply listed in this document for the care of a Member, provided that such items are:

1. Furnished at the direction or prescription of a Physician or Provider; and
2. Provided by a Hospital or Chemical Dependency Treatment Center;
3. Furnished to and used by the Member during an inpatient Hospital Admission.
4.

An expense shall be deemed to have been incurred on the date of provision of the service for which the charge is made.

Inpatient Hospital Expense shall include:

1. Room accommodation charges. If the Member is in a private room, the amount of the room charge in excess of the Hospital's average semiprivate room charge is not an Eligible Expense.

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.

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 Member's physical or mental condition.

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.

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 Treatment means interventions that focus on behavior and the variables and biological mechanisms 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 to 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 defined by Us, to Members including covered Prescription or refills.

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 been 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 an advanced practice nurse (A.P.R.N.), 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 less than 24 hours if the Member:

a. Has not been admitted as a resident inpatient;
b. Is physically detained in an emergency room, treatment room, observation room or other such area; or
c. 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 (about 12 months) from the date of discharge from the Hospital following a Covered Organ Transplant received while covered by [ACHP].

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 for Prescription Drugs and Medical servives but does not include:

- Services, supplies or charges limited or excluded by the Plan; or
- Expenses not covered because a benefit maximum has been reached;
- Penalties for failing to obtain Preauthorization;
- An Eligible Expense paid by the Primary Plan when [ACHP] is the Secondary Plan for purposes of coordination of benefits;
- Other Contract limits.

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 community integration, or nonresidential treatment settings.

Outpatient Services means services that are rendered to You while You 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. An independent laboratory; or
5. Clinic

Outpatient services include the following:

1. primary care and specialist physician services;
2. outpatient services by other providers;
3. diagnostic services, including laboratory, imaging, and radiologic services;
4. infusion or injection of medications;
5. therapeutic radiology services;
6. prenatal services, if maternity benefits are covered;

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

Partial Hospitalization means services for mental health and substance use disorders that are provided in an outpatient program by a Hospital or Healthcare Treatment Facility in which patients do not reside for a full 24-hour period.

- For a comprehensive and intensive interdisciplinary psychiatric treatment;
- That provides for social, psychological, and rehabilitative training programs with a focus on reintegration back into the community and admits children and adolescents who must have a treatment program designed to meet the special needs of that age range; and
- 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:

a. Custodial care; or
b. 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 as defined by us, to Members including covered Prescriptions or refills.

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 Members.

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 Members.

Pediatric refers to Members up to the age of 19. Coverage for Pediatric benefits will end on the last day of the month in which the Member turns 19.

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 an individual licensed to practice medicine in the State of Texas;

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

Post-Acute Care Treatment Services means services provided after acute-care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral, or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or 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 biologic. The drug, medicine, or medication, or biologics 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 Member 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 Member;
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 Member to be Hospital Confined or to have the outpatient Surgery or procedure.

Preventive Services means services to prevent disease or illness for adults, women and children, as

recommended by the U.S. Department of Health and Human Services (HHS), i.e., as described in 45 CFR 147.130; and/or as mandated by the State of Texas, and as described above in the Preventive Services section.

For the recommended Preventive Services that apply to [ACHP] contract, 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 [ACHP] ID card.

Primary Care Physician or Primary Care Provider (PCP) (PCP) means a Physician or Provider who has agreed with [ACHP] 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), 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 [ACHP], or [ACHP] designee, that a Service or Prescription Drug is Medically Necessary prior to it being provided.

Prosthetic Appliances means artificial devices including limbs or eyes, braces or similar prosthetic or orthopedic devices, which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). For purposes of this definition, a wig or hairpiece is not considered a Prosthetic Appliance, except as specified above in "**Durable Medical Equipment/Orthotics/Prosthetic Devices"**, after cancer treatment.

Provider means a Hospital, Physician, Behavioral Health Practitioner, Other Provider, or any other person, company, or institution furnishing to a Member an item of service or supply listed as Eligible Expenses.

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 performed on an abnormal body structure caused by congenital defects, developmental abnormalities, trauma, infection, tumor or disease in order to improve function.

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 multidisciplinary 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.

Rescission means the cancellation or discontinuance of coverage that has retroactive effect. It is a cancellation that treats a contract agreement as void from the time of the Contract Holder or [ACHP] enrollment.

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 which:

1. Is licensed as a 24-hour residential, intensive, inpatient facility, although NOT licensed as a Hospital;
2. Provides a multidisciplinary treatment plan in a controlled environment, with periodic supervision of a licensed Healthcare Practitioner or Ph.D. psychologist; and
3. Provides programs such as social, psychological, and rehabilitative training, age appropriate for the special needs of the age group of patients, 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 behavioral deterioration.

Routine Nursery Care means the charges made by a Hospital 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 Member 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 which a person may administer to himself/herself by means of intramuscular, intravenous or subcutaneous injection excluding insulin, and prescribed for use by the Member.

[ACHP] means [Access to Care Health Plan, LLC], a licensed health maintenance organization.

Serious Mental Illness means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

- bipolar disorders (hypomanic, manic, depressive, and mixed);
- depression in childhood and adolescence;
- major depressive disorders (single episode or recurrent);
- obsessive-compulsive disorders;
- paranoid and other psychotic disorders;
- schizo-affective disorders (bipolar or depressive); and
- schizophrenia

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 direct service benefits are available and accessible to Members, who live, reside or work within the geographic area and the legal residence of any enrolled dependents must be the same as the subscriber, or the subscriber must reside, live, or work in the service area and the residence of any enrolled dependents must be:

1. In the service area with the person having temporary or permanent conservatorship or guardianship of the dependents, including adoptees or children who have become the subject of a suit for adoption by the enrollee, where the subscriber has legal responsibility for the health care of the dependents;
2. In the service area under other circumstances where the subscriber is legally responsible for the health care of the dependents;
3. In the service area with the subscriber's spouse; or
4. Anywhere in the United States for a child whose coverage under a plan is required by a medical support order.

Your Plans' service area is listed at [Website], in the HMO Provider Directory If you have additional questions, or need a printed copy of the Provider Directory, contact Customer Service at [1-800-xxx-xxxx].

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 and substance use disorders, 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 Member with a disability;
2. A Member with an acute condition; or
3. A Member with a Life-Threatening Disease.
4. A Member 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 [ACHP], to Members.

Step Therapy means a type of Prior Authorization program that encourages prescribing and use of less costly, safe, and effective medications before we approve of coverage for more costly alternatives. We may require a Member to follow certain steps prior to [ACHP] coverage of some high-cost drugs, medicines, or medications, or biologicals. We may require a Member 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 Member. Alternatives may include over-the-counter drugs, Generic Medications, and brand-name medications.

- [ACHP] does not require more than one “Step” for Step Therapy for Serious Mental illness.
- [ACHP] prohibits step therapy for prescription drugs used to treat stage four advanced metastatic cancer. This prohibition only applies to an FDA-approved drug when its use is consistent with best practices for the treatment of stage four advanced metastatic cancer or an associated condition and is supported by peer-reviewed, evidence-based literature. If [ACHP] does not deny a step-therapy protocol exception request before 72 hours after the health benefit plan receives the request, [ACHP] will automatically grant an exception. If the

prescribing provider believes death or serious harm is probable, the request is considered granted if the plan does not deny the request before 24 hours.

Subacute Medical Care means a short-term comprehensive inpatient program of care for a Member who has an Illness or a Bodily Injury that:

1. Does not require the Member 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.

Subacute Rehabilitation Facility means a facility that provides Subacute 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 Subacute 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 and substance use disorders 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 a procedure 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.

Teledentistry dental service means a health care service delivered by a dentist, or a health professional acting under the delegation and supervision of a dentist, acting within the scope of the dentist's or health professional's license or certification to a patient at a different physical location than the dentist or health professional using telecommunications or information technology.

Telehealth Service means a health service, other than a 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 patient at a different physical location than the health professional using telecommunications or information technology.

Telemedicine Medical Services means a health care service delivered by a physician licensed in this state, or a health profession acting under the delegation and supervision of a physician licensed in this

state and acting within the scope of the physician's or health professional's license to a patient at a different physical location than the physician or health professional using telecommunications or information technology.

Urgent Care means immediate medical, mental health or substance use disorder services offering outpatient care for the treatment of acute and chronic illness and injury that does not require Emergency Care.

Urgent Care Center means any licensed public or private non-Hospital free standing facility which 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 [ACHP] means or otherwise refers to the insurer as shown on the cover page of this Contract.

You/Your means the Member.

Where to Mail Completed Claim Forms

Medical Claims
[Access to Care Health Plan]
Attention: Claims
[Claims mailing address]
]City, ST ZIP]

Prescription Drug Claims
[PBM] Health Solutions
[Division/ Dept]
[P.O. Box]
[City, ST Zip]

Behavioral Health Claims
[Access to Care Health Plan]
[P.O. Box]
[City, ST ZIP]

If a provider does not file a claim for services you received, you can submit the information yourself by completing the Claim Form on our website at https://[ACHP]health.com. Most providers will file claims for you. A claim is a detailed invoice that your health care provider (such as your doctor, clinic, or hospital) sends to the health insurer. This invoice shows exactly what services you received. If the provider does not file a claim for services you received, you can submit the information yourself by using the claim form found online at http://[ACHP]health.com. It is your responsibility to make sure your claim is submitted to [ACHP] within 95 days (about 3 months) from the date services were received.

To help assist your provider with submitting claims timely to [ACHP], please provide your insurance information as soon as possible and respond to any correspondence sent to you by the provider. You may be responsible for billed charges if your claim is not submitted to [ACHP] within 95 days from the date of service. [ACHP] will review the claim, and if the services received were provided by an in-network provider or facility within your health benefits plan network, we will pay the claim based on our contracted rate with the provider or facility. If you receive emergency services from an out-of-network physician or provider, [ACHP] will pay the provider at the usual and customary rate or at an agreed-upon rate. Non-emergency services received from an out-of-network provider or facility will not be covered.

Once complete, send your claim to the appropriate claim address above for review and consideration. If you have questions regarding the Claim Form, contact [ACHP]'s Customer Service department.

REVIEW OF CLAIM DETERMINATIONS

Claim Determinations
Following the receipt of a properly submitted claim (clean claim), [ACHP] will provide reimbursement for covered benefits in accordance with the plan's provisions. [ACHP] will acknowledge the receipt, acceptance, or rejection of [ACHP] claims no later than the 15th business day after the date [ACHP] receives all items, statements, and forms required to process the claim. [ACHP] will pay or deny a claim within 30 days (about 4 and a half weeks) of receipt. If [ACHP] requires further information in order to process the claim, [ACHP] will request it within that 30-day period. If [ACHP] agrees to pay a claim or part of a claim, [ACHP] will pay the claim no later than the 5th business day after the date of notice to pay is made.

You have the right to seek and obtain a full and fair review by [ACHP] of any determination of a claim, any determination of a request for Preauthorization, or any other determination made by [ACHP] of [ACHP] benefits under your plan.

If a Claim Is Denied or Not Paid in Full

On occasion, [ACHP] may deny all or part of your claim. There are a number of reasons why this may happen, including claims denied for services which are excluded by this Evidence of Coverage document. It may also include denial of claims for services rendered before or after termination of coverage with [ACHP]. We suggest that you first read the *Explanation of Benefits* summary prepared by [ACHP]; then review this EOC to see whether you understand the reason for determination. If you have additional information that you believe could change the decision, please follow the *claims appeal process.*

Claims Appeal Process

You or your authorized representative may request a review of this benefit determination by submitting your appeal to us in writing at the following address: [Access to Care Health Plan] Attention: Member Appeals {claims appeals address]. The request for your review must be made within 180 days (about 6 months) from the date you received this statement. If you request a review of your claim denial, we will complete our review no later than 30 days (about 4 and a half weeks) after we receive your request review. Your written request for review should include:

- The member's name and identification number.
- The actual service for which a no-benefit coverage decision was made
- The reasons why you feel benefit coverage should be provided
- Any available medical information to support your reasons for reversing the benefit decision, if applicable

You may have the right to file a civil action under ERISA if all required reviews of your claim have been completed.

Should you have a complaint regarding payments of healthcare services you contact Texas Department of Insurance Consumer Protection Division at 1-800-252-3439.

NOTICE

PER SB 968, 87TH LEGISLATIVE SESSION, [ACHP] WILL NOT REQUIRE A MEMBER TO PROVIDE ANY DOCUMENTATION CERTIFYING RECEIVING A COVID-19 VACCINE AS A CONDITION FOR OBTAINING COVERAGE OR RECEIVING BENEFITS UNDER A PLAN. ALSO, [ACHP] WILL NOT REQUIRE DOCUMENTATION OF POST-TRANSMISSION RECOVERY AS A CONDITION FOR OBTAINING COVERAGE OR RECEIVING BENEFITS UNDER THE PLAN.

PER HB3459, 87TH LEGISLATIVE SESSION, [ACHP] MAY EXEMPT A PHYSICIAN OR PROVIDER FROM OBTAINING PREAUTHORIZATION FOR A PARTICULAR HEALTH CARE SERVICE IF THE PHYSICIAN OR PROVIDER MEETS RELEVANT EXEMPTION CRITERIA.

PER HB1935, 87TH LEGISLATIVE SESSION, [ACHP] ENACTED COVERAGE REQUIREMENT FOR EMERGENCY REFILLS OF INSULIN AND INSULIN-RELATED EQUIPMENT IN THE SAME MANNER AS A NONEMERGENCY REFILL.

PER HB1919, 87TH LEGISLATIVE SESSION, [ACHP] PROHIBITS INDUCING AN ENROLLEE TO USE AN AFFILIATED PHARMACY OR DME PROVIDER, INCLUDING BY OFFERING REDUCED COST-SHARING.

NOTICE

ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A PART OF [ACCESS TO CARE HEALTH PLAN]' PROVIDER NETWORK, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER PROVIDERS WHO ARE NOT A PART OF [ACHP]'S PROVIDER NETWORK. THE NON-NETWORK FACILITY-BASED PHYSICIAN OR OTHER HEALTH CARE PRACTITIONER MAY BALANCE BILL YOU FOR AMOUNTS NOT PAID BY [ACHP]. IF YOU RECEIVE A BILL FROM A NON-NETWORK, FACILITY BASED PHYSICIAN, OR OTHER HEALTH CARE PRACTITIONER FOR EMERGENCY SERVICES, PLEASE CONTACT [ACHP] AT [1-800-xxx-xxxx]. YOU SHOULD NOT BE BALANCE BILLED FOR EMERGENCY SERVICES. YOU MAY BE REQUIRED TO SUBMIT A COPY OF THE ITEMIZED BILLING STATEMENT FOR INVESTIGATION PURPOSES.

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with [ACHP].

Mastectomy or Lymph Node Dissection

Minimum Inpatient Stay: If due to treatment of breast cancer, any person covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of:

1. 48 hours following a mastectomy; and
2. 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the covered person receiving the treatment and the attending physician determine that a shorter period of inpatient care is appropriate.

Prohibitions: We may not (a) offer the covered person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above; (b) condition, limit, or deny any covered person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above; or (c) reduce or limit the amount paid to the physician or provider, nor otherwise penalize, or provide a financial incentive to induce the physician or provider to provide care to a covered person in a manner inconsistent with the coverage and/or benefits shown above.

If any person covered by this plan has questions concerning the above, call [ACHP] at [1-800-xxx-xxxx], or write us at [Access to Care Health Plan] [address].

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with [ACHP].

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy-Enrollment

Coverage and/or benefits are provided to each covered person for reconstructive surgery after mastectomy, including:

1. All stages of the reconstruction of the breast on which mastectomy has been performed;
2. Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
3. Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

The coverage and/or benefits must be provided in a manner determined to be appropriate in consultation with the covered person and the attending physician.

Copayment Amounts as shown on [ACHP] Schedule of Benefits will be the same as those applied to other similarly covered Inpatient Hospital or Medical-Surgical, or Preventive Services.

Prohibitions: We may not (a) offer the covered person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above; (b) condition, limit, or deny any covered person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above; or (c) reduce or limit the amount paid to the physician or provider, nor otherwise penalize, or provide a financial incentive to induce the physician or provider to provide care to a covered person in a manner inconsistent with the coverage and/or benefits shown above.

If any person covered by this plan has questions concerning the above, call [ACHP] at [1-800-xxx-xxxx], or write us at [Access to Care Health Plan] [address].

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with [ACHP].

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy-Annual

Your contract, as required by the federal Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If any person covered by this plan has questions concerning the above, call [ACHP] at [1-800-xxx-xxxx], or write us at [Access to Care Health Plan] [address].

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with [ACHP].

Examinations for Detection of Prostate Cancer

Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include:

(a) A physical examination for the detection of prostate cancer; and
(b) A prostate-specific antigen test for each covered male who is:
    1) At least 50 years of age; or
    2) At least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

If any person covered by this plan has questions concerning the above, call [ACHP] at [1-800-xxx-xxxx], or write us at [Access to Care Health Plan] [address].

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with [ACHP].

Inpatient Stay Following Birth of a Child

For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

a. 48 hours (about 2 days) following an uncomplicated vaginal delivery; and
b. 96 hours (about 4 days) following an uncomplicated delivery by Cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to:

a. Give birth in a hospital or other health care facility; or
b. Remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours (about 4 days) has expired, we will provide coverage for post-delivery care. Post-delivery care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. Care will be provided by a physician, registered nurse or other appropriately licensed health care provider, and the mother will have the option of receiving the care at her home, the health care provider's office or a health care facility.

Prohibitions: We may not (a) modify the terms of this coverage based on any covered person requesting less than the minimum coverage required; (b) offer the mother financial incentives or other compensation for waiver of the minimum number of hours required; (c) refuse to accept a physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians; (d) reduce payments or reimbursements below the usual and customary rate; or (f) penalize a physician for

recommending inpatient care for the mother and/or the newborn child.

If any person covered by this plan has questions concerning the above, call [ACHP] at [1-800-xxx-xxxx], or write us at [Access to Care Health Plan] [address].

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with [ACHP].

Coverage for Tests for Detection of Colorectal Cancer

Benefits are provided, for each person enrolled in the plan who is 45 years of age or older, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include the covered person's choice of:

1. fecal occult blood test performed annually, and a flexible sigmoidoscopy performed every five years, or
2. a colonoscopy performed every 10 years.

If any person covered by this plan has questions concerning the above, call [Access to Care Health Plan] at [1-800-xxx-xxxx] or write us at [address].

NOTICE OF CERTAIN MANDATORY BENEFITS

Coverage of Tests for Detection of Human Papillomavirus and Cervical and Ovarian Cancer

Coverage is provided, for each woman enrolled in the plan who is 18 years of age or older, for expenses incurred for an annual medically recognized diagnostic examination for the early detection of cervical and ovarian cancer. Coverage required under this section includes a CA 125 blood test, and at a minimum a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

If any person covered by this plan has questions concerning the above, call [ACHP] at [1-800-xxx-xxxx], or write us at [Access to Care Health Plan] [address].

[Access to Care Health Plan]

HIPAA NOTICE OF PRIVACY PRACTICES

This Notice is effective October 1, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY [ACHP] AND HOW YOU CAN GET ACESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULY.

If you have questions about this Notice or need more information about [ACHP] privacy rights, you may contact [ACHP] at [1-800-xxx-xxxx].

PURPOSE:

[Access to Care Health Plan] ([ACHP]) takes [ACHP]'s legal responsibility under state and federal law to protect the privacy and security of Enrollee Protected Health Information (PHI). PHI is individually identifiable health information, including Member name, date of birth, Social Security Number, medical, genetic and demographic information, collected from You or created or received by [ACHP] that relates to past, present or future physical or mental health and substance use disorder condition; the health care that You receive; or the past, present, or future payment for the provision of health care services to you.

This Notice describes how [ACHP] uses and discloses Enrollee PHI in administering benefits, and the legal rights of Enrollees with respect to their PHI.

In this Notice, [Access to Care Health Plan] is referred to as "[ACHP]," "Us," "[ACHP]" or "We."

HOW [ACHP] MAY USE AND DISCLOSE ENROLLEE PHI:

1. **Treatment.** In order to provide you with coverage for the health care services that you receive, [ACHP] needs PHI about You. We obtain that PHI from You, or Your doctor. We may disclose [ACHP] PHI to a [ACHP] doctor, specialist, pharmacy, or hospital where you received health care services. For example, a [ACHP] doctor may request [ACHP] hospital or pharmacy records from us to make treatment decisions about you.

2. **Payment.** [ACHP] may use or disclose Enrollee PHI to pay or collect payment for You or Your child's covered health care services; for conducting utilization and Medical Necessity reviews, and for determining eligibility for services or medications; and for calculating copayment or coinsurance amounts. For example, we may use medical history to decide whether a particular treatment or service is Medically Necessary and what the payment for that treatment should be.

3. **Health Care Operations.** [ACHP] may use or disclose Enrollee PHI to operate [ACHP] HMO. That includes performing certain health care operations such as:

- activities to assess and improve the quality of You or Your child's health care services;
- reviewing the competence, qualifications, and performance of health providers who contract with Us to provide health care services;
- conducting performance measurement and outcomes assessments;
- disease management program for Enrollees with specific conditions such as diabetes and asthma; and
- business management or general administrative activities, including data and information management systems, communications with [ACHP] accountants, lawyers, consultants and other business associates to determine [ACHP] compliance with state and federal laws. We will first enter into a business associate agreement to ensure that such consultants or business associates agree to be bound by [ACHP] Privacy and Security Policies and Procedures and the requirements of state and federal law with respect to use and disclosure of [ACHP] PHI.

4. **As Required by Law.** We will disclose PHI about you when required to do so by federal or Texas laws or regulations.

5. **To Avert a Serious Threat to Health or Safety.** We may use and disclose PHI about You to medical or law enforcement personnel when necessary to prevent a serious threat to [ACHP] health and safety or the health and safety of another person.

6. **Research.** Under certain circumstances, we may use and disclose [ACHP] PHI for research purposes.

    - For example, a research project may involve comparing the outcome of Enrollees who were provided one type of medication with the outcome of Enrollees who were given another type of medication. All research projects, however, are subject to a special approval process. Prior to using or disclosing any PHI, the project must be approved through a research approval process. We will ask for [ACHP] specific authorization if the researcher will have access to [ACHP] name, address, or other information that reveals who you are.

SPECIAL SITUATIONS:

7. **Qualified Personnel.** We may disclose PHI for management audit, financial audit, or program evaluation, but the personnel may not directly or indirectly identify you in any report of the audit or evaluation, or otherwise disclose [ACHP] identity in any manner.

8. **Public Health Risks**. We may disclose medical information about you for public health activities. These activities generally include the following activities:

    - To prevent or control disease, injury, or disability;
    - To report reactions to medications or problems with products;
    - To notify people of recalls of products they may be using;
    - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
    - To notify the appropriate government authority if we believe you have been the victim of abuse, neglect, or domestic violence.

All such disclosures will be made in accordance with the requirements of Texas and Federal laws and regulations.

9. **Health Oversight Activities.** We may disclose PHI to a health oversight agency for activities authorized by law to oversee the health care system. These oversight activities include, but are not limited to, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, eligibility or compliance, and to enforce health-related civil rights and criminal laws.

10. **Lawsuits and Disputes**. If you are involved in certain lawsuits or administrative disputes, we may disclose PHI about you in response to a court or administrative order.

11. **Law Enforcement**. We may release medical information if asked to do so by a law enforcement official in response to a court order or subpoena; or

12. **Coroners**. Medical Examiners and Funeral Directors. We may release PHI to a coroner or medical examiner.

13. **Inmates**. If you are an inmate of a correctional facility, we may release medical information about you to the correctional facility for the facility to provide you treatment.

14. **Electronic Disclosure.** Texas law requires that we provide you with notice that your PHI is subject to electronic disclosure. Please note that we may use and disclose Your PHI electronically. For example, your PHI is maintained on an electronic health record. If another provider providing your treatment requests a copy of your medical record, we may forward such record electronically.

15. **Personal Representative**. We may disclose Your PHI to the personal representative of your estate.

16. **Marketing.** Marketing generally includes a communication made to describe a health- related product or service that may encourage you to purchase or use the product or service. For example, marketing includes communications to you about new state-of-the-art equipment. We will not use Your PHI for marketing purposes without your authorization. Marketing does not include communications from us to You to describe a health-related product or service that is included in, available through, added or replaced in [ACHP]'s plan of benefits, or is about the entities participating in [ACHP]'s health care provide network.

17. **Sale of your Medical Information**. [ACHP] will not disclose your PHI to any person in exchange for direct or indirect remuneration without your authorization, except to another covered entity unless the disclosure is to another covered entity for the purpose of payment, health care operations or performing an HMO function. *Any other sale of Protected Health Information requires your written authorization.*

18. **Government Programs.** [ACHP] may disclose an Enrollee's PHI to another government agency offering public benefits if:

- the information relates to whether an Enrollee qualifies for or is enrolled in CHIP or STAR and the law requires or specifically allows the disclosure; or
- the other government agency has the same privacy protections as [ACHP], has programs that serve similar types of people, and the disclosure is needed to coordinate or improve how the programs are run; and
- to alert a law enforcement official of a death that occurred from criminal conduct.

19. **For Judicial or Administrative Proceedings.** [ACHP] may disclose an Enrollee's PHI for judicial and administrative purposes, including an order from a regular or administrative court.

20. **Secretary of Health and Human Services.** [ACHP] must disclose Enrollee PHI to the Secretary of Health and Human Services when the Secretary requests the information to enforce privacy protections.

21. **Other Uses and Disclosures.** [ACHP] may use or disclose Enrollee PHI:

    - to create health information that does not identify any specific individual;
    - to the U.S. military or a foreign military for military purposes, if an Enrollee is a member of the group asking for the information;
    - for purposes of lawful national security;
    - to federal officials to protect the President and others;
    - to a prison or jail, if You are an inmate of that prison or jail, or to law enforcement personnel if the Enrollee is in custody; and
    - to comply with workers' compensation laws or similar laws.

ANY OTHER USES OR DISCLOSURE OF PHI WILL BE MADE ONLY UPON YOUR INDIVIDUAL WRITTEN AUTHORIZATION. YOU MAY REVOKE AN AUTHORIZATION AT ANY TIME PROVIDED IT IS IN WRITING AND WE HAVE NOT ALREADY RELIED ON THE AUTHORIZATION.

YOUR RIGHTS:

You have the following rights regarding the PHI we maintain:

1. **Right to Request Restrictions.** You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, or health care operations. We are not required to agree to or abide by your request. If we do agree, we will comply with your request unless the PHI is required to provide you with emergency treatment, or the agreement has been terminated in accordance with HIPAA guidelines. Requests must be received in writing. If you pay for treatment or service in full and in cash and ask your provider not to disclose to [ACHP] that you have received the treatment or service, your provider must agree to your request.

2. **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by telephone at work or that we only contact you by mail at home. Your request must specify how, where, or when you wish to be contacted. We will attempt to accommodate all reasonable requests.

3. **Right to Inspect and Receive a Copy.** Enrollees have the right to request access to inspect, receive a physical or electronic copy, or be provided a summary of the Enrollee's PHI or accounting information. We must provide you your records or the summary within 15 days of your request.

4. **Right to Amend.** If you believe that the PHI we have about you is incorrect or incomplete, you may request an amendment. You have the right to request an amendment for as long as the PHI is kept by or for [ACHP]. You must include a reason that supports your request. All requests for amendment should be made in writing. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny Your request if You ask us to amend PHI that: (1) was not created by us, unless the person or entity that created the PHI is no longer available to make the amendment; (2) is not part of the PHI kept by or for [ACHP]; (3) is not part of the PHI that You would be permitted to inspect and copy; or (4) is accurate and complete. [ACHP] will notify you if we deny the request and will include instructions as to how you may appeal the request or file a complaint.

5. **Right to be Notified.** You have a right to be notified regarding an unlawful breach of unsecured PHI and a breach of [ACHP]'s security system as defined by Texas law.

6. **Right to an Accounting of Disclosures.** You have the right to request an accounting of disclosures regarding your health information. Under federal law, you may request an accounting for a period of three years prior to the date the accounting is requested.

7. **Information Maintained in Paper Records.** You may request a record of disclosures that have been made to persons or entities other than for treatment, payment, or health care operations that have taken place in the past six (6) years.

8. **Right to a Copy of This Notice.** You have the right to a paper copy of this Notice at any time. You may also obtain an electronic copy of this notice at our website, [Website]/benefits/.

CHANGES TO THIS NOTICE OF PRIVACY PRACTICES:

[ACHP] reserves the right to change our practices and to make the new provisions effective for all PHI we maintain. If [ACHP]'s information practices change, [ACHP] will post an amended Notice of Privacy Practices in [ACHP]'s office and on [ACHP]'s website. You may request that a copy be provided to you by contacting the Privacy Officer. The new practices will apply to all the health information about you or your child, regardless of when [ACHP] received or created the information.

If you would like additional copies of this Notice or require a translation of this Notice in another language, please contact us at [1-800-xxx-xxxx].

NONDISCRIMINATION AND ACCESSIBILITY

[Access to Care Health Plan, LLC], (ACHP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. [ACHP] does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, or on the basis of political affiliation.
[ACHP]:

- 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)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact [ACHP].

If you believe that [ACHP] 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 with:

[Access to Care Health Plan]
Attn: Sharon Alvis, Chief Executive Officer & President
[Address]
Telephone: [1-800-xxx-xxxx], TTY: 711, Fax: [fax]
Complaints @[ACHP]health.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, [ACHP] Customer Service is available to help you.

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)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.