COMMUNITY FIRST
INSURANCE PLANS

INSURANCE POLICY

University Community Care Plan by Community First – Gold Plan

Limited Cost Share

Effective Date 01/01/2026

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

THIS INSURANCE POLICY IS NOT A POLICY OF WORKER'S COMPENSATION INSURANCE. AN EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY. 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.

Your rights with an exclusive provider benefit plan (EPO)
Notice from the Texas Department of Insurance

Your plan

Your health plan contracts with doctors, facilities, and other health care providers to treat its members at discounted rates. Providers that contract with your health plan are called "preferred providers" (also known as "in-network providers"). Preferred 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: 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 https://exchange.communityfirsthealthplans.com/network or by calling toll-free 1-888-512-2347 or local 210-358-6400.

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 www.tdi.texas.gov.

Insurance Policy

This Policy, Your completed and accepted Enrollment Application, Schedule of Benefits, any Riders, along with any attachments and amendments to those documents constitute the entire Agreement between the parties. No agent or other person, except the Chief Executive Officer of the Issuer, has the authority to waive any conditions or restrictions of the Agreement, to extend the time for making a payment, or to bind the Issuer by making any promise or representation, or by giving or receiving any information.

In consideration of the completed and accepted Enrollment Application and timely payment of the Required Payments, the Issuer agrees to provide or arrange to provide the covered benefits as described in this Policy.

In consideration of the Issuer providing or arranging to provide the covered benefits specified in this Policy and subject to the terms, the Subscriber promises to pay all Required Payments when due and abide by all the terms of the Agreement and comply with all applicable local, state and federal laws.

This Policy is guaranteed-renewable, subject to the Issuer's right to change the applicable Premium rates annually. The Subscriber has ten (10) days to examine this Policy after the Subscriber receives it from the Issuer. If after examining it the Subscriber is not satisfied for any reason, the Subscriber may return it to the Issuer within the 10-day period and the Premium the Subscriber has paid will be returned to the Subscriber. However, if Member receive any covered benefits prior to returning this Policy, the Subscriber will be responsible for the cost of those benefits.

The coverage provided under this Policy is Exclusive Provider Organization (EPO) coverage and not indemnity insurance.

The Issuer hereby certifies that it has issued a health care benefit plan (herein called the "Plan") for the Subscriber and any Covered Dependent(s). The Effective Date of coverage under the Agreement shall be as indicated on the Member's Identification Card and as confirmed by the Issuer. The Agreement shall continue in effect for one (1) year from the Effective Date until terminated in accordance with the terms of the Termination of Coverage section of this Policy.

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

Administered By
COMMUNITY FIRST INSURANCE PLANS
12238 Silicon Drive, Suite 100
San Antonio, Texas 78249
Telephone: 210-358-6400
or
Toll-Free: 1-888-512-2347

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company 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. If you don't, you may lose your right to appeal.

Community First Insurance Plans
To get information or file a complaint with your insurance company:

Call: Member Services at 210-358-6400
Toll-free: 888-512-2347
Mail: 12238 Silicon Drive, Ste. 100, San Antonio TX 78249

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

Call with a question: 800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Website: https://www.tdi.texas.gov/general/contactus.html
Physical Address: 1601 Congress Avenue Austin, Texas 78701
Mailing Address: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 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. 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. Si no lo hace, podría perder su derecho para apelar.

Community First Insurance Plans
Llame a: Member Services at 210-358-6400
Teléfono gratuito: 888-512-2347
Dirección postal: 12238 Silicon Drive, Ste. 100, San Antonio TX 78249

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: 800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Sitio Web: https://www.tdi.texas.gov/general/contactus.html
Dirección Fisica: 1601 Congress Avenue Austin, Texas 78701
Dirección Postal: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Boc 12030, Austin, TX 78711-2030.

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COMMUNITY FIRST INSURANCE PLANS
INDIVIDUAL INSURANCE POLICY

COMMUNITY FIRST INSURANCE PLANS (COMMUNITY FIRST) certifies that it will provide Individual Health Benefits Coverage to You and Your Dependents, in accordance with the terms of the Individual Contract. The Entire Individual Contract includes the following documents:

- This Policy, which shall be delivered to each Subscriber by hard copy or electronic means if Subscriber consents to electronic delivery and has not withdrawn consent.
- The Schedule of Copayments attached to this Policy.
- The forms You filled out to obtain this coverage.
- The Individual Contract document provided to the Individual Contract Holder.
- If the provisions of the Individual Contract do not conform to the requirements of Texas or federal law that apply to the Individual Contract, the Individual Contract shall automatically be changed to conform with the requirements of that law and such change will be shown in a written amendment to the Individual Contract that is signed by an authorized officer of Community First.

The contract holder to whom the contract is issued shall be permitted to return the contract within 10 days of receiving it and to have the premium paid refunded if, after examination of the contract, such contract holder is not satisfied with it for any reason. If such contract holder, pursuant to such provision, returns the contract to Community First or to the agent through whom it was purchased, it is considered void from the beginning and the parties are in the same position as if no contract had been issued. If services are rendered or claims are paid by Community First during the 10 days, the Subscriber is responsible for repaying Community First for such services or claims.

The contract holder may pay each premium, other than the first, within ninety (90) days (for those eligible for subsidies), and within thirty-one (31) days (for those not eligible for subsidies) of the premium due date. Those days are known as the grace period. If the premium is not paid in full before the grace period ends, coverage will cease at the end of the grace period. Premium rate changes may apply annually. Community First will give written notice to the contract holder at least ninety (90) days prior to a change in premium rates.

The Individual Contract Number and the Benefit Plan Design are shown below.

Covered Individual:	You are eligible to become covered under the Individual Contract if You are in the "Covered Classes" shown below and meet the requirements in the "Who is Eligible to Become Covered" section of this Policy. The "When You Become Covered" section states how and when You may become covered. Your coverage will end when the rules in the "When Your Coverage Ends" section so provide.
Benefit Plan Design:	**University Community Care Plan by Community First – Gold Plan Limited Cost Share**
Individual Contract/Product No.:	**63251TX001-03**
Effective Date:	01/01/2026: This Policy describes the benefits under the Individual Health Benefits Coverage as of the Effective Date.
Covered Classes:	All Eligible Individuals of the Federally Facilitated Marketplace (FFM) who live, work, or reside in the Service Area.

Limiting Age for Dependents	Age 26 for children. However, this age limitation does not apply to a child who is medically certified as disabled and dependent on the parent.
Service Area:	See Appendix A.
Community First's Address:	Mailing Address: 12238 Silicon Drive, Suite 100, San Antonio, Texas 78249 Physical Address: 12238 Silicon Drive, Suite 100, San Antonio, Texas 78249
Community First's Telephone Number:	210-227-2347
Member Services Number:	210-358-6400 or 1-888-512-2347
Arbitration Provision:	See Section VII.
Cost of the Coverage:	You will be informed of the amount of Your monthly premium when You enroll.

SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS

The following chart summarizes the coverage available under Your Exclusive Provider Organization (EPO) Policy. For details, refer to COVERED SERVICES AND BENEFITS. All Covered Services (except in emergencies) must be provided by or through a Participating Primary Care Physician/Practitioner, who may authorize You for further treatment by Providers in the applicable network of Participating Specialists and Hospitals, or by a Participating Specialist. Some services may require Preauthorization by Community First.

IMPORTANT NOTE: Copayments/Coinsurance shown below indicates the amount You are required to pay, are expressed as either a fixed dollar amount or a percentage of the Allowable Amount and will be applied for each occurrence, unless otherwise indicated. Copayments/Coinsurance, Deductibles and out-of-pocket maximums may be adjusted for various reasons as permitted by applicable law.

Services must be obtained through Participating Network Providers.

Some services may require Preauthorization.

Detailed Prior-Authorization requirements are listed in the Health Insurance Exchange Prior-Authorization List.

Services with a (*) indicate pre-authorization is required.
Services with a (+) indicate pre-authorization may be required.

Out of Pocket Maximums Per Calendar Year Including Pharmacy Benefits	
Per Individual Insured	$7,250
Per Family	$14,500
Deductibles Per Calendar Year Including Pharmacy Benefits	
Per Individual Insured	$0
Per Family	$0
Professional Services	
Primary Care Physician/Practitioner ("PCP") Office or Home Visit	$30 copay
Participating Specialist Physician ("Specialist") Office or Home Visit	$60 copay
Inpatient Hospital Services	
*Inpatient Hospital Services, physician/surgeon fee, per visit	No copay
*Inpatient Hospital Services, facility fee, for each admission	$800 copay per stay
Outpatient Surgery Physician and Facility Services	
Outpatient Surgery – Physician Services, per visit	$600 copay
Outpatient Surgery - Hospital Setting	$105 copay
Outpatient Surgery - Other Facility Setting	$105 copay
Radiation Therapy	$600 copay
Dialysis, per visit	$60 copay
Outpatient Infusion Therapy Services	

+Routine Maintenance Drug - Hospital Setting, per visit	$60 copay
+Routine Maintenance Drug – Home, Office, Infusion Suite Setting, per visit	$60 copay
+Non-Maintenance Drug, per visit	$60 copay
+Chemotherapy	$600 copay
Outpatient Laboratory and X-Ray Services	
+Hospital & Other Facility Setting Computerized Tomography (CT Scan), Computerized Tomography Angiography (CTA), Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET Scan), SPECT/Nuclear Cardiology studies, per procedure	$125 copay per test
Other X-Ray Services	$125 copay per test
+Outpatient Lab (*Genetic Testing Requires Authorization)	$125 copay per test
Rehabilitation and Habilitation Services	
***Rehabilitation Services, Habilitation Services and Therapies**, per visit: Limited to 35 visits per Calendar Year for Rehabilitation Services Limited to 35 visits per Calendar Year for Habilitation Services Visit limitations do not apply to Behavioral Health Services or the treatment of an acquired brain injury. Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any rehabilitation and habilitation services visit maximums.	$105 copay per modality unless otherwise covered under Inpatient Hospital Services
Chiropractic Care	
Chiropractic Care (35 visits per year) (+Authorization for Chiropractic not required)	$60 co-pay per visit
Maternity Care and Family Planning Services	

Maternity Care Prenatal and Postnatal Visit – After the initial office visit, subsequent office visits are covered in full Childbirth/Delivery professional services, per visit Inpatient Hospital Services, for each admission	$30 copay No copay $800 copay
Family Planning Services Diagnostic counseling, consultations and family planning services, per visit Insertion or removal of intrauterine device (IUD), including cost of device Diaphragm or cervical cap fitting, including cost of device Insertion or removal of birth control device implanted under the skin, including cost of device Injectable contraceptive drugs, including cost of drug	$30 copay for PCP $60 copay for Specialist; unless otherwise covered under Contraceptive Services and Supplies described in Health Maintenance and Preventive Services
Vasectomy	$800 copay for Inpatient Hospital Services; $105 copay for Outpatient Facility Services $600 copay for Outpatient Physician Services
Infertility Services Diagnostic counseling, consultations, family planning services and treatment services, per visit	$30 copay for PCP $60 copay for Specialist
Behavioral Health Services	
+Outpatient Mental Health Care, per visit	$30 copay
*Inpatient Mental Health Care, per stay	Any charges described in Inpatient Hospital Services will apply.
+Serious Mental Illness, per visit	$30 copay
+Chemical Dependency Services, per visit	$30 copay
Emergency Services	
Emergency Care (including emergency room services for Mental Health Care or Chemical Dependency), per visit	$250 copay; waived if admitted. (If admitted, any charges described in Inpatient Hospital Services will apply.)
Urgent Care	

Urgent Care Services, per visit	$30 copay Any additional charges as described in Outpatient Laboratory and X-Ray Services may also apply.
Ambulance Services	
*Ambulance Services, emergency medical transportation, per transport	$250 copay
Extended Care Services	
***Skilled Nursing Facility Services**, for each day, up to 25 days per calendar year	$300 copay per day
Hospice Care, for each day	$60 copay
***Home Health Care**, per visit, up to 60 visits per Calendar Year	$60 copay
Health Maintenance and Preventive Services	
Well-child care through age 17	No copay
Periodic health assessments for Insured age 18 and older	No copay
Immunizations -Childhood immunizations required by law for Insured through age 6 -Immunizations for Insured over 6	No copay
Bone mass measurement for osteoporosis 2 allowed per year	No copay
Well-woman exam, once every twelve months, includes, but not limited to, exam for cervical cancer (Pap smear)	No copay
Screening mammogram for female Insured age 35 and over, and for female Insured with other risk factors, once every twelve months Ages 35-39 one baseline allowed Ages 40 and older; one per year -Outpatient facility or imaging centers	No copay
Contraceptive Services and Supplies -Contraceptive education, counseling and certain female FDA approved contraceptive methods, female sterilization procedures and devices. Breastfeeding Support, Counseling and Supplies -Electric breast pumps are limited to one per Calendar Year.	No copay
Hearing Loss -Screening test from birth through 30 days -Follow-up care from birth through 24 months	No copay

Screening for the detection of colorectal cancer for Insured age 45 and older: -All colorectal cancer examinations, preventative services, and laboratory tests assigned a grade of “A” or “B” by the United States Preventative 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. -Annual fecal occult blood test, once every twelve months -Flexible sigmoidoscopy with hemoccult of the stool, limited to 1 every 5 years -Colonoscopy, limited to 1 every 10 years Colonoscopies are considered diagnostic and would follow the Outpatient Surgery schedule	No copay
Eye and ear screenings for Insured through age 17, once every twelve months Eye and ear screening for Insured age 18 and older, once every two years Note: Covered children to age 19 have additional benefits as described in PEDIATRIC VISION CARE BENEFITS. Routine eye exams and refractions are not a covered benefit for age 20 and above.	$30 copay for PCP $30 copay for PCP Any additional charges as described in Outpatient Laboratory and X-Ray Services may also apply.
Early detection test for cardiovascular disease, limited to 1 every 5 years - Computer tomography (CT) scanning - Ultrasonography	$125 copay
Early detection test for ovarian cancer (CA125 blood test), once every twelve months	$125 copay

Exam for prostate cancer, once every twelve months	$30 copay for PCP $60 copay for Specialist Any additional charges as described in Outpatient Laboratory and X-Ray Services may also apply.
Dental Surgical Procedures	
*Dental Surgical Procedures (limited Covered Services) **General and routine dental checkups and services are Not Covered for adults or children.**	$105 copay for Outpatient Facility Services, per visit $600 copay for Outpatient Physician Services, per visit or $800 copay for Inpatient Hospital Services, per visit, or For services provided in a Participating Provider's office, see "Professional Services".
Cosmetic, Reconstructive or Plastic Surgery	
*Cosmetic, Reconstructive or Plastic Surgery (limited Covered Services)	$105 copay for Outpatient Facility Services, per visit $600 copay for Outpatient Physician Services, per visit or $800 copay for Inpatient Hospital Services.
Allergy Care	
Testing and Evaluation Injections Serum	$60 copay
Diabetes Care	
Diabetes Self-Management Training, for each visit	No copay
Diabetes Equipment	$60 copay
Diabetes Supplies Some Diabetes Supplies are only available utilizing pharmacy benefits, through a Participating Pharmacy. You must pay the applicable PHARMACY BENEFITS amount shown in the SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS and any applicable pricing differences.	No copay
Prosthetic Appliances and Orthotic Devices	
***Prosthetic Appliances and Orthotic Devices**	$60 copay
***Hearing Aids** Per hearing aid. Limited to one (1) hearing aid per ear every 36 months.	$60 copay
***Cochlear Implants** Limit one (1) per impaired ear, with replacements as Medically Necessary or audiologically necessary.	$60 copay Any Outpatient Surgery charges described in Outpatient Facility Services may also apply.
Durable Medical Equipment	

***Durable Medical Equipment**	$60 copay
Speech and Hearing Services	
+Speech and Hearing Services Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any speech and hearing services visit maximums.	Copay same as any other physical illness.
Telehealth and Telemedicine Medical Services	
Telehealth and Telemedicine	Copay same as any other physical illness or behavioral health visit.
Prescription Drugs	
Generic	$10 copay
Preferred Brand Drugs	$25 copay
Non-preferred brand drugs	$50 copay
+Specialty Drugs	30% coinsurance

I. WHO IS ELIGIBLE TO BECOME COVERED

A. FOR INDIVIDUAL COVERAGE

1. **You are eligible for Individual Coverage** while:

   - You are an Eligible Individual.
   - You are in the Covered Classes.

   The Federally Facilitated Marketplace (FFM) determines the Covered Classes. The FFM must not discriminate among persons in like situations. The FFM cannot exclude You from a Covered Class based on a health status factor.

   You are eligible for a continuation of Individual Coverage if your marital status changes.

2. **You are not eligible for Individual Coverage** if Your coverage under any Community First Individual Health Benefits Coverage was terminated for cause, as described in the "When Your Coverage Ends" section.

3. Your Individual Coverage becomes effective as described in the "When You Become Covered" section.

B. FOR DEPENDENT COVERAGE

1. **You are eligible for Dependent Coverage** while:
   - You are an Eligible Individual; and
   - You are a Qualified Dependent.

2. **Your Eligible Dependents are:**
   - Your spouse.
   - Your Children under 26 years old.
   - A Child under age 26 does not have to be in college or some other educational institution.
   - A grandchild that is unmarried, younger than 25, and a dependent of the Subscriber for federal income tax purposes at the time of coverage application.
   - Any person who qualifies as a Dependent for federal income tax purposes and for whom premium has been paid, including a Child of any age who is medically certified as disabled and dependent on the parent.

3. **Exception(s)**

   a. The age 26 limit does not apply to a child who is incapable of self-sustaining employment due to mental retardation or physical disability and chiefly dependent upon You for support and maintenance. Community First may require You to furnish proof of such incapacity and dependency periodically, but not more than annually.

b. Your spouse or child does not qualify as Your Dependent while covered under the Individual Health Benefits Coverage.

4. **You are not eligible for Dependent Coverage** if Your coverage under any Community First Individual Health Benefits Coverage was terminated for cause as described in the "When Your Coverage Ends" section.

5. **Your Dependent Coverage becomes effective** as described in the "When You Become Covered" section.

II. WHEN YOU BECOME COVERED

You may only enroll Yourself or Your Dependents during an Initial Enrollment Period as described in section II.A.; an Enrollment Period as described in section II.B.; or Special Enrollment Periods described in section II.C. below.

A. INITIAL ENROLLMENT PERIOD.

1. **General Rule: When You Become an Eligible Individual.** You may enroll Yourself and Your Dependents for Individual Health Benefits Coverage within 31 days after first becoming an Eligible Individual.

2. **General Rule: Enrolling New Dependents.** You may enroll a Qualified Dependent within 31 days after the Dependent becomes eligible to be added because of marriage, birth, or adoption. Community First Individual Health Benefits Coverage will not begin sooner than the first of the month following Your request to enroll the Dependent.

3. **Special Dependent Coverage Rules for Newborn and Adopted Children**: A child born to You, an Adopted Child or a child that is the subject of a suit for adoption by You while You are covered for Individual Health Benefits Coverage, will be covered from the date of the child's birth, or the date the child becomes the subject of a suit for adoption, until coverage for the child terminates under this Policy or applicable law. Coverage for the child is subject to the "*When Your Coverage Ends*" section of this Policy and to the following provisions:

   a. The coverage for the child will not end during the thirty-one (31) day period starting with the child's birth or adoption because You fail to pay any required monthly premium for that coverage;

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

B. OPEN ENROLLMENT PERIODS.

During an Individual Enrollment Period, You may elect to cover yourself and Qualified Dependents under the Individual Health Benefits Coverage if You first become eligible for Individual Coverage during that Open Enrollment Period; **or**

1. If You elect for Yourself and Your Dependents to become covered under the Individual Health Benefits Coverage during an Open Enrollment Period, Your or Your Dependent's coverage will begin on the Individual Enrollment Date established by Community First, if all the conditions below are met on that date.

    a. You are eligible for Individual Coverage.

    b. You enrolled for the Coverage approved by the Federally Facilitated Marketplace and agreed to pay the required monthly premiums.

    c. You reside, live or work in the Service Area.

C. SPECIAL ENROLLMENT PERIODS.

1. **Special Enrollment Period for Individuals and Dependents Who Lose Coverage.** Eligible Individuals and Dependents who lose other coverage shall have 31 days to enroll in this Individual Health Benefits Coverage if:

    a. The Eligible Individual or Dependent is eligible for coverage and he or she failed to enroll when first eligible; and/or

    b. An Eligible Individual or Dependent has a change in marital status; and

    c. When enrollment was previously offered and declined, the Eligible Individual or Dependent had other coverage; and

    d. When enrollment was declined, the Eligible Individual stated in writing that he or she was declining coverage because he or she or the Dependent had other coverage; and

    e. When enrollment was declined:

        (1) The Eligible Individual or Dependent was covered under COBRA or state continuation periods and the continuation period has since been exhausted; or

        (2) When enrollment was declined, the Eligible Individual had coverage other than COBRA or state continuation coverage that has since terminated due to loss of eligibility.

        Loss of eligibility includes the following:

        - loss of coverage as a result of a legal separation, divorce, or death;

- any loss of eligibility;
- no longer living or working in the service area;

f. A special enrollment period is not available to an eligible Person and/or Dependents if previous coverage was terminated for cause or failure to timely pay premiums.

2. **Special Enrollment Period for Court-Ordered Coverage of a Spouse or Child.**

a. **Coverage automatic for 31 days.** If an Individual receives a medical support order or notice of a medical support order requiring You to enroll Your spouse or Child for health insurance coverage, Community First shall cover the spouse or Child for 31 days after the Individual received the order or notice.

b. **Enrollment required to continue coverage.** Coverage for such spouse or Child will end unless You or another person authorized applies for enrollment of the spouse or Child and pays any additional premium for the added dependent coverage by the last day of the month in which the 31-day automatic coverage period expires.

3. **Special Enrollment Period for Changes in Family Circumstances.**

a. **Enrollment of Eligible Individual. An Eligible Individual** may enroll in Community First outside of an Initial or Open Enrollment Period if the Individual:

(1) Is eligible for the Individual Health Benefits Coverage;
(2) Is not enrolled because he or she previously declined enrollment; and
(3) Applies for enrollment and pays the required monthly premium within 31 days after either:
  i. Acquiring a new Dependent through marriage, birth, adoption, or placement for adoption; or
  ii. The Individual receives a medical support order or notice of a medical support order requiring the Individual to cover his or her spouse or child.

b. **Enrollment of Spouse of Eligible Individual.** An Eligible Individual may enroll his or her spouse in Community First outside of an Initial or Open Enrollment Period if:

(1) The Eligible Individual and his or her spouse have a Child who becomes a Dependent through birth or Adoption, and
(2) The Eligible Individual applies for enrollment and pays the required monthly premium for his or her spouse within 31 days after the Child is born or Adopted.

D. NOTICE OF CHANGE IN FAMILY STATUS.

It is important that You inform Community First promptly when:

- You acquire a Qualified Dependent;
- A new Qualified Dependent becomes eligible; or
- A Qualified Dependent becomes ineligible.

Forms are available for reporting these changes.

E. SPECIAL COVERAGE RULES IN CASE OF A HOSPITAL STAY

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

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

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

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

III. INDIVIDUAL HEALTH BENEFITS COVERAGE

A. FOR YOU AND YOUR DEPENDENTS

1. **In General**: This Coverage provides benefits for many of the services and supplies needed for care and treatment of Your or Your Qualified Dependents' Illnesses and Injuries and to maintain Your or Your Qualified Dependents' good health. Not all services and supplies are eligible, and some are eligible only to a limited extent. Insured are responsible for knowing their coverage and for determining whether services and supplies are covered before receiving services and supplies. Insured should work with their Primary Care Provider (PCP) or Network Provider and Community First to solve any question on whether a service or supply is a covered benefit before receiving the service or supply.

2. **Primary Care Provider (PCP) Selection**: Once You have chosen Community

First, you may select a PCP, who will provide the majority of Your and Your Qualified Dependents' health care services. Your PCP will be the one You call when You need medical advice, when You are ill and when You need preventive care. Each Covered Person may select his or her own PCP from the Community First Participating Provider directory. Your PCP will generally be licensed in one of the following specialties: internal medicine, general medicine, pediatrics and/or family practice.

Community First Health Plans encourages you to choose a PCP. You may designate any PCP who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the PCP. For information on how to select a PCP, contact Community First Member Services at (210) 358-6400 or toll-free at 1-888-512-2347.

Should You have a chronic, disabling, or Life-Threatening Illness, You may request to use a Participating Specialty Provider as a PCP, provided that the Participating Specialty Provider is willing to accept the coordination of all of Your health care needs.

3. **OB/GYN Selection.** A female Insured entitled to coverage shall be permitted direct access to the health care services of a participating obstetrician or gynecologist.

   You do not need prior authorization from Community First or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, follow a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Community First Member Services, at (210) 358-6400 or toll-free at 1-888-512-2347.

4. **Changing Your Primary Care Provider (PCP).** Community First believes that a strong PCP-patient relationship is critical. However, we also realize that there may be a need for an Insured to change his/her PCP. If You have selected a PCP and must change Your PCP, You may do so by calling Community First's Member Services Department at (210) 358-6400 or toll-free at 1-888-512-2347. Requests for changes will take effect immediately.

5. **Continuity of Care.** In this section, the term "continuing care patient" means an individual who, with respect to a provider or facility:

   a. is undergoing a course of treatment for a serious and complex condition from the provider or facility;
   b. is undergoing a course of institutional or inpatient care from the provider or facility;
   c. is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect

to such a surgery;

d. is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

e. is terminally ill and is receiving treatment for such illness from such provider or facility.

If Community First terminates a contractual relationship with a provider or facility while an Insured is a continuing care patient (except for terminations due to failure to meet applicable quality standards or for fraud), the organization shall (i) notify the Insured of such termination and the Insured's right to elect continued transitional care from such provider or facility; (ii) permit the Insured to continue the course of treatment furnished by such provider or facility relating to such continuing transitional care under the same terms and conditions as would have applied if the contract had not been terminated, until the earlier of 90-days or the date on which Insured is no longer a continuing care patient with respect to such provider or facility.

B. COVERED SERVICES AND SUPPLIES

1. **In General**: Community First will arrange or provide for benefits for the Covered Services and Supplies set forth in Section III.B.3. below. Some services, such as hospital confinements, will require Pre-Authorization by Community First. However, You will not need Pre-Authorization for Emergency Care. See Schedule of Copayments.

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

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

NOTE Benefits Payable on Behalf of a Child. Community First must provide for the repayment of the actual costs of medical expenses the Texas Health and Human Services Commission pays through medical assistance for an Insured person if, under the policy, the Insured is entitled to payment for the medical expenses.

a. Covered Services:

All Covered Services must be furnished to an Insured:

(1) by a PCP (if selected); or

(2) by another Participating Provider;
(3) by a Non-Participating Provider if referred by a PCP or Network Provider and preauthorized by Community First;
(4) by a Participating Specialty Care Provider approved by Community First's Medical Director to perform the services of a PCP pursuant to a request of an Insured with a chronic, disabling, or Life-Threatening illness; or
(5) by a participating obstetrician or gynecologist or a participating behavioral health Provider.

Pre-authorization may be required to obtain specific services or supplies prior to undergoing hospitalization, outpatient surgery or diagnostic procedures. Pre-authorization may also be required for habilitation, rehabilitation, and skilled nursing care.

If Medically Necessary Covered Services are not available through a Participating Provider, Community First will, at the request of a Participating Provider, within a reasonable time but in no event to exceed five business days after receipt of reasonably requested documentation, allow referral to a Non-Participating Provider and shall reimburse the Non-Participating Provider at the usual and customary rate or at a negotiated rate. Before such a requested referral can be denied, Community First must have the request reviewed by a specialist of the same or similar specialty as the Provider or Provider to whom the referral is requested.

b. After Hours Care:

Illnesses and Injuries often do not happen during normal office hours. Your PCP or selected Network Provider is available 24 hours a day, 7 days a week. You should contact him or her if You need after hours care. If Your call is placed after Your provider's office hours, You may receive instructions from your provider's answering service; a live answering service may notify the Provider on call, who can advise You on how to proceed; or You may call Community First to reach the 24-hour nurse advice service, at (210) 358-6400 or toll-free at 1-888-512-2347.

c. Urgent Care Services:

(1) Urgent Care in the Service Area. In the event of an urgent situation (Illness or Injury) that is severe or painful enough to require a Provider's care within 24 hours, contact Your PCP or Network Provider who will direct You to an in-network facility. See Schedule of Copayments.

d. Medical Emergency:

Necessary Emergency Care services will be provided to Insured, including treating and stabilizing a Medical Emergency, and any medical screening

or evaluation required by state or federal law necessary to determine if a Medical Emergency exists.

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

Community First will have staff available during regular business hours to review your emergency care. If You receive Emergency Care and the Provider who treated You indicates that you will need follow-up care to complete the treatment, the follow-up care must be by the Insured's PCP or Network Provider, not by the Out of Network Provider who treated You for the Medical Emergency. The Insured, or someone acting on the Insured's behalf, should contact the Insured's PCP or Network Provider within 24 hours, or as soon as reasonably possible, so that he or she may arrange for follow-up care.

Insured should not use the Emergency Room or Urgent Care facility for routine or non-emergent services. If You choose to use the Emergency Room or Urgent care facilities for routine or non-emergent services, then You will be responsible for all billed charges relating to the services. You can use Community First's Complaint and Appeals Process to resolve a dispute regarding Emergency Care. If You have any questions regarding whether a situation constitutes a Medical Emergency, please contact Your PCP or Network Provider.

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

Services provided by a Non-Participating Provider out of the Community First network (except for emergency care) are not authorized-. You will be responsible for all charges if services are provided outside of the Community First EPO network.

You should ask about the contract status of the Providers from whom you receive treatment, especially when You are referred by your PCP or Network Provider to a Specialty Care Provider and when You receive services at a Participating Hospital as some facility based Providers or other health care practitioners such as anesthesiologist, pathologist, neonatologist, emergency room Providers and radiologist, may not be included in Community First's network and may balance bill You for amounts not paid by Community First.

If you receive a bill for authorized services from any in-network Participating Provider asking you to pay for something other than a Copayment, for services

that are authorized (or those that do not require authorization) please notify Community First's Member Services Department immediately.

a. **Premiums.** Insured may pay a premium for the Individual Insurance Policy. The premium amount and payment arrangements are made to Community First.

b. **Copayments.** You will be responsible for appropriate Copayments, up to Out-of-Pocket maximums. The Copayments that apply to certain Covered Services, as well as Out-of-Pocket maximums, are described in the Schedule of Cost Sharing attached to and made a part of this Policy. Community First's Participating Providers will look only to Community First and not to You for payment of Covered Services, except for payment of applicable Copayments.

c. **Services or Supplies that are not Covered under this Individual Insurance Policy.** If You receive health care services or supplies that are not Covered Services and Supplies, You will be financially responsible for the entire cost of service.

d. **Unauthorized Services.** You will be held financially responsible for the entire cost of services if you obtain health care services, in circumstances other than a Medical Emergency or urgent care, from a Non-Participating Provider without Preauthorization from Community First.

3. **Covered Services**: The Covered Services are those that are listed below. Section C ("Limitations") describes any modification of these Covered Services for certain Illnesses. A service or supply is not a Covered Service or Supply if excluded. It is excluded to the extent it falls outside any limits described in Section C ("Limitations") or is described in Section D ("Exclusions"). Some Covered Services and/or Supplies below may require review for Medical Necessity prior to services being rendered.

Inpatient Hospital Services

Services, except Emergency Care and treatment of breast cancer, must be arranged by Your PCP or Network Provider and Preauthorized by Community First. Covered Services include:

a. semi-private room and board, with no limit to number of days unless otherwise indicated;
b. private rooms when Medically Necessary and authorized by Community First;
c. special diets and meals when Medically;
d. use of intensive care or cardiac care units and related services when Medically Necessary;
e. use of operating and delivery rooms and related facilities;
f. anesthesia and oxygen services;
g. laboratory, x-ray, and other diagnostic services;

h. drugs, medications, biologicals, and their administration;
i. general nursing care;
j. special duty and private duty nursing when Medically Necessary and authorized by Community First;
k. radiation therapy, inhalation therapy and chemotherapy;
l. blood, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for You;
m. short-term rehabilitation therapy services in an acute hospital setting;
n. treatment of breast cancer, with no Preauthorization required, for a minimum of forty-eight (48) hours following a mastectomy and twenty-four (24) hours following a lymph node dissection; provided, however, that such minimum hours of coverage are not required if You and Your attending Provider determine that a shorter period of inpatient care is appropriate. Upon request, the length-of-stay may be extended if Community First determines that an extension is Medically Necessary; and
o. organ and tissue transplants. Preauthorization is required for any organ or tissue transplant, even if the patient is already in a Hospital under another Preauthorization. At the time of Preauthorization, Community First will assign a length-of-stay for the admission. Upon request, the length of-stay may be extended if the plan determines that an extension is Medically Necessary.

   i. Services, including donor expenses, for organ and tissue transplants are covered, but only if all the following conditions are met:
      (1) The transplant procedure is not Experimental/Investigational in nature;
      (2) Donated human organs or tissue or a United States Food and Drug Administration approved artificial device are used;
      (3) The recipient is an Insured;
      (4) The Insured meets all of the criteria established by Community First in pertinent written medical policies; and
      (5) The Insured meets all of the protocols established by the Hospital in which the transplant is performed.
   ii. Covered Services and supplies related to an organ or tissue transplant include, but are not limited to x-rays, laboratory testing, chemotherapy, radiation therapy, prescription drugs, procurement of organs or tissues from a living or deceased donor, and complications arising from such transplant.
   iii. Benefits will be determined on the same basis as any other sickness when the transplant procedure is considered Medically Necessary and meets all of the conditions cited above.
      Benefits will be available for:
      (1) A recipient who is an Insured covered under the plan;
      (2) A donor who is an Insured covered under the plan; or
      (3) A donor who is not an Insured covered under the plan.
   iv. Covered Services and supplies include those provided for the:
      (1) Donor search and acceptability testing of potential live donors;
      (2) Evaluation of organs or tissues including, but not limited to, the determination of tissue matches;

(3) Removal of organs or tissues from living or deceased donors; and
(4) Transportation and short-term storage of donated organs or tissues.

v. No benefits are available for an Insured for the following services and supplies:
(1) Living and/or travel expenses of the recipient or a live donor;
(2) Expenses related to maintenance of life of a donor for purposes of organ or tissue donation;
(3) Purchase of the organ or tissue other than payment for Covered Services and supplies identified above; and
(4) Organ or tissue (xenograft) obtained from another species.

vi. Community First will not cover a human organ transplant, or post-transplant care if
(1) The operation is performed in China, or another country known to have participated in forced organ harvesting.
(2) The human organ to be transplanted was procured by a sale or donation originating from China or another country known to have participated in forced organ harvesting.

Outpatient Facility Services

Services provided through a Participating Hospital outpatient department or a free-standing facility must be prescribed by the PCP or Network Provider. Preauthorization may be required for the following services:

a. Outpatient surgery;

b. Radiation therapy and chemotherapy; and

c. Dialysis.

Outpatient Laboratory and X-Ray Services

Laboratory and radiographic procedures, services and materials, including (but not limited to) diagnostic x-rays, x-ray therapy, chemotherapy, fluoroscopy, electrocardiograms, laboratory tests and therapeutic radiology services must be ordered and arranged by the PCP or Network Provider and provided through a Participating facility. Preauthorization from Community First may be required.

Community First will reimburse out of network diagnostic imaging providers and laboratory service providers when services are performed in connection with a medical or health care service(s) performed by a provider in the network. Reimbursement will occur at the usual and customary fee or at the agreed rate.

Any out of network provider who is a diagnostic imaging provider or laboratory service provider or a person asserting a claim as an agent or assignee of the provider may not bill an Insured individual receiving a medical care or health care service or supply, and the Insured does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the Insured's health insurance policy that:

a. Is based on:
   i. The amount initially determined payable by the insurer; or
   ii. If applicable, the modified amount as determined under the insurer's internal appeal process; and

b. Is not based on any additional amount determined to be owed to the provider.

Rehabilitation Services

Rehabilitation services and physical, speech and occupational therapies that in the opinion of a Provider are Medically Necessary and meet or exceed Your treatment goals are provided when prescribed by Your PCP, Network Provider or Specialist and preauthorized by Community First. For a physically disabled person, treatment goals may include maintenance of functioning or prevention or slowing of further deterioration. Rehabilitation Services may be provided in the Provider's office, in a Hospital as an inpatient, in an outpatient facility, or as home health care visits. Rehabilitation services are available from a Participating Provider when Preauthorized by Community First and prescribed by Your PCP or Network Provider.

Treatment of Acquired Brain Injury will be covered the same as any other physical condition. Cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation; neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing or treatment; neurofeedback therapy, remediation, post-acute transition services and community reintegration services, including outpatient day treatment services, or any other post-acute treatment services are covered, if such services are necessary as a result of and related to an Acquired Brain Injury. To ensure that appropriate post-acute care treatment is provided, Community First includes coverage for periodic reevaluation for an Insured who: (1) has incurred an Acquired Brain Injury; (2) has been unresponsive to treatment; and (3) becomes responsive to treatment at a later date. Services may be provided at a Hospital, an acute or post-acute rehabilitation hospital, an assisted living facility or any other facility at which appropriate services or therapies may be provided.

Except for treatment of Acquired Brain Injury, rehabilitation services are limited as indicated on the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**.

Chiropractic Care

Medical or surgical services or procedures that are within the scope of the chiropractor's license. Services include spinal manipulation/adjustment for a documented functional impairment, pain, or developmental delay or defect for diagnosed muscle, nerve, and joint problems to restore or improve motion, reduce pain, and/or increase function.

Maternity Care and Family Planning Services

Maternity Care. Community First provides coverage for inpatient care for the mother and the newborn in a Hospital for a minimum of forty-eight (48) hours following an uncomplicated vaginal delivery, or ninety-six (96) hours following an

uncomplicated delivery by cesarean section. Preauthorization is not required for the admission of forty-eight or ninety-six hours as stated above. Upon request, the length-of-stay may be extended if Community First determines that an extension is Medically Necessary.

Covered Services, which may require Preauthorization, include:

a. prenatal visits;

b. administration of newborn screening test, including the cost of a test kit in the amount required by Health and Safety Code 33.019;

c. use of Hospital delivery rooms and related facilities. A separate Hospital admission Copayment is required for a newborn child at time of delivery. If a newborn child is discharged and readmitted to a Hospital more than five (5) days after the date of birth, a separate Hospital admission Copayment for such readmission will be required;

d. use of newborn nursery and related facilities;

e. Medically Necessary special procedures requested by Your PCP, Network Provider, or designated Obstetrician/Gynecologist and preauthorized by Community First; and

f. postnatal visits. If the mother or newborn is discharged before the minimum hours of inpatient coverage have passed, the plan provides coverage for Post-Delivery Care for the mother and newborn. Post-Delivery Care may be provided at the mother's home or a Participating Provider's office or facility. A newborn child will not be required to receive health care services only from Participating Providers if born outside the Service Area due to an emergency or born in a non-network facility to a mother who is not an Insured. Community First may require the newborn to be transferred to a Participating facility, at Community First's expense, when determined to be medically appropriate by the newborn's treating Provider.

Complications of Pregnancy. Covered Services for Complications of Pregnancy will be the same as for treatment of any other physical illness and may require Preauthorization.

Complications of pregnancy means:

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

b. non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.

Family Planning. Covered Services, which may require Preauthorization, include:

a. diagnostic counseling, consultations, and planning services for family planning;

b. insertion or removal of an intrauterine device (IUD), including the cost of the device;

c. diaphragm or cervical cap fitting, including the cost of the device;

d. insertion or removal of birth control device implanted under the skin, including the cost of the device;

e. injectable contraceptive drugs, including the cost of the drug; and

f. voluntary sterilizations, including vasectomy and tubal ligation.

Note: some benefits for family planning are available under **Health Maintenance and Preventive Services.**

Infertility Services. Coverage includes Insureds currently receiving cancer treatment. This includes surgery, chemotherapy, or radiation, as such services may directly or indirectly cause impaired fertility. Covered Services, which may require Preauthorization, include diagnostic counseling, consultations, family planning services and treatment for problems of fertility and Infertility, subject to the exclusions in **LIMITATIONS AND EXCLUSIONS**. Once the Infertility workup and testing have been completed, subsequent workups and testing will require approval of a Community First Medical Director.

Behavioral Health Services

Outpatient Mental Health Care. Covered Services include diagnostic evaluation and treatment or crisis intervention when authorized by Community First.

Inpatient Mental Health Care. Covered Services include inpatient Mental Health Care when authorized by Community First. Covered Services must be rendered based on an individual treatment plan with specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program. Services in a Residential Treatment Center for Children and Adolescents, a Residential Treatment Center or a Crisis Stabilization Unit are available only when the Insured has an acute condition that substantially impairs thought, perception of reality, emotional process or judgment, or grossly impairs behavior as manifested by recent disturbed behavior, which would otherwise necessitate confinement in a Participating Mental Health Treatment Facility.

Serious Mental Illness. Covered Services include treatment of Serious Mental Illness when authorized by Community First or its designated behavioral health administrator and rendered by a Participating Provider. Services are subject to the same limitations as any other **Behavioral Health Services**.

Chemical Dependency Services. Treatment of Chemical Dependency is the same as treatment of any other **Behavioral Health Services** but is restricted as described in **LIMITATIONS AND EXCLUSIONS.** Inpatient treatment of Chemical Dependency must be provided in a Chemical Dependency Treatment Center**.** Some services may require Preauthorization by Community First.

Emergency Services

PCPs or other selected Network Providers provide coverage for Members 24 hours a day, 365 days a year. Notify Your PCP or Network Provider within forty-eight (48) hours of receiving Emergency Care, or as soon as possible without being medically harmful or injurious to You. Community First will pay for a medical screening examination or other evaluation required by Texas or federal law and provided in the emergency department of a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility that is necessary to determine whether an emergency medical condition exists.

Emergency Care. Emergency Care services whether rendered by a Participating or non-Participating Providers will be covered, based upon the signs and symptoms presented at the time of treatment as documented by the attending health care personnel, whether the Emergency Care services were received within the Service Area or Out-of-Area. Emergency Care services are subject to the applicable Copayment, unless You are admitted as an inpatient directly from the emergency room, in which case You pay the inpatient Hospital Copayment and any other amounts due.

If post stabilization care is required after an Emergency Care condition has been treated and stabilized, the treating Provider will contact Community First, who must approve or deny coverage of the post stabilization care requested within one hour of receiving the call.

Notwithstanding anything in this Policy to the contrary, for Emergency Care rendered by Providers who are not part of Community First's network of Participating Providers (non-Participating Provider) or otherwise contracted with the Exclusive Provider Organization (EPO), the Allowable Amount shall be equal to the greatest of the following possible amounts - not to exceed billed charges:

a. The median amount negotiated with Participating Providers for emergency services furnished; or

b. The amount for the Emergency Care service calculated using the same method Community First generally uses to determine payments for non-Participating Provider services by substituting the Participating Providers cost-sharing provisions for the non-Participating Providers cost sharing provisions;

c. The amount that would be paid under Medicare for the Emergency Care;

d. The agreed rate, or usual and customary rate.

Each of these amounts is calculated excluding any in-network Copayment imposed with respect to the Insured.

You may receive Emergency Care services in an Urgent Care center.

Out-of-Area Services. Only Emergency Care services as described above are covered. Continuing or follow-up treatment for accidental injury or Emergency Care is limited to care required before You can return to the Service Area without medically harmful or injurious consequences.

Urgent Care Services

Urgent Care services are covered when rendered by an in-network Urgent Care Provider for the immediate treatment of a medical condition that requires prompt medical attention but where a brief time lapse before receiving services will not endanger life or permanent health and does not require Emergency Care services. Additional charges described in **Outpatient Laboratory and X-ray Services,** or **Outpatient Facility Services** may also apply.

Unless designated and recognized by Community First as an in-network Urgent Care center, neither a hospital nor an emergency room will be considered an Urgent Care center.

Ambulance Services

Professional local ground ambulance service or air ambulance service to the nearest Hospital is covered for Emergency Care, as defined in this Policy. When use of air ambulance is being considered and circumstances permit, Community First must approve prior to use.

Emergency ambulance service is covered when the ambulance is ordered by an employer, school, or public safety official, or when You are not in a position to refuse the service.

Your PCP or Participating Provider may request use of a ground or air ambulance service for non-emergent transportation and requires preauthorization from Community First.

Extended Care Services

Covered Services include the following when prescribed by the PCP or Network Provider and authorized by the plan. Services may have additional limitations as indicated on the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** and restrictions or exclusions described in **LIMITATIONS AND EXCLUSIONS**.

Skilled Nursing Facility Services. Services must be temporary and lead to rehabilitation and an increased ability to function. Custodial Care is not covered. If You remain in a Skilled Nursing Facility after the PCP or Network Provider

discharges You or after You reach the maximum benefit period or period authorized by Community First, You will be liable for all subsequent costs incurred.

Hospice Care. Care that is provided by a Hospital, Skilled Nursing Facility, Hospice, or a duly licensed Hospice Care agency, is approved by Community First, and is focused on a palliative rather than curative treatment for Insured who have a medical condition and a prognosis of terminal illness. Services include bereavement counseling.

Home Health Care. Care in the home by Health Care Professionals who are Participating Providers, including but not limited to registered nurses, licensed practical nurses, physical therapists, inhalation therapists, speech or hearing therapists or home health aides. Services must be provided or arranged by the PCP or Network Provider.

Health Maintenance and Preventive Services

Covered Services, which may require Preauthorization and will not be subject to any Copayment, include 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) or as required by state law:

a. Well childcare for Insured through age seventeen (17) which includes evidenced-informed preventive care and screenings recommended by the American Academy of Pediatrics (AAP);

b. Periodic health assessments for Insured eighteen (18) and older, based on age, sex and medical history and recommended by the Centers for Disease Control (CDC);

c. Routine immunizations recommended by the American Academy of Pediatrics and the Advisory Committee on Immunization Practices of the CDC. Examples of covered immunizations include diphtheria, Haemophilus influenza type b (Hib), hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella and other immunizations that are required by the law. (Allergy injections are not considered immunizations under this benefit provision.);

d. Physical exam and an annual prostate-specific antigen (PSA) test (once every twelve months) for the detection of prostate cancer for male Insured who are at least fifty (50) years of age and asymptomatic; or at least forty (40) years of age with a family history of prostate cancer or another prostate cancer risk factor;

e. Bone mass measurement for the detection of low bone mass and to determine risk of osteoporosis and fractures associated with osteoporosis, for qualified individuals including postmenopausal women who are not receiving estrogen replacement therapy; individuals with vertebral abnormalities, primary hyperparathyroidism or a history of bone fractures; or individuals receiving long-term glucocorticoid therapy or being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy;

f. Preventive care and screenings provided with respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the HRSA such as a well woman gynecological exam (once every twelve months) for female Insured, and a medically Recognized diagnostic exam for the early detection of cervical cancer for female Insured age eighteen (18) and older. Your PCP or Network Provider or any Obstetrician/Gynecologist in Your network of Participating Providers may perform the well-woman exam. The exam may include, but is not limited to, a conventional Pap smear screening; a screening using liquid-based cytology methods alone or in combination with a test approved by the United States Food and Drug Administration for the detection of human papillomavirus. For help in selecting an Obstetrician/Gynecologist, refer to the Community First EPO Provider directory, contact Your PCP or Network Provider or call Member Services at (210) 358-6400 or toll-free at 1-888-512-2347;

g. Screening (non-diagnostic) mammogram (once every twelve months) to detect breast cancer for female Insured over the age of thirty-five (35), and for female Insured with other risk factors. Mammograms may be obtained whether or not a well-woman exam is performed at the same time;

h. Preventive care and screenings provided with respect to women's services will be provided for the following Covered Services and are not subject to a Copayment:

Contraceptive Services and Supplies. Benefits are available for female sterilization procedures and Outpatient Contraceptive Services for women of reproductive capacity. Outpatient Contraceptive Services means a consultation, examination, procedure, or medical service that is related to the use of a drug or device intended to prevent pregnancy.

Benefits will be provided to women with reproductive capacity for specified drugs and devices in each of the following categories of FDA approved contraceptive drugs and devices, including certain: progestin-only contraceptives; combination contraceptives; emergency contraceptives; extended-cycle/continuous oral contraceptives; cervical caps; diaphragms; implantable contraceptives; intra-uterine devices; injectables; transdermal contraceptives and vaginal contraceptive devices. NOTE: Prescription contraceptive medications are covered under **PHARMACY BENEFITS**.

To determine if a specific drug or device is available under this Preventive Services benefit contact Member Services at (210) 358-6040 or toll-free at 1-888-512-2347. This list may change as FDA guidelines, medical management and medical policies are modified. Benefits will also be provided to women with reproductive capacity for FDA approved over-the-counter contraceptives for women with a written prescription by a Participating Provider. You may be required to pay the full amount and submit a reimbursement claim form along with the written prescription to

Community First with itemized receipts. Visit the website at https://exchange.communityfirsthealthplans.comto obtain a claim form.

i. Screening test for hearing loss for Insured from birth through age thirty (30) days, and necessary diagnostic follow-up care related to the screening test from birth through age twenty-four (24) months; and

j. Screening for the detection of colorectal cancer for Insured age forty-five (45) or older. Colorectal cancer testing, exams, preventive services, and lab tests with an "A" or "B" grade from the USPSTF starting at age 45 must be covered. If tests, colonoscopy, or procedure results are abnormal, follow-up colonoscopy is covered.

k. Any test or screening approved by the United States Food and Drug Administration for the detection of ovarian cancer. This includes expanded minimum coverage requirements for certain tests of papillomavirus, ovarian cancer, and cervical cancer.

l. Examples of other covered preventive services that are not subject to Copayment include smoking cessation counseling services, health diet counseling and obesity screening/counseling.

The covered preventive services described above may change as the USPSTF, CDC, or AAP guidelines and state laws are modified. If a recommendation or guideline for a particular preventive service does not specify the frequency, method, treatment or setting in which it must be provided, Community First may use reasonable medical management techniques to determine benefits. For more information, contact Member Services at (210) 358-6400 or toll-free at 1-888-512-2347.

If a covered preventive service is provided during an office visit and is billed separately from the office visit, You may be responsible for Copayment for the office visit only. If an office visit and the preventive health service are not billed separately and the primary purpose of the visit was not the preventive health service, You may be responsible for Copayment for the office visit.

Additional preventive screening services, which may require Preauthorization and may be subject to Copayment, include:

i. Eye and ear screenings (once every twelve months) performed or authorized by the PCP or Network Provider for Insured through age seventeen (17) to identify vision and hearing problems. Eye screenings may be performed in the PCP or Network Provider office and do not include refractions.

ii. Eye and ear screenings (once every two years) performed or authorized by the PCP or Network Provider for Insured eighteen (18) and older to identify vision and hearing problems. Eye screenings

may be performed in the PCP or Network Provider office and do not include refractions.

Note: Covered children to age 19 have additional benefits as described in **PEDIATRIC VISION CARE BENEFITS.**

iii. Early detection test for cardiovascular disease. Benefits are available for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five years when performed by a laboratory that is certified by a recognized national organization:
(1) computed tomography (CT) scanning measuring coronary artery calcifications; or
(2) ultrasonography measuring carotid intima-media thickness and plaque.

Tests are available to each covered Insured who is (1) a male older than 45 years of age and younger than 76 years of age, or (2) a female older than 55 years of age and younger than 76 years of age. The Insured must be a diabetic or have a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher. Benefits are limited as indicated on the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**.

Dental Surgical Procedures

General and routine dental services are not covered for adults and children, but limited oral surgical procedures are covered when prescribed by Your PCP or Network Provider and performed in a Participating Provider's office or in the inpatient or outpatient setting.

The following Covered Services may require Preauthorization by Community First:

a. Treatment for accidental injury to Sound Natural Adult Teeth, the jaw bones or surrounding tissues, not caused by biting or chewing, when treatment is completed within twenty-four (24) months of the initial treatment. "Sound Natural Adult Teeth" means teeth that are free of active or chronic clinical decay, have at least 50% bony support, are functional in the arch, and have not been excessively weakened by multiple dental procedures;

b. Treatment or correction of a non-dental physiological condition which has resulted in severe functional impairment;

c. Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

d. Diagnostic and surgical treatment of conditions affecting the temporomandibular joint (including the jaw or craniomandibular joint) as a result of an accident, a trauma, a congenital defect, a developmental defect, or a pathology; and

e. Removal of complete bony impacted teeth.

Cosmetic, Reconstructive or Plastic Surgery
Coverage will be the same as for treatment of any other physical illness generally, only when prescribed or arranged by Your PCP or Network Provider, and may require Preauthorization by Community First. Covered Services are limited to the following:

a. surgery to correct a defect resulting from accidental injury;

b. surgery to correct a functional defect which results from a congenital and/or acquired disease or anomaly;

c. surgical reconstruction of the breast following a mastectomy, and surgical reconstruction of the other breast to achieve a symmetrical appearance; and

d. Reconstructive Surgery for Craniofacial Abnormalities for an Insured under age nineteen (19).

Allergy Care
Covered Services for testing and treatment must be provided or arranged by the PCP or Network Provider.

Diabetes Care

Diabetes Self-Management Training. Covered Services, which may require Preauthorization, include instructions enabling a person with diabetes and/or his caretaker to understand the care and management of diabetes; development of an individualized management plan; nutritional counseling and proper use of diabetes equipment and supplies. Diabetes self-management training is provided upon the following occasions:

a. The initial diagnosis of diabetes;

b. A significant change in symptoms or condition that requires changes in Your self-management regime, as diagnosed by a Participating Provider or practitioner;

c. The prescription of periodic or episodic continuing education warranted by the development of new techniques and treatments for diabetes; or

d. The need for a caretaker or a change in caretakers for the person with diabetes necessitates diabetes management training for the caretaker.

Diabetes Equipment and Supplies. Diabetes equipment and supplies are covered for Insured diagnosed with insulin dependent or non-insulin dependent diabetes; elevated blood glucose levels induced by pregnancy; or another medical condition associated with elevated blood glucose levels.

You may purchase diabetes supplies utilizing Your pharmacy benefits. When the following diabetes equipment and supplies are obtained, You must pay the applicable **PHARMACY BENEFITS** Copayment in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** and any applicable pricing differences. No claim forms are required. You may choose to pay the full amount of the equipment and supplies and submit a reimbursement claim form to Community First with Your itemized receipts. To obtain a claim form, visit the website at https://exchange.communityfirsthealthplans.com.

Diabetes equipment and supplies include, but are not limited to:

- blood glucose monitors
- noninvasive glucose monitors and monitors for the blind
- insulin pumps and necessary accessories
- insulin infusion devices
- biohazard disposable containers
- podiatric appliances (including up to two pairs of therapeutic footwear per Calendar Year)

The diabetes equipment and supplies in the list below are only available utilizing Your pharmacy benefits. When You purchase these items utilizing pharmacy benefits, You must pay the applicable **PHARMACY BENEFITS** Copayment in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** and any applicable pricing differences. No claim forms are required.

- glucose meter solution
- test strips specified for use with a corresponding blood glucose monitor
- visual reading and urine test strips and tablets that test for glucose, ketones and protein
- lancets and lancet devices
- injection aids, including devices used to assist with insulin injection and needleless systems
- glucagon emergency kits
- prescription orders for insulin and insulin analog preparations
- insulin syringes
- prescriptive and nonprescriptive oral agents for controlling blood sugar levels

Prosthetic Appliances and Orthotic Devices

The following covered appliances and devices must be provided or arranged by the PCP or Network Provider, and may require Preauthorization by Community First.

a. Initial Prosthetic Appliances are covered subject to restrictions in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** and **LIMITATIONS AND EXCLUSIONS**.

b. Repair and replacement of Prosthetic Appliances and orthotic devices are covered unless the repair or replacement is a result of misuse or loss by You.

c. Orthopedic braces, such as orthopedic appliances used to support, align, or hold bodily parts in a correct position; crutches, including rigid back, leg or

neck braces; casts for treatment of any part of the legs, arms, shoulders, hips or back; special surgical and back corsets; and Provider prescribed, directed or applied dressings, bandages, trusses and splints that are custom designed for the purpose of assisting the function of a joint.

d. Initial breast prostheses and two surgical brassieres after mastectomy.

Durable Medical Equipment (DME)
You must obtain services and devices through a Participating DME Provider, which must be consistent with the Medicare DME Manual (guides exchange products) and may require Preauthorization by Community First. The plan will determine whether DME is rented or purchased and retains the option to recover the DME upon cancellation or termination of Your coverage.

Examples of DME are standard wheelchairs, crutches, walkers, orthopedic tractions, Hospital beds, oxygen, bedside commodes, suction machines, etc. Excluded items are listed in **LIMITATIONS AND EXCLUSIONS**.

Hearing Aids
Covered Services and equipment, which may require Preauthorization, include one audiometric examination to determine type and extent of hearing loss once every thirty-six (36) months and the fitting and purchase of hearing aid device(s). An Insured's claim may not be denied solely on the basis that the price of the hearing aid is more than the benefit available under the health benefit plan. Exclusions are listed in **LIMITATIONS AND EXCLUSIONS**.

Speech and Hearing Services
Covered Services, which may require Preauthorization, include inpatient and outpatient care and treatment for loss or impairment of speech or hearing that is not less favorable than for physical illness generally. Medically necessary hearing aids or cochlear implant and related services and supplies are covered for individuals 18 years or younger. This includes fitting and dispensing services, treatment for habilitation and rehabilitation, and (for cochlear implant) an external speech processor and controller with necessary component and replacement every three years.

Autism Spectrum Disorder
Generally recognized services prescribed in relation to Autism Spectrum Disorder by Your PCP or Network Provider in a treatment plan recommended by that Provider are covered. No benefit maximums will apply.

Individuals providing treatment prescribed under that plan must be:

a. A health care practitioner:
   - who is licensed, certified, or registered by an appropriate agency of the state of Texas;
   - whose professional credential is recognized and accepted by an appropriate agency of the United States; or

- who is certified as a Provider under the TRICARE military health system.

b. An individual acting under the supervision of a health care practitioner described in item "a" above.

Treatment may include services such as:

- evaluation and assessment services;
- screening at 18 and 24 months;
- applied behavior analysis;
- behavior training and behavior management;
- speech therapy;
- occupational therapy;
- physical therapy; or
- medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder.

All standard contractual provisions of this Policy will apply, including but not limited to, defined terms, limitations and exclusions.

Routine Patient Costs for Participants in Certain Clinical Trials

Covered Services for Routine Patient Care Costs, as defined in **DEFINITIONS** are provided in connection with a phase I, phase II, phase III, or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following federally funded or approved trials:

- The Centers for Disease Control and Prevention of the United States Department of Health and Human Services
- The National Institutes of Health (NIH)
- Centers for Medicare and Medicaid Services
- Agency for Healthcare Research and Quality
- A cooperative group or center of any of the previous entities
- The United States Food and Drug Administration
- The United States Department of Defense (DOD)
- The United States Department of Veterans Affairs (VA)
- A qualified non-governmental research entity identified in guidelines issued by the NIH for center support grants or the DOD, VA or Department of Energy if the study has been reviewed and approved through a peer review system
- An institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services
- A clinical trial conducted under an FDA investigational new drug application
- A drug trial that is exempt from the requirement of an FDA investigational new drug application

Services are not available under this section 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. Services must be provided or arranged by the PCP or Network Provider.

Community First provides coverage to ensure limited disruption in care including biopsies and biospecimen samples based on medical necessity. Biomarker testing including gene mutations; and protein expression.

(A) Single-analyte test;

(B) Multiplex panel test and;

(C) Whole genome sequencing.

C. LIMITATIONS AND EXCLUSIONS

This Section describes limits and exclusions for the Covered Services under Section B above. It also describes any modifications of those Covered Services for certain Illnesses.

The following benefits are not covered unless specifically provided for in **COVERED SERVICES AND BENEFITS** or **PHARMACY BENEFITS**.

1. Services or supplies of non-Participating Providers, except:

   a. Emergency Care;

   b. When authorized by Community First or Your provider; and

   c. Female Insured may directly access an Obstetrician/Gynecologist for:
      i. Well-woman exams;
      ii. Obstetrical care;
      iii. Care for all active gynecological conditions; and
      iv. Diagnosis, treatment and referral for any disease or condition within the scope of the professional practice of the Obstetrician/Gynecologist.

2. Services or supplies which in the judgment of the PCP or Network Provider or Community First are not Medically Necessary and essential to the diagnosis or direct care and treatment of an illness, injury, condition, disease or bodily malfunction as defined herein. Denials based on non-medical services are adverse determinations and subject to the utilization review processes including reviews by independent review organizations.

3. If a service is not covered, Community First will not cover any services related to it. Related services are:

   a. Services in preparation for the non-covered service;

b. Services in connection with providing the non-covered service;

c. Hospitalization required to perform the non-covered service; or

d. Services that are usually provided following the non-covered service, such as follow-up care or therapy after surgery.

4. Experimental/Investigational services and supplies. Denials based on experimental/investigational services are adverse determinations and subject to the utilization review process, including review by an independent review organization.

5. Any charges resulting from the failure to keep a scheduled visit with a Participating Provider or for acquisition of medical records.

6. Special medical reports not directly related to treatment.

7. Examinations, testing, vaccinations or other services required by employers, insurers, schools, camps, courts, licensing authorities, other third parties or for personal travel.

8. Services or supplies provided by a person who is related to an Insured by blood or marriage and self-administered services.

9. Services or supplies for injuries sustained as a result of war, declared or undeclared, or any act of war or while on active or reserve duty in the armed forces of any country or international authority.

10. Benefits for which You are eligible through Medicare Part B.

11. Care for conditions that federal, state or local law requires to be treated in a public facility.

12. Appearances at court hearings and other legal proceedings, and any services relating to judicial or administrative proceedings or conducted as part of medical research.

13. Services or supplies provided in connection with an occupational illness or an injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.

14. Any services and supplies provided to an Insured incurred outside the United States if the Insured traveled to the location for the purposes of receiving medical services, supplies, or drugs.

15. Transportation services except as described in **Ambulance Services**, or when approved by Community First.

16. Personal or comfort items, including but not limited to televisions, telephones, guest beds, admission kits, and maternity kits provided by a Hospital or other inpatient facility.

17. Private rooms unless Medically Necessary and authorized by Community First. If a semi-private room is not available, the plan covers a private room until a semi-private room is available.

18. Any and all transplants of organs, cells, and other tissues, except as described in Inpatient Hospital Services. Services or supplies related to organ and tissue transplant or other procedures when You are the donor and the recipient is not an Insured are not covered.

19. Services or supplies for Custodial Care.

20. Services or supplies furnished by an institution that is primarily a place of rest, a place for the aged or any similar institution.

21. Private duty nursing, except when determined to be Medically Necessary and requested by the PCP or Network Provider and preauthorized by Community First.

22. Services or supplies for Dietary and Nutritional Services, including home testing kits, vitamins, dietary supplements and replacements, and special food items, except:

    a. An inpatient nutritional assessment program provided in and by a Hospital and approved by Community First;

    b. Dietary formulas necessary for the treatment of phenylketonuria or other heritable diseases;

    c. As described in Diabetes Care;

    d. As described in Autism Spectrum Disorder.

23. Services or supplies for Cosmetic, Reconstructive or Plastic Surgery, including breast reduction or augmentation (enlargement) surgery, even when Medically Necessary, except as described in **Cosmetic, Reconstructive or Plastic Surgery**.

24. Services or supplies provided primarily for:

    a. Environmental Sensitivity; or

    b. Clinical Ecology or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists;

    c. inpatient allergy testing or treatment.

25. Services or supplies provided for, in preparation for, or in conjunction with the following, except as described in **Maternity Care** and **Family Planning Services.**

    a. Sterilization reversal (male or female);

    b. Transsexual surgery and related treatment, including hormone therapy and medical or psychological counseling;

    c. Treatment of sexual dysfunction including medications, penile prostheses and other surgery, and vascular or plethysmographic studies that are used only for diagnosing impotence;

    d. Promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination super ovulation uterine capacitation enhancement, direct-intraperitoneal insemination, trans-uterine tubal insemination, gamete intrafallopian transfer, pronuclear oocyte stage transfer, zygote

    e. Intrafallopian transfer and tubal embryo transfer;

    f. Any services or supplies related to in vitro fertilization or other procedures when You are the donor and the recipient is not an Insured;

    g. In vitro fertilization and fertility drugs.

26. Services or supplies in connection with foot care for flat feet, fallen arches, or chronic foot strain.

27. Services or supplies for reduction of obesity or weight, including surgical procedures and prescription drugs, even if the Insured has other health conditions which might be helped by a reduction of obesity or weight, except for healthy diet counseling and obesity screening/counseling as may be provided under **Preventive Services.**

28. Services or supplies for, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.

29. Services or supplies for dental care, except as described in **Dental Surgical Procedures.**

30. Non-surgical or non-diagnostic services or supplies for treatment or related services to the temporomandibular (jaw) joint or jaw-related neuromuscular conditions with oral appliances, oral splints, oral orthotics, devices, prosthetics, dental restorations, orthodontics, physical therapy, or alteration of the occlusal relationships of the teeth or jaws to eliminate pain or dysfunction of the temporomandibular joint and all adjacent or related muscles and nerves. Medically Necessary diagnostic and/or surgical treatment is covered for conditions affecting the temporomandibular joint (including the jaw or craniomandibular joint) as a

result of an accident, trauma, congenital defect, developmental defect or pathology, as described in **Dental Surgical Procedures.**

31. Alternative treatments such as acupuncture, acupressure, hypnotism, massage therapy and aroma therapy.

32. Services or supplies for:

    a. Intersegmental traction;

    b. Surface EMGs;

    c. Spinal manipulation under anesthesia;

    d. Muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.

33. Galvanic stimulators or TENS units.

34. Disposable or consumable outpatient supplies, such as syringes, needles, blood or urine testing supplies (except as used in the treatment of diabetes); sheaths, bags, elastic garments, stockings and bandages, garter belts, ostomy bags.

35. Prosthetic Appliances or orthotic devices not described in **Diabetes Care** or **Prosthetic Appliances and Orthotic Devices** including, but not limited to:

    a. Orthodontic or other dental appliances or dentures;

    b. Splints or bandages provided by a Provider in a non-Hospital setting or purchased over the counter for the support of strains and sprains;

    c. Corrective orthopedic shoes, including those which are a separable part of a covered brace; specially-ordered, custom-made or built-up shoes and cast shoes; shoe inserts designed to support the arch or effect changes in the foot or foot alignment; arch supports; orthotics;

    d. Braces; splints or other foot care items.

36. Psychological/neuropsychological testing and psychotherapy services including, but not limited to:

    a. Educational testing;

    b. Employer/government mandated testing;

    c. Testing to determine eligibility for disability benefits;

    d. Testing for legal purposes (e.g., custody/placement evaluations, forensic evaluations, and court mandated testing;

e. Testing for vocational purposes (e.g., interest inventories, work related inventories, and career development);

f. Services directed at enhancing one's personality or lifestyle;

g. Vocational or religious counseling;

h. Activities primarily of an educational nature;

i. Music or dance therapy;

j. Bioenergetic therapy; or

k. Psychotherapeutic services accessed concurrently by more than one Mental Healthcare Provider.

37. Biofeedback (except for an Acquired Brain Injury diagnosis) or other behavior modification services.

38. Mental health services except as described in **Behavioral Health Services** or as may be provided under **Autism Spectrum Disorder**.

39. Residential Treatment Centers for Chemical Dependency that are not:

a. Affiliated with a Hospital under a contractual agreement with an established system for patient Referral;

b. Accredited as such a facility by the Joint Commission on Accreditation of Hospitals;

c. Licensed as a Chemical Dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or

d. Licensed, certified or approved as a Chemical Dependency treatment program or center by any other state agency having legal authority to so license, certify or approve.

40. Trauma or wilderness programs for behavioral health or Chemical Dependency treatment.

41. Replacement for loss, damage or functional defect of hearing aids. Batteries are not covered unless needed at the time of the initial placement of the hearing aid device(s).

42. Deluxe equipment such as motor driven wheelchairs and beds (unless determined to be Medically Necessary); comfort items; bed boards; bathtub lifts; over-bed tables; air purifiers; sauna baths; exercise equipment; stethoscopes and sphygmomanometers; Experimental and/or research items; and replacement,

repairs or maintenance of the DME.

43. Over-the-counter supplies or medicines and prescription drugs and medications of any kind, except:

    a. As provided while confined as an inpatient,

    b. As provided under **Autism Spectrum Disorder**;

    c. As provided under **Diabetes Care**;

    d. Contraceptive devices and FDA-approved over-the-counter contraceptives for women with a written prescription from a Participating Provider; or

    e. If covered under **PHARMACY BENEFITS**.

44. Male contraceptive devices, including over-the-counter contraceptive products such as condoms; female contraceptive devices, including over-the-counter contraceptive products such as spermicide, when not prescribed by a Participating Provider.

IV. RIGHT OF SUBROGATION AND REIMBURSEMENT UNDER THE INDIVIDUAL HEALTH BENEFITS COVERAGE

A. Sometimes another person or entity may be liable to You for medical services covered by Community First under this Individual Policy. For example, if an Insured is injured in an automobile accident caused by another driver, the other driver or that driver's automobile insurance carrier may be liable to the Insured for medical expenses incurred because of the injuries. If Community First pays or provides benefits for Insured under this Individual Health Care Coverage, Community First is subrogated to all rights of recovery which the Insured has in contract, tort or otherwise against any person, organization or insurer for the amount of benefits Community First has paid or provided. That means Community First may pursue Insured's rights in its own name or the name of the Insured, to recover money through judgment, settlement or otherwise from any person, organization or insurer.

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

Each Insured agrees to reimburse Community First as described in these provisions in return for Community First providing services, supplies or benefits for an Insured's Illness or Injury:

1. For which another person, corporation, or other entity is considered responsible; or

2. That arises out of, or in the course of, any work for wage or profit and is covered

by any workers' compensation law, occupational disease law, or similar law.

B. Community First also has a right of reimbursement where an Insured has recovered amounts from any sources due to an injury, illness or omission including but not limited to:

1. Payment made by a Third Party or any insurance company on behalf of the Third Party

2. Uninsured or underinsured motorist coverage policy

3. Workers' Compensation or disability award or settlement

4. Automobile policy medical payments coverage

5. Premises or homeowners medical payments coverage

6. Premises or homeowners insurance coverage

7. Any other payments from a source intended to compensate a Member for injuries.

Immediately upon receipt of any payments or collection of damages (as a settlement, award, and judgment or in any other way) with respect to such Illness or Injury, the Insured involved (or if incapable, that person's legal representative) will reimburse Community First for:

1. The actual costs incurred for any benefits provided directly by Community First as a result of the Illness or Injury; and

2. The actual costs paid by Community First for medical services required by the Insured as a result of the Illness or Injury.

Such reimbursement will be made only to the extent of any such payments or collections actually received from a responsible Party as a settlement, judgment, or in any other way.

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

D. With respect to subrogation and reimbursement by Community First under these provisions, Community First will not be responsible for any legal fees and expenses unless specifically agreed to in writing.

E. The Insured agrees to cooperate with Community First in order to protect Community First's subrogation and reimbursement rights. The Insured agrees to promptly furnish to Community First all information which the Insured has concerning Insured's rights of

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

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

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

H. Community First's recoveries under subrogation are limited to the extent allowed by the Texas Civil Practices and Remedies Code Chapter 140, including Subsections 140.005, 140.007 and 140.008.

V. CLAIM RULES

These rules apply if a charge is made to an Insured for any service or supply with respect to which benefits would be provided under the Individual Health Benefits Coverage.

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

Only Emergency Care is covered outside of Community First's network and/or Service Area, except in the case of Court-Ordered Dependent coverage, or unless Medically Necessary Covered Services are not available through Participating Providers. In these situations, Community First will reimburse the Non-Participating Provider at the negotiated or usual and customary rate for Medically Necessary Covered Services requested by Participating Providers and preauthorized by Community First. Non-Participating Providers may demand immediate payment for their services and supplies, and you may be responsible for a portion of the charges billed by the Non-Participating Provider if the Provider does not accept Community First's payment as payment in full. If You pay a bill for Covered Services and you believe that Community First is responsible for those charges, submit a copy of the paid bill along with a completed claim form to Community First's Member Services Department to request reimbursement (Claim forms may be obtained from the Member Services Department). Include all of the following information on Your request:

1. Your name, address and the identification number from Your identification card, and Your relationship to the Subscriber.

2. Name and address of the Provider of Your service (if not on the bill).

3. If You receive a bill for authorized Covered Services from a Non-Participating Provider, You may ask Community First to pay the Provider directly. Send the bill to Community First according to the procedures listed above.

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

Community First will provide an explanation of benefits to you and the physician or provider in connection with a health care service or supply or transport provided by a non-network physician or provider. The notice will include:

1. a statement of the billing prohibition
2. the total amount the physician or provider may bill you under your policy, including an itemization of copayments, coinsurance, deductibles, and other amounts included in the total; and
3. for an explanation of benefits provided to the physician or provider, information advising the physician or provider of the availability of mediation or arbitration

B. PROOF OF LOSS

Community First must be given written proof of the loss for which claim is made under the Coverage. For a claim for loss for which this policy provides any periodic payment contingent on continuing loss, a written proof of loss must be provided to Community First before the 91st day after the termination of the period for which the insurer is liable. For a claim for any other loss, a written proof of loss must be provided to Community First before the 91st day after the date of the loss. Failure to provide the proof within the required time does not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time. In that case, the proof must be provided as soon as reasonably possible but not later than one year after the time proof is otherwise required, except in the event of a legal incapacity. This proof must cover the occurrence, character, and extent of that loss must be furnished to Community First as soon as reasonably possible but no later than 12 months from the date proof is otherwise required, except for Prescription Drug claims which must be filed within ninety (90) day from the date of purchase to qualify for reimbursement under the Pharmacy Benefit. It is Your responsibility to notify Community First if you receive a billing statement from a Provider. Community First is not responsible for bills that have not been submitted within one year of date of service.

C. WHEN BENEFITS ARE PAID TO THE INSURED

All benefits for allowed charges for a Covered Service or Supply with respect to which benefits would be provided under the Individual Health Benefits Coverage will generally be paid by Community First to the Provider of the service or supply. If You furnish

Community First satisfactory evidence that You have made payment to a Provider with respect to allowed charges that are covered under this Individual Policy and the charges are the obligation of Community First, reimbursement for those charges will be paid to You.

Claim Forms: Community First, on receipt of a notice of claim, will provide to the claimant the forms usually provided by the insurer for filing proof of loss. If the forms are not provided before the 16th day after the date of the notice, the claimant shall be considered to have complied with the requirements of this policy as to proof of loss on submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, the character, and the extent of the loss for which the claim is made.

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

1. No later than fifteen (15) business days after receipt of a claim, Community First shall:

    a. Acknowledge receipt of the claim;

    b. Commence investigation of the claim; and

    c. Request all information from the claimant as deemed necessary by Community First. Subsequent additional requests may be necessary.

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

    a. Notify the claimant in writing of acceptance or rejection of the claim. If the claim is rejected, the notice will state the reason(s) for the rejection; or

    b. Notify claimant in writing of the reason(s) Community First needs additional time.

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

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

5. All claims must be submitted to Community First within 60 calendar days from the date expenses were incurred or as soon as is reasonably possible to do so. Any claim submitted after 60 days will not be eligible for reimbursement, unless a written statement requesting additional time (not to exceed 45 days) is received.

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

D. **DAMAGES**

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

E. **PHYSICAL EXAM**

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

F. **LEGAL ACTION**

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

VI. INCONTESTABILITY OF COVERAGE

This section limits Community First's use of Your statements in contesting Your Coverage under the Individual Health Benefits Coverage. These are statements made to persuade Community First to affect that coverage, and all such statements are considered representations and not warranties. They will be considered to be truthful and made to the best of Your knowledge and belief. The following rules apply to each statement, except for statements related to health status:

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

1. It is in a written application signed by You; and

2. A copy of that application is or has been furnished to You or Your personal representative.

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

Premium rate changes may apply annually. Community First must provide the Individual Contract Holder 90 days prior written notice of any premium rate change.

VII. GENERAL INFORMATION

A. COMPLAINT & COMPLAINT APPEAL PROCESS

1. **GENERAL.** Insured are required to submit all Complaints through Community First's internal Complaint and Appeal process, which we have outlined for You below.

Community First encourages the informal resolution of Complaints. Community First will not retaliate against You, including cancellation of coverage or refusal to renew coverage, simply because You, or person acting on behalf of You has filed a Complaint against Community First or Appealed a decision of Community First.

Community First will not retaliate against any Participating Provider, including termination of or refusal to renew a contract, simply because a Participating Provider has, on Your behalf filed a Complaint against Community First or Appealed a decision of Community First. At any time, You have the right to contact the Texas Department of Insurance at 1-800-252-3439 or in writing at Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030.

2. **WHERE TO FILE A COMPLAINT**. Complaints/Appeals should be directed to Community First's Member Services Department at 1-888-512-2347 or in writing to: 12238 Silicon Drive, Suite 100, San Antonio, Texas 78249.

3. **PROCESS FOR COMPLAINT RESOLUTION.** Complaints will be handled in the following manner:

<u>Step Action</u>

a. You, or someone acting on Your behalf, notifies Community First orally or in writing of a Complaint.

b. Upon receipt of a written Complaint, we will send You a letter acknowledging receipt of Your Complaint within five (5) business days of receipt of the Complaint. This letter will include the date Community First received the Complaint as well as a description of the Complaint and Appeals process and timeframes.

c. If Community First receives an oral Complaint, we will include a one-page Complaint form with the acknowledgement letter, which should be completed and returned immediately for prompt resolution of the Complaint.

d. Community First will acknowledge, investigate and resolve Your Complaint within 30 calendar days from the date we receive Your written Complaint, or Your completed Complaint form. Community First will send You or Your designated representative a letter explaining the resolution of Your Complaint.

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

4. **COMPLAINT APPEAL PROCESS**

Complaint Appeals will be handled in the following manner:

Step Action

a. If You are not satisfied with Community First's resolution of Your Complaint, You or Your designated representative may notify Community First, in writing, of Your wish to Appeal our decision.

b. Community First will send You a letter acknowledging receipt of Your Complaint Appeal within five (5) business days of receiving your written request for Appeal.

c. Community First will schedule a hearing before a Complaint Appeal Panel where You or Your Dependent normally receive health care services within the Service Area, unless You and Community First agree to another site. In lieu of appearing in person, You may conference in by telephone or You may address a written Appeal to the Complaint Appeal Panel.

   The Panel will consist of individuals appointed by Community First. The Panel consists of equal numbers of Community First staff, Providers, and Insured. No individual serving on the Panel may have previously been involved in the disputed decision that is the subject of the Appeal.

   All Providers serving on the Panel must have experience in the area of care that is in dispute and must be independent of the Provider(s) who made any prior determination(s). If specialty care is in dispute, the Appeal Panel will include an additional person who is a specialist in the field of care to which the Appeal relates. Members serving on the Appeal Panel may not be employees of Community First.

d. No later than five (5) business days before the hearing, unless You agree otherwise, Community First shall provide You or Your designated representative:

   i. any documentation that Community First staff will present to the Panel;
   ii. the specialization of any Providers consulted during the investigation; and
   iii. the name and affiliation of each Community First representative on the Panel.

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

   i. Appear in person before the Appeals Panel;
   ii. Present alternative expert testimony; and
   iii. Request the presence of and question any person responsible for making the decision resulting in the Appeal.

Relevant documents will be reviewed by the Appeals Panel and considered along with relevant presentations and discussions. You or Your designated representative and Community First will be allowed to present any relevant information and have witnesses or counsel present.

e. The Complaint Appeal Panel renders a recommendation and Community First notifies You or Your designated representative of Community First's decision regarding Your Appeal.

f. Community First will complete the Complaint Appeal process no later than 30 calendar days after the date Your written request for an Appeal is received by Community First. Any review by an Appeal Panel will be obtained within this time frame.

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

5. **ARBITRATION.** If You remain dissatisfied after completion of the process described above, You may exercise Your right to submit the matter to Arbitration. Decisions at arbitration are final and binding. All claims, disputes, controversies and other matters in question related to any of the terms of this Individual Policy may be arbitrated. If You voluntarily choose to have arbitration, the arbitration proceeding will be conducted pursuant to the Texas Arbitration Act.

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

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

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

7. **PROCESS FOR APPEALING AN ADVERSE DETERMINATION**

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

   You, your authorized representative, a Provider of record acting on your behalf may appeal an Adverse Determination orally or in writing. You must submit your

appeal within 180 calendar days from the date on the notice of an Adverse Determination. Appeals of Adverse Determinations will be handled in the following manner:

a. Within five (5) business days from receipt of the Appeal, Community First will send the appealing party a letter acknowledging the date of Community First's receipt of the Appeal. This letter will include a reasonable list of documents which need to be submitted to Community First for the Appeal.

b. When Community First receives an oral Appeal of an Adverse Determination, Community First will send the appealing party a one-page Appeal form.

c. Emergency Care denials, denials for care of Life-Threatening Conditions and denials of continued stays for Hospital patients or other health care services for an Insured who has received emergency services but has not been discharged from a facility may follow an expedited Appeal procedure, if requested. This procedure will include a review by a health care Provider who has not previously reviewed the case, and who is of the same or a similar specialty as the Provider who typically manages the medical condition, procedure, or treatment under review.

   Expedited reviews are available for Insured who are denied the provision of prescription drugs or intravenous infusions for which the patient is receiving benefits under this policy and for care of life-threatening conditions, which could seriously jeopardize the Insured's life or health, or a denial of another service if the requesting health care provider includes a written statement with supporting documentation that the service is necessary to treat a life-threatening condition or prevent serious harm to the patient. Expedited reviews are also available for the denial of a step therapy exception request.

   The time frame in which such an expedited Appeal must be completed will be based on the medical or dental immediacy of the condition, procedure, or treatment, but will not exceed one (1) business day following the date that the Appeal, is made to Community First.

   Adverse Determination Appeals will include a review by a health care Provider who has not previously reviewed the case and who is not a subordinate of the initial reviewer. Community First will notify You, Your designated representative and Your Provider of record of the outcome of the Appeal of the Adverse Determination, explaining the resolution of the Appeal. Community First will provide written notification to the appealing party as soon as practical, but no later than 30 calendar days after we receive the oral or written Appeal.

d. An appropriate health care Provider will make all Appeal decisions for Adverse Determinations. If the Appeal is denied, and within ten (10) business days the health care Provider sets forth, in writing, good cause for

having a particular type of a specialty Provider review the case, the denial will be reviewed by a health care Provider in the same or similar specialty as typically manages the medical, dental, or specialty condition, procedure, or treatment under discussion for review. Such specialty review will be completed within fifteen (15) business days of receipt of the request.

8. **PROCESS FOR REQUESTING INDEPENDENT REVIEW OF AN ADVERSE DETERMINATION**

a. You, Your designated representative and Your Provider of record will be notified at the time of the denial of the Appeal of an Adverse Determination of Your right to have Your Appeal reviewed by an Independent Review Organization (IRO). You may only seek independent review in the case of an Adverse Determination.

b. The IRO notification in the Appeal denial letter includes the procedure for requesting an IRO review; a copy of a request for review by an IRO form; how to obtain more information regarding IRO Appeal rights, and a statement that You are not required to bear the cost of the IRO review, including filing fees.

c. The prescribed form must be completed and returned to Community First, including the medical release section signed by You or the Insured's legal guardian in order to begin the Independent Review process.

d. In a circumstance involving a Life-Threatening Condition, continued hospitalization, or prescription drugs or intravenous infusions for which You are currently receiving benefits, You are entitled to an immediate Appeal to an IRO and are not required to comply with the procedures for an Adverse Determination Appeal to Community First. In these circumstances, You, Your designated representative, or Your Provider of record may contact Community First by telephone to request the review and provide the required information.

e. There is no right of Appeal of the IRO determination by You, Your designated representative, Your Provider of record, or Community First. This Appeals process does not prohibit You from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or relief available under law.

B. IDENTIFICATION CARDS

Identification cards (ID cards) will be issued to the Insured within 30 calendar days of receiving notice of the Insured's selection of a PCP (if PCP is selected). The ID card will include all necessary information to allow You to access services under the Individual Health Benefits Coverage.

Identification cards issued by Community First, in connection with the Individual Health Benefits Coverage are for identification only and remain the property of Community First.

Possession of an ID Card does not convey any rights to benefits under the Individual Health Benefits Coverage. Any person who receives services, supplies, or other benefits to which the person is not entitled by the terms of the Individual Health Benefits Coverage and of the Individual Contract will be charged for the actual costs incurred by Community First for any such services or supplies or for the amount of any such benefits. If an Insured permits another person to use the Insured's ID Card, Community First may:

1. Invalidate that Insured's ID Card; and

2. Terminate that Insured's Coverage as provided in the "WHEN YOUR COVERAGE ENDS" section.

C. CONFIDENTIAL NATURE OF MEDICAL RECORDS

Any information from an Insured's medical records received from Providers or Hospitals incident to the Provider-patient or Hospital-patient relationships will be kept confidential as permitted by applicable law. Such information may not be disclosed without the consent of the Insured, except as is reasonably necessary in connection with the administration of the Individual Health Benefits Coverage or as permitted by law. Each Insured agrees that Participating Providers or Consulting Providers may release medical records to Community First, and any of its subsidiaries or affiliates, as is reasonably necessary for claim determination, litigation, or other normal business activities.

D. ASSIGNMENTS

Benefits provided to an Insured under the Individual Health Benefits Coverage are personal to the Insured and are not assignable or otherwise transferable.

E. RELATION AMONG PARTIES AFFECTED BY THE CONTRACT

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

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

Neither the Federally Facilitated Marketplace (FFM) nor any Insured under the Individual Contract is the agent or representative of Community First. Any Insured under the Individual Contract will not be liable for any acts or omissions of Community First, its agents or employees, or of any Hospital, Doctor, or other health care Provider with which Community First, its agents or employees make arrangements for furnishing supplies and services to the Insured.

An Insured may, for personal reasons, refuse to accept procedures or courses of treatment recommended by Participating Providers. Participating Providers will use their best efforts to render all needed, appropriate professional services in a manner compatible with the Insured's wishes. Each Participating Provider will do this to the extent it is consistent with the Provider's judgment as to the needs of the person and proper medical practice. If an Insured refuses to follow a recommended treatment or procedure and the Participating Provider believes that there is no professionally acceptable alternative, the Insured will be so advised.

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

1. The Insured will be given no further treatment for the condition being treated; and

2. neither Participating Providers, Hospitals, nor Community First, will have any further responsibility to provide care for that condition.

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

F. NOTICES AND OTHER INFORMATION

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

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

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

G. WHEN YOUR COVERAGE ENDS

1. INDIVIDUAL AND DEPENDENT COVERAGE.

a. **YOUR INDIVIDUAL COVERAGE OR YOUR DEPENDENT COVERAGE WILL END WHEN THE FIRST OF THESE OCCURS:**

(1) The Individual Contract ends.

(2) You fail to pay before the end of the grace period, any monthly premium required for Your Individual Coverage. Failure to contribute for Dependent Coverage will not cause Your

Individual Coverage to end.

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

(4) You become eligible under Part A of Medicare by reason of reaching age 65, You elect Medicare as Your primary benefit program (for active Eligible Member and their Qualified Dependents), and choose not to continue the Individual Health Benefits Coverage.

(5) The coverage is Dependent Coverage and Your Individual Coverage ends.

(6) Discontinuance and Replacement. Community First must provide a 90-day notice to the Insured prior to discontinuance, an explanation of the Insured's option to purchase any other individual plan, and terminations will be uniformly applied and not based on health status related factors of a covered person.

(7) Withdraw from Marketplace. If Community First withdraws from the marketplace, a 180-day notice will be sent to the Insured and Texas Department of Insurance Commissioner. Termination will be uniformly applied and not based on health status related factors of a covered person.

(8) Continuance of Coverage for Spouse in the Event of the Primary Insured's Death. If the policy is guaranteed renewable, coverage of the spouse must continue after the death of the primary Insured.

b. **YOUR DEPENDENT COVERAGE FOR A QUALIFIED DEPENDENT WILL END WHEN THAT PERSON:**

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

(2) Ceases to be a Qualified Dependent. (See the section entitled "Continued Coverage for an Incapacitated Child" below.)

c. **CANCELLATION AND NON-RENEWAL OF COVERAGE:**

If any of the following conditions exist, Community First will give written notice to the Insured that the person is no longer an Insured for the Individual Health Benefits Coverage:

(1) *FRAUD OR INTENTIONAL MATERIAL MISREPRESENTATION.* If You furnish incorrect or incomplete

information in a statement made for the purpose of effecting coverage under the Individual Health Benefits Coverage, Your coverage may be cancelled after no less than fifteen (15) days written notice. This condition is subject to the provisions of the section entitled "INCONTESTABILITY OF COVERAGE."

(2) *FRAUD IN THE USE OF YOUR IDENTIFICATION CARD, FACILITIES OR SERVICES.* If You permit any other person who is not a member of the Family Unit to use any identification card issued by Community First to You, or if You fraudulently access any Participating Facilities or services provided by Community First, Your coverage may be cancelled after no less than fifteen (15) days written notice.

(3) *FAILURE TO RESIDE, LIVE OR WORK IN COMMUNITY FIRST'S SERVICE AREA.* If an Insured neither resides, lives or works in Community First's Service Area, coverage may be canceled after a thirty (30) day written notice, but only if coverage is terminated uniformly without regard to any Health Status-Related Factor of the Member. Coverage for a Court- Ordered Dependent cannot be cancelled solely because the Child does not reside, live or work in the Service Area.

If Community First gives the Insured such written notice of termination of Coverage:

(a) that person will cease to be an Insured for the benefits of the Coverage on the date immediately following thirty (30) days after such written notice is given by Community First; and

(b) no benefits will be provided to the person under the Coverage after such date.

Any action by Community First under these provisions is subject to review in accordance with the Complaint and Complaint Appeal Process established by Community First.

d. REINSTATEMENT OF COVERAGE: If an Insured or Dependent loses coverage that is not covered under Special Enrollment Periods, and provided that such Insured or Dependent meets all eligibility requirements for coverage, such Insured or Dependent may be reinstated during the subsequent open enrollment period set forth by the Centers for Medicare and Medicaid Services (CMS) through the FFM.

VIII. PEDIATRIC VISION CARE BENEFITS

Pediatric Vision Care is made part of and is in addition to any information You may have in Your

EPO Policy. Information about coverage for the routine vision care services are outlined below and are specifically excluded under Your medical health care plan. (Services that are covered under Your medical plan are not covered under this Pediatric Vision Care Benefit.) All provisions in the Policy apply to Pediatric Vision Care Benefits unless specifically indicated otherwise below.

A. VISION CARE BENEFITS DEFINITIONS

Medically Necessary Contact Lenses: Contact lenses may be determined to be Medically Necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be Medically Necessary in the treatment of the following conditions: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism.

Provider: For purposes of this Pediatric Vision Care Benefit, a licensed therapeutic optometrist, ophthalmologist or optometrist operating within the scope of his or her license, or a dispensing optician.

Vision Materials: Corrective lenses and/or frames or contact lenses.

1. Eligibility.

Children who are covered under Your Policy, to age 19, are eligible for coverage under this Pediatric Vision Care Benefit. NOTE: Once coverage is lost under Your Policy, all benefits cease under this Pediatric Vision Care Benefit.

2. Limitations and Exclusions

The limitations and exclusions in this section apply to all pediatric vision benefits. Although Community First may list a specific service as a benefit, we will not cover it unless we determine it is necessary for the prevention, diagnosis, care or treatment of a covered condition.

We do not cover the following:

- Any vision service, treatment or materials not specifically listed as a covered service
- Services and materials that are Experimental or Investigational
- Services and materials that are rendered prior to Your effective date
- Services and materials incurred after the termination date of Your coverage unless otherwise indicated
- Services and materials not meeting accepted standards of optometric practice
- Services and materials resulting from Your failure to comply with professionally prescribed treatment
- Telephone consultations
- Any charges for failure to keep a scheduled appointment
- Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of Prosthetic Appliances

- Office infection control charges
- Charges for copies of Your records, charts, or any costs associated with forwarding/mailing copies of Your records or charts
- State or territorial taxes on vision services performed
- Medical treatment of eye disease or injury
- Visual therapy
- Special lens designs or coatings other than those described in this benefit
- Replacement of lost/stolen eyewear
- Non-prescription (Plano) lenses
- Non-prescription sunglasses
- Two pairs of eyeglasses in lieu of bifocals
- Services not performed by licensed personnel
- Prosthetic devices and services
- Insurance of contact lenses
- Professional services You receive from immediate relatives or household members, such as a spouse, parent, child, brother or sister, by blood, marriage or adoption
- Orthoptic or vision training
- Aniseikonic spectacle lenses

3. **How the Vision Benefits Work**

You may visit any Participating Provider and receive benefits for a vision examination and covered Vision Materials. Before You go to a Participating Provider for an eye examination, eyeglasses, or contact lenses, please call ahead for an appointment. When You arrive, show the receptionist Your identification card. If You forget to take Your card, be sure to say that You are an Member of the Community First EPO vision care plan so that Your eligibility can be verified. For the most current list of Participating Providers visit the website at https://exchange.communityfirsthealthplans.com/. You may also refer to Your Provider directory or call customer service at the toll-free telephone number on the back of Your identification card. You may receive Your eye examination and eyeglasses/contacts on different dates or through different Provider locations, if desired. However, complete eyeglasses must be obtained at one time, from one Participating Provider. Continuity of care will best be maintained when all available services are obtained at one time from one Participating Provider and there may be additional professional charges if You seek contact lenses from a Participating Provider other than the one who performed Your eye examination. Fees charged for services other than a covered vision examination or covered Vision Materials, and amounts in excess of those payable under this Pediatric Vision Care Benefit, must be paid in full by You to the Provider, whether or not the Provider participates in the vision care plan. These Pediatric Vision Care Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Allowances are one-time use benefits; no remaining balances are carried over to be used later.

Vision Care Services	Insured Cost or Discount	Out of Network Allowance
Exam	$30 copay	Not Allowable
Frames		
Provider Designated Frames	No copay	Not Allowable
Non-Provider Designated Frames	No copay	Not Allowable
Frequency		
Examination, Lenses/Frames, or Contact Lenses	Once per Calendar Year	Not Allowable
Standard Plastic, Glass, or Poly Spectacle Lenses:		
Single Vision	$30 copay	Not Allowable
Bifocal	$30 copay	Not Allowable
Trifocal	$30 copay	Not Allowable
Lenticular	$30 copay	Not Allowable
Note: Lenses include ultraviolet protective coating, fashion and gradient tinting, oversized and glass-grey #3 prescription sunglasses lenses.		
Lens Options		
Tint	No copay	Not Allowable
Standard Plastic Scratch Coating	No copay	Not Allowable
Standard Polycarbonate	No copay	Not Allowable
Contact Lenses: covered once per Calendar Year - in lieu of spectacle lenses		
Elective (Conventional and Disposable)	$30 copay; $150 allowance	Not Allowable
Medically Necessary Contact Lenses - Preauthorization required	$30 copay	Not Allowable
Routine eye exams do not include professional services for contact lens evaluations. Any applicable fees are the responsibility of the patient.		

Additional Benefits
Medically Necessary Contact Lenses are dispensed in lieu of other eyewear. Participating Providers will obtain the necessary Preauthorization for these services.

Low Vision: Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices and provide training and instruction to maximize the remaining usable vision for our Member with low vision. After Preauthorization, covered low vision services will include one comprehensive low vision evaluation every 5 years, low vision aid items such as high-power spectacles, magnifiers and telescopes; and follow-up care – four visits in any five-year period. Participating Providers will obtain the necessary Preauthorization for these services.
Warranty: Warranty limitations may apply to provider or retailer supplied frames and/or eyeglass lenses. Please ask Your Provider for details of the warranty that is available to You.

IX. DEFINITIONS

ACQUIRED BRAIN INJURY: A NEUROLOGICAL INSULT TO THE BRAIN, WHICH IS NOT HEREDITARY, CONGENITAL, OR DEGENERATIVE. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior. Covered services for Acquired Brain Injury include the following:

1. COGNITIVE COMMUNICATION THERAPY: Services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.
2. COGNITIVE REHABILITATION THERAPY: Services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain- behavioral deficits.
3. COMMUNITY REINTEGRATION SERVICES: Services that facilitate the continuum of care as an affected individual transitions into the community.
4. NEUROBEHAVIORAL TESTING: An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.
5. NEUROBEHAVIORAL TREATMENT: Interventions that focus on behavior and the variables that control behavior.
6. NEUROCOGNITIVE REHABILITATION: Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.
7. NEUROCOGNITIVE THERAPY: Services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.
8. NEUROFEEDBACK THERAPY: Services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.
9. NEUROPHYSIOLOGICAL TESTING: An evaluation of the functions of the nervous system.
10. NEUROPHYSIOLOGICAL TREATMENT: Interventions that focus on the functions of

the nervous system.

11. NEUROPSYCHOLOGICAL TESTING: The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.
12. NEUROPSYCHOLOGICAL TREATMENT: Interventions designed to improve or minimize deficits in behavioral and cognitive processes.
13. POST-ACUTE TRANSITION SERVICES: Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.
14. PSCHOPHYSIOLOGICAL TESTING: An evaluation of inter-relationships between the nervous system and other bodily organs and behavior.
15. PSYCHOPHYSIOLOGICAL TREATMENT: Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.
16. REMEDIATION: The process(es) of restoring or improving a specific function.
17. OUTPATIENT DAY TREATMENT SERVICES: Structured services provided to address deficits in physiological, behavioral, and/or cognitive functions. Such services may be delivered in settings that include transitional residential, community integration, or non-residential treatment settings.
18. POST-ACUTE CARE TREATMENT SERVICES: Services provided after acute care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral, or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.

ADOPTED CHILD: A child for whom an adoption is final or a child who has become the subject of a suit for adoption by an Eligible Individual. For the purposes of eligibility, an Adopted Child must be enrolled, at the option of the Eligible Individual, within either:

1. Thirty-one (31) days after the Eligible Individual is a party in a suit for adoption; or
2. Thirty-one (31) days after the date the adoption is final.

ADVERSE DETERMINATION: The determination by Community First that the health care services furnished or proposed to be furnished to an Insured are not Medically Necessary or are experimental or investigational or not appropriate. The term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review.

AFTER HOURS CARE: Health care services provided to an Insured for an illness or an injury that occurs after Provider's normal office hours.

ALLOWABLE AMOUNT: The maximum amount determined by EPO to be eligible for consideration of payment for a particular service, supply or procedure rendered by a Participating Provider. The Allowable Amount is based on the provisions of the Participating Provider contract and the payment methodology in effect on the date of service, whether diagnostic related grouping (DRG), capitation, relative value, fee schedule, per diem or other.

APPEAL: The formal process by which Community First addresses requests to review an adverse

determination.

AUTISM SPECTRUM DISORDER: A neurobiological disorder that includes autism, Asperger's syndrome, or Pervasive Developmental Disorder (Not otherwise specified). A neurobiological disorder is an illness of the nervous system caused by genetic, metabolic, or other biological factors.

BALANCE BILLING: The practice of charging an Insured in a health benefit plan that uses a Provider network the balance of a non-network health care Provider's which is not fully reimbursed by the Insured's health benefit plan.

CALENDAR YEAR: The period beginning January 1 of any year and ending December 31 of the same year.

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

CHEMICAL DEPENDENCY TREATMENT CENTER: A facility that provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved and monitored by a Provider and meets one of these tests:

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

CHILDREN: Includes Your natural-born children, an Adopted Child or Children who have become subject of a suit for adoption by the Eligible Individual, Your stepchildren, foster Children who depend on You for support and maintenance, and any Children for whom You must provide medical support under an order issued under Section 14.061, Family Code, or enforceable by a Court in this State.

COMMUNITY FIRST: Community First Insurance Plans, an Individual Health Benefits Coverage.

COMPLAINANT: A Provider, Insured, or other person designated to act on behalf of an Insured, who files a complaint.

COMPLAINT: Any dissatisfaction expressed by a Complainant to Community First, orally or in writing, with any aspect of Community First's organization or operation, including but not limited to, dissatisfaction with plan administration; procedures related to review or Appeal of an Adverse Determination; the denial, reduction, or termination of a service for reasons not related to medical necessity; the way a service is provided; or disenrollment decisions. 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 Insured, and does not include a Provider's or Insured's oral or written dissatisfaction or disagreement with an Adverse Determination.

COMPLAINT APPEAL PANEL OR PANEL: A Panel, composed of equal numbers of

Community First staff, Providers, and Insured, which advises Community First on the resolution of a complaint appeal.

CONTRACT YEAR: The twelve (12) month period, commencing with the effective date of the Individual Policy, during which coverage is in effect.

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

COPAYMENT: An amount required to be paid by an Insured, in addition to premium, in connection with certain Covered Services and Supplies. A Copayment is a set dollar amount.

COSMETIC SURGERY: Services and Supplies furnished mainly to change a person's appearance. This includes surgery performed to treat a mental, psychoneurotic or personality disorder through change of appearance.

COST SHARE: An amount required to be paid by an Insured, in addition to premium, in connection with certain Covered Services and Supplies. This may be a copayment.

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

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

COVERED SERVICES AND SUPPLIES: The services and supplies covered under the Individual Health Benefits Coverage.

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

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

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

DEPENDENT: Your Dependent is someone who:

- Is Your spouse or your Child and who meets the eligibility requirements of this Individual Policy;
- Is listed by You on the enrollment form;
- Is someone for whom the required premium has been paid;

- Is a Court-ordered Dependent; and/or
- Is a Child of any age who is medically certified as disabled and dependent on the parent. Community First requires proof of Dependent eligibility status for any Dependent over the Limiting Age for Dependents.

DEPENDENT COVERAGE: Coverage that applies to a Dependent.

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

DIABETES SELF MANAGEMENT TRAINING: Instruction enabling an Insured to understand the care and management of diabetes, including nutritional counseling and proper use of diabetes equipment and supplies.

DIABETIC SUPPLIES: Test strips for blood glucose monitors; visual reading and urine test strips; lancets and lancet devices; insulin and insulin analogs; Injection aids; syringes; prescriptive and nonprescriptive oral agents for controlling blood sugar levels; biohazard containers; and glucagon emergency kits.

DIAGNOSTIC IMAGING: An imaging examination using mammography, ultrasound imaging, or magnetic resonance imaging that is designed to evaluate a subjective or objective abnormality detected by a physician or patient in a breast; an abnormality seen by a physician on a screening mammogram; an abnormality previously identified by a physician as probably benign in a breast for which follow-up imaging is recommended by a physician; or an individual with a personal history of breast cancer or dense breast tissue.

DURABLE MEDICAL EQUIPMENT: Equipment prescribed by the attending Provider that meets each of the following:

- Is medically necessary;
- Is not primarily or customarily used for non-medical purposes;
- Is designated for prolonged use; and
- Serves a specific therapeutic purpose in the treatment of any injury or illness.

ELIGIBLE EXPENSE: Medical costs or other charges deemed by Community First Insurance Plans as being eligible for coverage.

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

1. Placing his or her health in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any body organ or part;

4. Serious disfigurement; or
5. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

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

1. Full and final approval has not been granted by the US Food and Drug Administration for the treatment of the patient's medical condition;
2. Specific evidence shows that the service, technology, supply, treatment, procedure, drug therapy or device is being provided subject to a) Phase I or Phase II clinical trial or the experimental arm of a Phase III or Phase IV clinical trial, b) a protocol to determine the safety, toxicity, maximum tolerated dose, efficacy, or efficacy in comparison to the standard means of treatment or diagnosis, or c) protocol approved by and under the supervision of an institutional review board;
3. The published authoritative medical and scientific literature a) has not defined, or supports further research to define, the safety, toxicity, maximum tolerated dose, efficacy or efficacy in comparison to the standard means of treatment or diagnosis, and b) does not demonstrate statistically significant improvement in the efficacy or outcomes for the service, technology, supply, treatment, procedure, drug therapy or device compared to standard services, technologies, supplies, treatments, procedures, drug therapies or devices.

EYE EXAM: Examination to determine the need for corrective lenses.

FACILITY BASED PROVIDER: A radiologist, anesthesiologist, pathologist, emergency department Provider or neonatologist to whom a facility has granted clinical privileges and provides services to patients of the facility.

FAMILY UNIT: Collectively, You and Your Dependents who are Insured.

FREESTANDING EMERGENCY MEDICAL CARE FACILITY: A facility, structurally separate and distinct from a hospital that receives an individual and provides emergency care.

HEALTH CARE FACILITY: A hospital, emergency clinic, outpatient clinic, birthing center, ambulatory surgical center or other facility providing health care services.

HEALTH STATUS RELATED FACTOR: Any of the following in relation to an Insured: health status, medical condition (including both physical and mental Illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence, including family violence, or disability).

HERITABLE DISEASE: An inherited disease that may result in mental or psychological retardation or death.

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

HOME HEALTH CARE AGENCY: An organization that has been licensed or certified as a home health agency in the state of Texas, or is a home health agency as defined in Medicare.

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

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

HOSPITAL INPATIENT STAY: A Hospital stay for which a room and board charge is made by the Hospital.

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

IMPLANT: A surgically implanted artificial device that functions to correct a significant functional disorder (e.g., hip joints, heart pacemakers, penile implants, and implanted electrical stimulators).

INDEPENDENT REVIEW ORGANIZATION: An organization that is certified by the Texas Department of Insurance to perform independent review of Adverse Determinations, as provided under Chapter 4201 of the Texas Insurance Code.

INDIVIDUAL COVERAGE: Coverage that applies to an Eligible Individual.

INDIVIDUAL HEALTH BENEFITS COVERAGE: The services that are included in this Individual Policy. Also referred to as "Coverage."

INITIAL ENROLLMENT PERIOD: The initial period of enrollment after a potential Insured first becomes Eligible or first becomes a Qualified Dependent.

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

INJURY: Trauma or damage to some part of the body of an Insured.

INDIVIDUAL TREATMENT PLAN: A plan with specific attainable goals and objectives appropriate both to the Insured and the treatment modality of the program.

INSURED: A Person who is covered under the Individual Health Benefits Coverage described in this Individual Policy; or a Dependent with respect to whom an Insured is covered for Dependent Coverage described in this Individual Policy.

LIFE-THREATENING CONDITION: A disease or other medical condition with respect to which death is probable unless the course of the disease is interrupted. An Insured or the Insured 's Provider of record shall determine the existence of a Life-Threatening Condition on the basis that a prudent layperson possessing an average knowledge of medicine and health would believe that his or her disease or condition is life-threatening.

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

MEDICAL DIRECTOR: A Provider who is retained by Community First to coordinate and supervise the delivery of health care services for Insured through Participating Providers.

MEDICAL EMERGENCY: A recent onset of a medical and/or behavioral health condition requiring Emergency Care.

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

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

NON-PARTICIPATING PROVIDER: A Provider, Hospital, or other Provider of medical services or supplies that is not contracted with Community First.

OBSERVATION PERIOD: A short-term outpatient hospital stay lasting less than 24 hours.

OPEN ENROLLMENT PERIOD: A period of at least thirty-one (31) days each year, set by CMS, during which an Eligible Individual, may elect coverage under the Individual's Health Benefits Plan.

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

OUT-OF-AREA: Outside the approved Service Area of Community First.

OUT-OF-POCKET: The Copayment amounts that are the Insured's responsibility each Contract Year. The specific Out-of-Pocket maximum Copayment that applies under this Individual Policy is listed in the attached Schedule of Cost Sharing. Community First will assist the Insured in determining when he or she has satisfied the Out-of-Pocket maximum Copayment, so it is important to keep all receipts for Copayments actually paid. Copayments that are paid toward certain Covered Services are not applicable to an Insured's Out-of-Pocket as set forth in the attached Schedule of Cost Sharing.

OUT-OF-POCKET EXPENSE CREDIT: Community First credits toward an insured's deductible and annual maximum out-of-pocket expenses an amount the insured pays directly to any

physician or health care provider for a medically necessary covered medical or health care service or supply if a claim for the service or supply is not submitted to Community First and the amount paid by the insured to the physician or health care provider is less than the average discounted rate for the service or supply paid to an equivalently licensed or authorized preferred provider. Contact the Member Services Department for Out-of-Pocket credit assistance.

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

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

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

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

PREAUTHORIZATION: The verbal or written approval by Community First, or its designee, obtained prior to admitting an Insured to a Facility or providing certain other Covered Services to an Insured when approval is required for such services. Preauthorization is not the same as a Referral, and an Insured who has been referred to another Provider by another Network Provider may still need to obtain Preauthorization prior to certain services being rendered by the Referring Provider. The pre-authorization renewal process permits a renewal request at least 60 days before and existing preauthorization expires.

PRESCRIPTION MEDICATION AND/OR SUPPLIES: A medicinal substance that, by law, can be dispensed only by prescription; or other items that require a prescription order to be dispensed.

PRIMARY CARE PROVIDER (PCP): A Participating Provider (generally an internal medicine, general medicine, pediatrics or family practice) who is chosen by or for an Insured to:

1. Provide primary medical care to the Insured;
2. Maintain the continuity of the Insured's medical care and initiate referrals to Non-Participating Providers.

PROSTHESIS: An external or removable artificial device that replaces a limb or body part (e.g. prosthetic arms or legs).

PSYCHIATRIC DAY TREATMENT FACILITY: A mental health facility that provides treatment for individuals suffering from acute, mental, and nervous disorders in a structured psychiatric program using Individual Treatment Plans and that is clinically supervised by a Doctor of Medicine or Doctor of Osteopathic Medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology.

QUALIFIED DEPENDENT: A person who depends on the Subscriber for financial support, who

Community First deems eligible for benefits under the policy contract.

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

REFERRAL: A recommendation by an Insured's PCP or other treating Provider for a patient to be evaluated or treated by another Provider.

RELATED HOSPITAL INPATIENT STAYS: Separate hospital inpatient stays of a person that occur as a result of the same illness or injury. Hospital inpatient stays will be considered unrelated if:

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

RESIDENTIAL TREATMENT CENTER FOR CHILDREN AND ADOLESCENTS: A child-care institution that provides residential care and treatment for emotionally disturbed children and adolescents and that is licensed or operated by the appropriate state agency or board.

SERIES OF TREATMENTS: A series of treatments is a planned, structured, and organized program to promote chemical free status which may include different facilities or modalities and is complete when the covered individual is discharged on medical advice from inpatient detoxification, inpatient rehabilitation/treatment, partial hospitalization or intensive outpatient or a series of these levels of treatments without a lapse in treatment or when a person fails to materially comply with the treatment program for a period of thirty (30) days.

SERIOUS MENTAL ILLNESS: The following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM): (A) bipolar disorders (hypomanic, manic, depressive, and mixed, (B) depression in childhood and adolescence (C) major depressive disorders (single episode or recurrent) (D) obsessive-compulsive disorders (E) paranoid and other psychotic disorders (F) schizo-affective disorders (bipolar or depressive (G) schizophrenia.

SERVICE AREA: The geographic area within which Covered Services and Supplies for medical care and treatment are available and provided, by Participating Providers, under the Individual Contract, to Insured who live, reside or work within that geographic area. The Service Area applicable to Insured is shown as **Attachment A** to Your Individual Insurance Policy.

SKILLED NURSING FACILITY: An institution that:

1. Meets all Texas licensing requirements and is legally operated.
2. Mainly provides short-term nursing and rehabilitation services for persons recovering from Illness or Injury. The services are provided for a fee, and include both room and board and 24-hour-a-day skilled nursing service.
3. Provides the services under the full-time supervision of a Provider or registered graduate nurse (R.N.); or, if full-time supervision by a Provider is not provided, it has the services

of a Provider available under a contractual agreement.

4. Does not include an institution or part of one that is used mainly as a place for custodial care, rest or for the aged.

SUBSCRIBER: The person who is responsible for payment of the Individual Health Insurance premiums.

SPECIAL ENROLLMENT PERIOD: A period outside of the Initial Enrollment Period and the Open Enrollment Period during which an Individual or Dependent can enroll in the Plan. The Special Enrollment Period for both Individuals and Dependents can be activated by:

1. Loss of other coverage (other than for cause or non-payment of premium);
2. A New Dependent acquired by an Individual through marriage, birth, adoption or placement for adoption.
3. A court order requiring the Individual to cover a spouse or child.

SPECIALTY CARE DOCTOR: A Participating Provider who provides certain specialty medical care to Insured. Under special circumstances a Specialty Care Provider may function as a PCP if approved by the Medical Director. Member who are referred to Specialty Care Provider may still need to obtain Preauthorization to receive certain services from the Specialty Care Provider and should work with his/her PCP and Specialty Care Provider in order to obtain Preauthorization when required.

SUBSCRIBER: The person who is responsible for payment of the Individual Health Insurance premiums.

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

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

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

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

TELEMEDICINE MEDICAL SERVICE: A health care service initiated by a Provider or another Provider authorized to act under Provider delegation and supervision for purposes of patient assessment by a Provider, diagnosis or consultation by a Provider, treatment, or the transfer of medical data, that requires the use of advanced telecommunications technology, other than by

telephone or facsimile, including:

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

TERMINALLY-ILL PERSON: A person whose life expectancy is six (6) months or less, as certified by a Participating Provider.

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

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

USUAL AND CUSTOMARY (U&C) FEE OR RATE: The claim payment amount established by Community First for a particular service, supply or medication, and type of Provider based on usual and customary fee for the same service in the geographic area, standards in the industry or other relevant factors.

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

UTILIZATION REVIEW AGENT: Community First, or an entity licensed by the Texas Department of Insurance as a Utilization Review Agent, that conducts Utilization Review for Community First.

YOU AND YOUR: An Individual or an Insured.

COMMUNITY FIRST INSURANCE PLANS
APPENDIX A - SERVICE AREA

The approved Service Area for Community First Insurance Plans. Exclusive Provider Organization (EPO) Network includes the following Texas county: Bexar.

See Community First's Provider Directory for a Service Area Map, a listing of zip codes included within the Service Area, and locations for all health care delivery sites. Visit the website at https://exchange.communityfirsthealthplans.com/.

COMMUNITY FIRST INSURANCE PLANS
APPENDIX B - OUTPATIENT PRESCRIPTION RIDER

I. PHARMACY BENEFITS

A. Definitions

In addition to the applicable terms provided in the **DEFINITIONS** section of this Policy, the following terms will apply specifically to this **PHARMACY BENEFITS** section.

Allowable Amount: The maximum amount determined by the plan to be eligible for consideration of payment for a particular covered drug. As applied to Participating Pharmacies the Allowable Amount is based on the provisions of the contract between Community First and the Participating Pharmacy in effect on the date of service. As applied to **Prescription Drugs Purchased Outside of the Service Area**, the Allowable Amount is based on the Participating Pharmacy contract rate.

Brand Name Drug: A drug or product manufactured by a single manufacturer as defined by a nationally recognized Provider of drug product database information. There may be some cases where two manufacturers will produce the same product under one license, known as a co-licensed product, which would also be considered as a Brand Name Drug. There may also be situations where a drug's classification changes from generic to Preferred Brand Name due to a change in the market resulting in the generic being a single source, or the drug product database information changing, which would also result in a corresponding change in Copayment obligations from generic to Preferred Brand Name.

Copayment: The dollar amount paid by the Insured for each Prescription Order filled or refilled through a Participating Pharmacy.

Drug List: A list of all drugs that may be covered under Your Pharmacy Benefits. The Drug List is available by accessing the website at https://exchange.communityfirsthealthplans.com. You may also contact the Member Services department at (210) 358-6400 or toll-free number at 1-888-512-2347.

Generic Drug: A drug that has the same active ingredient as the Brand Name Drug and is allowed to be produced after the brand name drug's patent has expired. In determining the Brand or Generic classification for covered drugs and corresponding Insured Copayment responsibility, Community First utilizes the generic/brand status assigned by a nationally recognized Provider of drug product database information. The Drug List identifying preferred and non-preferred Generic Drugs is available by accessing the website at https://exchange.communityfirsthealthplans.com or You may contact the Member Services department at (210) 358-6400 or toll-free number at 1-888-512-2347..

Health Care Practitioner: An Advanced Practice Nurse, Doctor of Medicine, Doctor of Dentistry, Physician Assistant, Doctor of Osteopathy, Doctor of Podiatry, or other licensed person with prescription authority.

Legend Drug: A drug, biological, or compounded prescription which is required by law to have a label stating "Caution - Federal Law Prohibits Dispensing Without a Prescription," and which are approved by the FDA for a particular use or purpose.

National Drug Code (NDC): A national classification system for the identification of drugs.

Non-Preferred Brand Name Drug: Brand Name Drug which appears on the applicable Drug List and is subject to the Non-Preferred Brand Name Drug Copayment. The Drug List is available by accessing the website at https://exchange.communityfirsthealthplans.com. You may also contact the Member Services department at (210) 358-6400 or toll-free number at 1-888-512-2347.

Participating Pharmacy: An independent retail Pharmacy, chain of retail Pharmacies, mail-order program Pharmacy or a Specialty Pharmacy Provider which have entered into a written agreement with Community First to provide pharmaceutical services to Insured under this Policy.

Pharmacy: A state and federally licensed establishment where the practice of pharmacy occurs, that is physically separate and apart from any Provider's office, and where Legend Drugs and devices are dispensed under Prescription Orders to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he practices.

Preferred Brand Name Drug: A Brand Name Drug which appears on the applicable Drug List and is subject to the Preferred Brand Name Drug Copayment. This list is available by accessing the website at https://exchange.communityfirsthealthplans.com. You may also contact the Member Services department to obtain a copy of the list, at (210) 358-6400 or toll-free number at 1-888-512-2347.

Prescription Order: A written or verbal order from Your authorized Health Care Practitioner to a pharmacist for a drug or device to be dispensed.

Specialty Drugs: A high cost prescription drug that meets any of the following criteria:

1. Used in limited patient populations or indications,
2. Typically self-injected,
3. Limited availability, requires special dispensing, or delivery and/or patient support is required and
4. Therefore, they are difficult to obtain via traditional Pharmacy channels,
5. Complex reimbursement procedures are required, and/or
6. A considerable portion of the use and costs are frequently generated through office-based medical claims.

Specialty Pharmacy Provider: A Participating Pharmacy which has entered into a written agreement with Community First to provide Specialty Drugs to Insured under this Policy.

II. COVERED DRUGS AND SUPPLIES

Benefits for Medically Necessary covered drugs prescribed to treat You for a chronic, disabling, or life-threatening illness covered by Community First are available if the drug is on the applicable Drug List and has been approved by the United States Food and Drug Administration (FDA) for at least one indication and is recognized by the following for treatment of the indication for which the drug is prescribed:

- A prescription drug reference compendium approved by the Texas Department of Insurance, or
- Substantially accepted peer-reviewed medical literature.

As new drugs are approved by the Food and Drug Administration (FDA), such drugs, unless the intended use is specifically excluded by Community First, may be eligible for benefits if included on the applicable Drug List. Some equivalent drugs are manufactured under multiple brand names. In such cases, Community First may limit benefits to only one of the brand equivalents available.

Amino Acid-Based Elemental Formulas. Formulas, regardless of the formula delivery method, used for the diagnosis and treatment of:

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

A Prescription Order from your Health Care Practitioner is required.

Clinician-Administered Drugs. For Insureds with chronic, complex, rare, or life-threatening medical conditions, Community First will not:

1. Restrict clinician-administered drugs to specific pharmacies or those within the plan's network.
2. Limit or exclude coverage of clinician-administered drugs based on the Insured's chosen pharmacy or if dispensed outside the plan's network.
3. Require network physicians or providers to bill for these drugs under the pharmacy benefit instead of the medical benefit without:
    a. The insured's informed written consent.
    b. A written attestation from the Insured's physician or provider confirming that a delay won't increase health risk.
4. Impose additional fees, higher copays, higher coinsurance, or any price increase for drugs based on the Insured's pharmacy choice or if dispensed outside the network.

These rules apply if the Insured's physician or provider determines that:

1. A delay in care could likely lead to disease progression.
2. Using a network pharmacy could:
    a. Likely cause death or harm to the Insured.
    b. Create a barrier to the insured's adherence to their care plan.
    c. Require delivery by another pharmacy due to timeliness or dosage needs.

Covered Prescription Contraceptives. Community First will cover up to:

- a three-month supply of the covered prescription contraceptive drug at one time the first time the Insured obtains the drug; and
- a 12-month supply of the covered prescription contraceptive drug at one time each subsequent time the Insured obtains the same drug, regardless of whether the Insured was enrolled in the health benefit plan the first time the Insured obtained the drug.
- An Insured may obtain only one 12-month supply of a covered prescription contraceptive drug during each 12-month period.

Diabetes Supplies for Diabetes Care. Insulin, insulin analogs, insulin pens, insulin syringes, needles, injection devices, glucagon emergency kits, lancets, lancet devices, blood glucose monitors, glucose meter solution, test strips specified for use with a corresponding blood glucose monitor, visual reading strips and urine and blood testing strips, and tablets which test for glucose, ketones, and protein, and prescriptive and nonprescriptive oral agents for controlling blood sugar levels are covered.

A separate Copayment will apply to each fill of a prescription purchased on the same day for insulin and insulin syringes.

Cost-sharing for insulin that is on the formulary cannot exceed $25 per prescription for a 30 day supply. A formulary must include at least one insulin from each therapeutic class.

Emergency refills of insulin and insulin related equipment are covered in the same manner as a non-emergency refill.

Formulas for the Treatment of Phenylketonuria or Other Heritable Diseases. Dietary formulas necessary for the treatment of phenylketonuria or other heritable diseases are covered.

Injectable Drugs. Injectable drugs approved by the FDA for self-administration are covered. Injectable drugs include, but are not limited to, insulin and Imitrex.

The day supply of disposable syringes and needles You will need for self-administered injections will be limited on each occasion dispensed to amounts appropriate to the dosage amounts of covered injectable drugs actually prescribed and dispensed, but cannot exceed 100 syringes and needles per Prescription Order in a 30-day period.

Orally Administered Anticancer Medication. Benefits are available for Medically Necessary orally administered anticancer medication that is used to kill or slow the growth of cancerous cells. Copayments will not apply to certain orally administered anticancer medications. To determine if a specific drug is included in this benefit, You may contact the Member Services department at (210) 358-6400 or toll-free number at 1-888-512-2347.

Preventive Care. Over-the-counter drugs which have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF") or as required by state law will be covered and will not be subject to any Copayment or dollar maximums.

Specialty Drugs. Benefits are available for Specialty Drugs as described in Specialty Pharmacy Program.

Vaccinations obtained through certain Participating Pharmacies. Benefits for vaccinations are

shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**. These vaccinations are available through certain Participating Pharmacies that have contracted with Community First to provide this service. To locate one of these Participating Pharmacies and to determine which vaccinations are covered under this benefit, contact the Member Services department at (210) 358-6400 or toll-free number at 1-888-512-2347.
Each Participating Pharmacy that has contracted with Community First to provide this service may have age, scheduling, or other requirements that will apply, so you are encouraged to contact them in advance.

III. SELECTING A PHARMACY

When You need a Prescription Order filled, You should use a Participating Pharmacy. Each prescription or refill is subject to the Copayment shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**.

Participating Pharmacy. When You go to a Participating Pharmacy, You must pay any Copayment and any applicable pricing differences. You may be required to pay for limited or non-Covered Services. No claim forms are required. If You are unsure whether a Pharmacy is a Participating Pharmacy, You may access the website at https://exchange.communityfirsthealthplans.com or contact the Member Services department at (210) 358-6400 or toll-free number at 1-888-512-2347.
Mail-Order Program. If You elect to use the mail-order service, You must mail Your Prescription Order to the address provided on the mail-order prescription form and send in Your payment for each prescription filled or refilled. Each prescription or refill is subject to the Copayment shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** and any applicable pricing differences, payable by the Member directly to the mail order Pharmacy.

Some drugs may not be available through the mail-order program. If You have any questions about the mail-order program, need assistance in determining the amount of Your payment, or need to obtain the mail-order prescription claim form, access the website at https://exchange.communityfirsthealthplans.com or contact the Member Services department at (210) 358-6400 or toll-free number at 1-888-512-2347. Mail the completed form, Your Prescription Order(s) and payment to the address indicated on the form.

Prescription Drugs Purchased Outside of the Service Area. Community First will not reimburse You for prescription drugs purchased outside of the EPO formulary.

IV. YOUR COST

You are responsible for any Copayments for covered drugs shown in the SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS and any pricing differences that may apply to the covered drug dispensed.

How Copayment Amounts Apply. If the Allowable Amount of the Drug is less than the Copayment, You pay the lower cost. You will pay no more than the applicable Preferred Brand Name Drug or Non-Preferred Brand Name Drug Copayment if the prescription has no generic equivalent. If You receive a Brand Name Drug when a generic equivalent is available, the Copayment will be the total of the Generic Drug Copayment plus the difference between the cost of the Generic Drug equivalent and the cost of the Brand Name Drug.

V. ABOUT YOUR BENEFITS

Covered Drug List. A list of all covered drugs is shown on the Drug List. Community First will periodically review the preferred drug list and adjust it to modify the preferred/non-preferred Brand Name Drug status of new and existing drugs. Changes to the Drug List will be implemented on the next renewal date of Your Individual Health Benefits Coverage policy The Insured will receive at least a 60 day notice prior to any such modification. The Drug List and any modifications thereto will be made available to the Insured. This list is available by accessing the website at https://exchange.communityfirsthealthplans.com or by calling the Member Services department at (210) 358-6400 or toll-free number at 1-888-512-2347.

Exception Requests. If Your drug is not on the Drug List, You, Your authorized representative, or Your Health Care Practitioner can request an exception by contacting the Member Services department at (210) 358-6400 or toll-free number at 1-888-512-2347. Along with your request, Your Health Care Practitioner should submit a supporting statement explaining why the drug is needed to treat Your condition. Community First will provide notice of our decision no later than72 hours after receipt of Your Health Care Practitioner's supporting statement. If approved, the drug will be covered at a cost-sharing level that Community First has pre-determined.

If you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or if You are undergoing a current course of treatment using a drug that is not on the Drug List, expedited review may be requested. The supporting statement from Your Health Care Practitioner should indicate that an exigency exists, discuss the harm that could result if the requested drug is not provided on an expedited basis, and explain why the drug is needed to treat Your condition. Community First will provide notice of our decision no later than 24 hours after receipt of the supporting statement from Your Health Care Practitioner. If Your exception request is approved, the drug will be covered for the duration of the exigency at a cost sharing level pre-determined by Community First.

If your exception request is denied, You may appeal the decision as described in the **PROCESS FOR APPEALING AN ADVERSE DETERMINATION** section of this Policy. You will also receive information about the appeals process with the denial letter.

Day Supply. Benefits for covered drugs obtained from a Participating Pharmacy are provided up to the maximum day supply limit as shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**. Community First has the right to determine the day supply. Payment for benefits covered by Community First may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum day supply limitation.

If You are leaving the country or need an extended supply of medications, call customer service at least two weeks before You intend to leave. Extended supplies or vacation override are not available through the mail-order program but may be approved through the retail Pharmacy only. In some cases, You may be asked to provide proof of continued membership eligibility under the Policy.

Dispensing/Quantity Versus Time Limits. The maximum quantity of a given prescription drug indicates the number of units to be dispensed and is determined based on pertinent medical information and clinical efficacy and safety. Quantities of some drugs are restricted regardless of the quantity ordered by the Health Care Practitioner. To determine if a specific drug is subject to this limitation, You may access the website at https://exchange.communityfirsthealthplans.com or contact the Member Services department at (210) 358-6400 or toll-free number at 1-888-512-2347.

If a Prescription Order is written for a certain quantity of medication to be taken in a time period directed by a Health Care Practitioner, the Prescription Order will only be covered for a clinically appropriate predetermined quantity of medication for the specified amount of time. Dispensing limits are based upon FDA dosing recommendations and nationally recognized clinical guidelines.

Community First has the right to determine dispensing limits at its sole discretion. Payment for benefits covered by Community First may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum quantity limitation. If You require a Prescription Order in excess of the dispensing limit established by Community First, ask Your Health Care Practitioner to submit a request for clinical review on Your behalf. The Health Care Practitioner can obtain an override request form by accessing our website at https://exchange.communityfirsthealthplans.com.

Any pertinent medical information along with the completed form should be faxed to Clinical Pharmacy Programs at the fax number indicated on the form. The request will be approved or denied after evaluation of the submitted clinical information.

Controlled Substance Limits. In the event Community First determines that an Member may be receiving quantities of a Controlled Substance not supported by FDA approved dosages or recognized treatment guidelines, any additional drugs may be subject to a review for medical necessity, appropriateness and other coverage restrictions such as limiting coverage to services by a certain Provider and/or Participating Pharmacy for the prescribing and dispensing of the Controlled Substance.

Certain Prescription Drug Payments and Refills. Community First may not require an Insured to make a payment for a prescription drug at the point of sale in an amount greater than the lesser of:

A. The applicable copayment;

B. The allowable claim amount for the prescription drug; or

C. The amount an individual would pay for the drug if the individual purchased the drug without using a health benefit plan or any other source of drug benefits or discounts.

Community First covers prescription eye drops to treat a chronic eye disease or condition and must allow the refill of prescription eye drops if the Insured timely pays at the point of sale the maximum amount allowed by Subsection (a) and:

A. The original prescription states that additional quantities of the eye drops are needed;

B. The refill does not exceed the total quantity of dosage units authorized by the prescribing provider on the original prescription, including refills; and

C. The refill is dispensed on or before the last day of the prescribed dosage period and:

1. Not earlier than the 21st day after the date a prescription for a 30-day supply of eye drops is dispensed;

2. Not earlier than the 42nd day after the date a prescription for a 60-day supply of eye drops is dispensed; or

3. Not earlier than the 63rd day after the date a prescription for a 90-day supply of eye drops is dispensed.

Prescription Drug Synchronization. Community First must:

A. Provide in plain language in the coverage documentation provided to each Insured:

1. Notice that the plan uses one or more drug formularies;

2. An explanation of what a drug formulary is;

3. A statement regarding the method the issuer uses to determine the prescription drugs to be included in or excluded from a drug formulary;

4. A statement of how often the issuer reviews the contents of each drug formulary; and

5. Notice that an Insured may contact the issuer to determine whether a specific drug is included in a particular drug formulary;

B. Disclose to an individual on request, not later than the third business day after the date of the request, whether a specific drug is included in a particular drug formulary; and

C. Notify an Insured and any other individual who requests information under this section that the inclusion of a drug in a drug formulary does not guarantee that an Insured's health care provider will prescribe that drug for a particular medical condition or mental illness.

Proration of Cost-sharing Amount Required. Community First shall prorate any cost-sharing amount charged for a partial supply of a prescription drug if the pharmacy or the Insured's prescribing physician or health care provider notifies the health benefit plan that:

A. The quantity dispensed is to synchronize the dates that the pharmacy dispenses the Insured's prescription drugs; and

B. The synchronization of the dates is in the best interest of the Insured; and

C. The Insured agrees to the synchronization.

The proration described must be based on the number of days' supply of the drug actually dispensed.

Step Therapy. Coverage for certain prescription drugs or drug classes is subject to a step therapy program. Step therapy programs favor the use of clinically acceptable alternative medications that may be less costly for you prior to those medications on the step therapy list of drugs being covered under Community First.

The Insured or prescribing provider may request a step-therapy exception. Below indicates how this may occur:

A. Community First may modify drug coverage provided under a health benefit plan if:

1. The modification occurs at the time of coverage renewal;

2. The modification is effective uniformly among all group health benefit plan sponsors covered by identical or substantially identical health benefit plans or all individuals covered by identical or substantially identical individual health benefit plans, as applicable; and

3. Not later than the 60th day before the date the modification is effective, the issuer provides written notice of the modification to the commissioner, each affected group health benefit plan sponsor, each affected Insured in an affected group health benefit plan, and each affected individual health benefit plan holder.

B. Modifications affecting drug coverage that require notice include:

1. Removing a drug from a formulary;

2. Adding a requirement that an Insured receive prior authorization for a drug;

3. Imposing or altering a quantity limit for a drug;

4. Imposing a step-therapy restriction for a drug; and

5. Moving a drug to a higher cost-sharing tier unless a generic drug alternative to the drug is available.

C. Community First may elect to offer an Insured in the plan the option of receiving these notifications by e-mail.

When You submit a Prescription Order to a Participating Pharmacy for one of these designated medications, the pharmacist will be alerted if the online review of Your prescription claims history indicates an acceptable alternative medication has not been previously tried. If so, a toll-free phone number will be provided to You for Your Health Care Practitioner to call and obtain additional program and criteria information. A list of step therapy medications is available to You and Your Health Care Practitioner on our website at https://exchange.communityfirsthealthplans.com or contact the Member Services department at (210) 358-6400 or toll-free number at 1-888-512-2347.

If it is Medically Necessary, coverage can be obtained for the prescription drugs or drug classes subject to the step therapy program without trying an alternative medication first. In this case, Your Health Care Practitioner must contact Community First to obtain prior authorization for coverage of such drug. If authorization is granted, the Health Care Practitioner will be notified and the medication will then be covered at the applicable Copayment.

Although You are currently on step therapy, Your claim may need to be reviewed to see if the criteria for coverage of treatment has been met. A documented treatment with a generic or brand therapeutic alternative medication may be required for continued coverage of a Brand Name Drug.

This provision does not apply to prescription drugs associated with the treatment of stage-four advanced, metastatic cancer or associated conditions.

For an Insured who is 18 years of age or older with a diagnosis of a serious mental illness, Community First will not:

1. require an Insured to fail to successfully respond to more than one different drug for each drug prescribed, excluding the generic or pharmaceutical equivalent of the prescribed drug; or
2. prove a history of failure of more than one different drug for each drug prescribed, excluding the generic or pharmaceutical equivalent of the prescribed drug.

If Community First does not deny an exception request within 72 hours of the request, the request is considered granted. When the provider believes death or serious harm is probable, the request is considered granted if Community First does not deny the request within 24 hours. A denial of an exception is considered an Adverse Determination subject to an expedited review.

Prior Authorization. Coverage for certain designated prescription drugs is subject to prior authorization criteria. This means that in order to ensure that a drug is safe, effective, and part of a specific treatment plan, certain medications may require prior authorization and the evaluation of additional clinical information before dispensing. You and Your Health Care Practitioner may access a list of the medications which require prior authorization on our website at https://exchange.communityfirsthealthplans.com or contact the Member Services department at (210) 358-6400 or toll-free number at 1-888-512-2347.
When You submit a Prescription Order to a Participating Pharmacy for one of these designated medications, the pharmacist will be alerted online if Your Prescription Order is on the list of medications which require prior authorization before it can be filled. If this occurs, Your Health Care Practitioner will be required to submit an authorization request. This form may also be submitted by Your Health Care Practitioner in advance of the request to the Pharmacy. The Health Care Practitioner can obtain the authorization form by accessing our website at https://exchange.communityfirsthealthplans.com. The requested medication may be approved or denied for coverage by Community First based upon its accordance with established clinical criteria.

Community First will not require an Insured to receive more than one prior authorization annually of the prescription drug benefit for a prescription drug prescribed to treat an autoimmune disease, hemophilia, or Von Willebrand disease. Excludes opioids, benzodiazepines, barbiturates, and carisoprodol and does not apply to prescription drugs that have a typical treatment period of less than 12 months.

Right of Appeal. You have the right to appeal as explained in the **PROCESS FOR APPEALING AN ADVERSE DETERMINATION** section of this Policy.

VI. Limitations and Exclusions

A. Pharmacy benefits are not available for:

1. Drugs that are not shown on the Drug List.

2. Drugs which by law do not require a Prescription Order from an authorized Health Care Practitioner and Legend Drugs or covered devices for which no valid Prescription Order is obtained. (Insulin, insulin analogs, insulin pens, prescriptive and nonprescriptive oral agents for controlling blood sugar levels, and vaccinations administered through certain Participating Pharmacies shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** are covered.)

3. Prescription drugs if there is an over-the-counter product available with the same active ingredient(s) in the same strength, unless otherwise determined by Community First.

4. Drugs required by law to be labeled: "Caution - Limited by Federal Law to Investigational Use," or Experimental drugs, even though a charge is made for the drugs.

5. Drugs, that the use or intended use of would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.

6. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the identification card.

7. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction that is not covered under Community First, or for which benefits have been exhausted.

8. Drugs injected, ingested, or applied in a Provider's office or during confinement while a patient in a Hospital, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.

9. Drugs for which the Pharmacy's usual retail price to the general public is less than or equal to the Copayment.

10. Drugs purchased from a non-Participating Pharmacy in the Service Area.

11. Devices or Durable Medical Equipment (DME) such as but not limited to therapeutic devices, including support garments and other non-medicinal substances, even though such devices may require a Prescription Order. (Disposable hypodermic needles, syringes for self-administered injections and contraceptive devices are covered). However, You do have certain DME benefits available under the **Durable Medical Equipment** section in **COVERED SERVICES AND BENEFITS.** Coverage for female contraceptive devices and the rental (or, at Community First's option the purchase) of manual or electric breast pumps is provided as indicated under the **Health Maintenance and Preventives Services** section in **Covered Services and Benefits.**

12. Male contraceptive devices, including over-the-counter contraceptive products such as condoms; female contraceptive devices, including over-the-counter contraceptive products such as spermicide, when not prescribed by a Participating Provider.

13. Any special services provided by a Pharmacy, including but not limited to counseling and delivery. Vaccinations shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** administered through certain Participating Pharmacies are an exception to this exclusion.

14. Drugs dispensed in quantities in excess of the day supply amounts indicated in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**, or refills of any prescriptions in excess of the number of refills specified by the authorized Health Care Practitioner or by law, or any drugs or medicines dispensed more than one (1) year after the Prescription Order date.

15. Administration or injection of any drugs.

16. Injectable drugs except Specialty Drugs or those approved by the FDA for self-administration.

17. Legend Drugs which are not approved by the FDA for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation.

18. Non-commercially available compounded medications, regardless of whether or not one or more ingredients in the compound requires a Prescription Order (Non-commercially available compounded are those made by mixing or reconstituting ingredients in a manner or ratio that is inconsistent with the United States Food and Drug Administration-approved indications provided by the ingredients' manufacturers.

19. Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used or intended to be used by intravenous, intramuscular unless approved by the FDA for self-administration, intrathecal, intraarticular injection or gastrointestinal (enteral) infusion in the home setting.

20. Vitamins (except those vitamins which by law require a Prescription Order and for which there is no non-prescription alternative).

21. Allergy serum and allergy testing materials. However, You do have certain benefits available under **Allergy Care** in **COVERED SERVICES AND BENEFITS**.

22. Athletic performance enhancement drugs.

23. Rogaine, minoxidil or any other drugs, medications, solutions, or preparations used or intended for use in the treatment of hair loss, hair thinning or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.

24. Any prescription antiseptic or fluoride mouthwashes, mouth rinses or topical oral solutions or preparations.

25. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.

26. Retin A or pharmacologically similar topical drugs.

27. Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss or dietary control.

28. Drugs to treat sexual dysfunction including but not limited to sildenafil citrate, phentolamine, apomorphine, and alprostadil in oral and topical form.

29. Drugs for the treatment of Infertility (oral and injectable).

30. Prescription Orders which do not meet the required step therapy criteria.

31. Prescription Orders which do not meet the required prior authorization criteria.

32. Some equivalent drugs manufactured under multiple brand names. Community First may limit benefits to only one of the brand equivalents available. If You do not accept the brand that is covered under this Policy, the Brand Name Drug purchases will not be covered under any benefit level.

33. Replacement of drugs or other items that have been lost, stolen, destroyed or misplaced.

34. Shipping, handling, or delivery charges.

35. Brand Name Drugs in a drug class where there is an over-the-counter alternative available.

36. Prescription Orders written by a member of Your immediate family, or a self-prescribed Prescription Order.

37. Drugs which are repackaged by anyone other than the original manufacturer.