COMMUNITY FIRST HEALTH PLANS, INC.

ADMINISTRATIVE OFFICES
12238 Silicon Drive, Suite 100 San Antonio, Texas 78249

TELEPHONE 210-227-2347

or

1-800-434-2347

This Certificate of Group Health Care Coverage provides for arbitration of certain disputes pursuant to the Texas Arbitration Act. Please refer to the section entitled "Arbitration" for specific information. The table of contents will provide the relevant page number.

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.
Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Community First Health Plans, Inc.
To get information or file a complaint with your insurance company or HMO:

Call: Member Services at 210-358-6070
Toll-free: 1-800-434-2347

Online:

CommunityFirstHealthCoverage.com
Email: aservices@cfhp.com
Mail:12238 Silicon Dr. Ste. 100 San Antonio, Texas 78249

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

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Website:https://www.tdi.texas.gov/general/contactus.html

Physical Address: 1601 Congress Avenue Austin, Texas 78701
Mailing Address: Complaints Processing, MC: CO-CP, 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 o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

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

Llame a: Servicios al Miembro al 210-358-6070
Teléfono gratuito: 1-800-434-2347

En línea:

CommunityFirstHealthCoverage.com
Correo electrónico: aservices@cfhp.com
Dirección postal: 12238 Silicon Dr. Ste. 100 San Antonio, Texas 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: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Sitio Web: https://www.tdi.texas.gov/general/contactus.html
Direccion Fisica: 1601 Congress Avenue Austin, Texas 78701Dirección postal: Complaints Processing, MC: CO-CP, P.O. Box 12030, Austin, TX 78711-2030

ATTACH THIS NOTICE TO YOUR PLAN DOCUMENT: This notice is for information only and does not become a part or condition of the attached document.

UNA ESTE AVISO A SU DOCUMENTO DEL PLAN:
Este aviso es solo para proposito de información y no se convierte en parte o condicion del documento adjunto.

NOTICE OF SPECIAL TOLL-FREE COMPLAINT NUMBER

TO MAKE A COMPLAINT ABOUT A PRIVATE PSYCHIATRIC HOSPITAL, CHEMICAL DEPENDENCY TREATMENT CENTER, OR PSYCHIATRIC OR CHEMICAL DEPENDENCY SERVICE AT A GENERAL HOSPITAL, CALL:

1-800-832-9623

Your complaint will be referred to the state agency that regulates the Hospital or chemical dependency treatment center.

AVISO DE NUMERO TELEFONICO GRATIS ESPECIAL PARA QUEJAS

PARA SOMETER UNA QUEJA ACERCA DE UN HOSPITAL PSIQUIATRICO PRIVADO, DE CENTRO TRATAMIENTO PARA LA DEPENDENCIA QUIMICA, DE SERVICIOS PSIQUIATRICOS O DE DEPENDENCIA QUIMICA EN UN HOSPITAL GENERAL, LLAME A:

1-800-832-9623

Su queja será referida a la agencia estatal que regula la Hospital o centro de tratamiento para la dependencia química.

NOTICE OF RIGHTS

A health maintenance organization (HMO) plan provides no benefits for services you receive from out-of-network physicians or providers, with specific exceptions as described in your evidence of coverage and below.

You have the right to an adequate network of in-network physicians and providers (known as network physicians and providers).

If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance at: www.tdi.texas.gov/consumer/get-help-with-an-insurance-complaint.html.

If your HMO approves a referral for out-of-network services because no network physician or provider is available, or if you have received out-of-network emergency care, the HMO must, in most cases, resolve the out-of-network physician's or provider's bill so that you only have to pay any applicable in-network copayment and coinsurance amounts.

You may obtain a current directory of network physicians and providers at the following website: (CommunityFirstHealthCoverage.com) or by calling (210-358-6070) for assistance in finding available network physicians and providers. If you relied on materially inaccurate directory information, you may be entitled to have a claim by an out-of- network physician or provider paid as if it were from a network physician or provider, if you present a copy of the inaccurate directory information to the HMO, dated no more than 30 days before you received the service.

Community First Health Plans may present, deliver, or store communication via electronic means in compliance with Chapter 322, Business & Commerce Code. Delivery of a written communication in compliance with this section is equivalent to any delivery method required by law, including delivery by first class mail, first class mail, postage prepaid, or certified mail. You have the right to opt out and may request written communication to be provided or made available in paper or another non-electronic form.

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COMMUNITY FIRST HEALTH PLANS, INC.
CERTIFICATE OF GROUP HEALTH CARE COVERAGE

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

- This Certificate of Coverage, any Riders or amendments attached to the Certificate, which shall be delivered to each subscriber electronically or hard copy.
- The Schedule of Copayments attached to this Certificate.
- The forms You and Your Employer filled out to obtain this coverage.
- The Group Contract document provided to the Group Contract Holder, which is Your Employer or an Associated Company of Your Employer.
- If the provisions of the Group Contract do not conform to the requirements of Texas or federal law that apply to the Group Contract, the Group 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 Group Contract that is signed by an authorized officer of Community First.

The Contract holder may pay each premium, other than the first, within thirty-one (31) days of the premium due date to avoid being charged interest. Those days are known as the grace period. Community First will give written notice to the Contract Holder at least sixty (60) days prior to a change in premium rates. In addition to any other premium for which the Group Contract holder is liable, the Group Contract holder is liable for a member's premium from the time the member is no longer part of the group eligible for coverage under the contract until the end of the month in which the contract holder notifies Community First that the member is no longer part to the group eligible for coverage. The member remains covered by the contract until the end of that period.

The Contract Holder and the Group Contract Number are shown below.

Covered Employee:	You are eligible to become covered under the Group 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 Certificate. 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.
Contract Holder:	Wallace Cook Insurance Agency
Group Contract No.:	002064 0003 - 0004
Certificate Date:	August 1, 2024, This Certificate describes the benefits under the Group Health Care Coverage as of the Certificate Date.

Covered Classes:	All Eligible Employees of the Contract Holder and Associated Companies who live, work, or reside in the Service Area but are not covered under the Employer's Other Health Benefits Coverage.
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 Attachment 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:	210-358-6070 or 1-800-434-2347
Arbitration Provision:	See Section IX.

Cost of the Coverage: Your contribution is based on the amount marked below:

- [] Both Employee and Dependent Coverage is Contributory Coverage. You will be informed of the amount of Your contribution when You are asked to enroll.
- [] Both Employee and Dependent Coverage is Non-contributory Coverage. The entire cost of the Coverage is being paid by the Contract Holder.
- [X] The Employee Coverage is Non-contributory Coverage.
- [X] The Dependent Coverage is Contributory Coverage. You will be informed of the amount of Your contribution when You are asked to enroll.

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

I. WHO IS ELIGIBLE TO BECOME COVERED

A. FOR EMPLOYEE COVERAGE

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

   - You are an Eligible Employee or Eligible Retiree.
   - You are in the Covered Classes; and
   - You have completed any employment waiting period required by the Employer.

   The Contract Holder determines the Covered Classes. The Contract Holder must not discriminate among persons in like situations. The Group Contract Holder cannot exclude You from a Covered Class based on a Health Status Related Factor.

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

Your Employee 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 Employee; and
   - You have 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 Child under age 26 who is Your grandchild living with you in Your household,
     - Any person who qualifies as a Dependent under eligibility rules set by the Employer and agreed to in writing by Community First.
   - 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 intellectually and developmentally disability 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 Group Health Care Coverage as an Employee.

4. **A child will not be considered a Dependent of more than one Employee from the same employer group**.

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

6. **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; a Group Enrollment Period as described in section II.B; or Special Enrollment Periods described in section II.C.

A. INITIAL ENROLLMENT PERIOD.

1. **General Rule: When You Become an Eligible Employee.** You may enroll Yourself and Your Dependents for Group Health Care Coverage within 31 days after first becoming an Eligible Employee or, if the Employer's Waiting Period exceeds 31 days, within 31 days after the end of the Waiting Period. Community First Group Health Care Coverage will not begin before the first of the month following the end of the Waiting Period.

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 Health

Plans Health Care 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 Employee Coverage under the Group Health Care Coverage, Your child will be covered from the date of the child's birth, or date the child becomes the subject of a suit for adoption until coverage for the child terminates under this Certificate or applicable law. Coverage for the child is subject to the "*When Your Coverage Ends*" section of this Certificate 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 contribution 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 contribution to premium You owe 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.**

4. **Late Enrollee:** Any employee or dependent eligible for enrollment who requests enrollment after the expiration of the initial enrollment period established under the terms of the plan for which the employee or dependent was eligible through after the expiration of an open enrollment period.

   An employee or dependent eligible for and requesting enrollment cannot be excluded until the next open enrollment period and, when enrolled, is not a late enrollee, in the following special circumstances:
   (A) the individual:
   (i) was covered under another health benefit plan or self-funded employer health benefit plan at the time the individual was eligible to enroll;
   (ii) declines in writing, at the time of initial eligibility, stating that coverage under another health benefit plan or self-funded employer health benefit plan was the reason for declining enrollment;
   (iii) has lost coverage under another health benefit plan or self-funded employer health benefit plan as a result of the termination of employment, the reduction in the number of hours of employment, the termination of the other plan's coverage, the termination of contributions toward the premium made by the employer; or the death of a spouse, or divorce; and

(iv) requests enrollment not later than the 31st day after the date on which coverage under the other health benefit plan or self-funded employer health benefit plan terminates;
(B) the individual is employed by an employer who offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period;
(C) a court has ordered coverage to be provided for a spouse under a covered employee's plan and the request for enrollment is made not later than the 31st day after the date on which the court order is issued;
(D) a court has ordered coverage to be provided for a child under a covered employee's plan and the request for enrollment is made not later than the 31st day after the date on which the employer receives the court order or notification of the court order;
(E) the individual is a child of a covered employee and has lost coverage under Chapter 62, Health and Safety Code, Child Health Plan for Certain Low-Income Children or Title XIX of the Social Security Act (42 U.S.C. §§1396, et seq., Grants to States for Medical Assistance Programs), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. §1396s, Program for Distribution of Pediatric Vaccines);
(F) the individual has a change in family composition due to marriage, birth of a child, adoption of a child, or because an insured becomes a party in a suit for the adoption of a child;
(G) an individual becomes a dependent due to marriage, birth of a newborn child, adoption of a child, or because an insured becomes a party in a suit for the adoption of a child; and
(H) the individual described in subparagraphs (E), (F) and (G) of this paragraph requests enrollment no later than the 31st day after the date of the marriage, birth, adoption of the child, loss of the child's coverage, or within 31 days of the date an insured becomes a party in a suit for the adoption of a child.

B. GROUP ENROLLMENT PERIODS

1. During a Group Enrollment Period, You may elect to cover yourself and Qualified Dependents under the Group Health Care Coverage if:

   a. You and Your Qualified Dependents are covered under the Employer's Other Health Benefits Coverage, and You wish to switch coverage to Community First; or

   b You first become eligible for Employee Coverage during that Group Enrollment Period; or

   c. You were previously eligible to enroll for Employee Coverage but did not enroll or are no longer enrolled.

2. If You elect for Yourself and Your Dependents to become covered under the Group Health Care Coverage during a Group Enrollment Period, Your or Your Dependent's coverage will begin on the Group Enrollment Date established by the Group Contract Holder and agreed to by Community First, if all the conditions below are met on that date.

   a. You are eligible for Employee Coverage.

   b. You have enrolled for the Coverage on a form approved by Community First and, for Contributory Coverage, agreed to pay the required contributions.

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

C. SPECIAL ENROLLMENT PERIODS.

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

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

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

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

   When enrollment was declined:

   (1) The Eligible Employee 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 Employee had coverage other than COBRA or state continuation coverage that has since terminated due to loss of eligibility or because the employer ceased contributions to the plan.

   Loss of eligibility includes the following:
   - loss of coverage as a result of a legal separation, divorce, or death;

- termination of employment;
- reduction in hours;
- any loss of eligibility;
- no longer living or working in the service area;

(3) 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 the Employer 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 Employer 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 Employee. An Eligible Employee** may enroll in Community First outside of an Initial or Group Enrollment Period if the Employee:

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

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

(1) The Eligible Employee and his or her spouse have a Child who

becomes a Dependent through birth or Adoption, and

(2) The Eligible Employee applies for enrollment and pays the required contribution 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 the Employer 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 AN INPATIENT CONFINEMENT

1. **Confined as an Inpatient:** If You or Your Dependent are confined in a Hospital or other facility on the date that You or Your Dependent become enrolled for Group Health Care 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.

   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.

   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 Group Health Care Coverage. To be covered, You must utilize Participating Providers and is subject to all the terms and conditions set forth in the Group Health Care Coverage.

   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. GROUP HEALTH CARE 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, or to maintain Your or Your Qualified Dependents' good health, as determined by Your PCP. Not all services and supplies are eligible, and some are eligible only to a limited extent. Members are responsible for knowing their coverage and for determining whether services and supplies are covered prior to receiving such services and supplies. Members should work with his/her PCP and Community First to resolve any question on whether a particular service or supply is a covered benefit prior to receiving the service or supply.

2. **Primary Care Physician (PCP) Selection**: Once You have chosen Community First, you must 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 such as immunizations. 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 medical specialties: internal medicine, general medicine, pediatrics and/or family practice.

   Should You have a chronic, disabling, or Life-Threatening Illness, You may apply to Community First's Medical Director to utilize a Participating Specialty Physician as a PCP, provided that (1) the request includes information specified by Community First, including certification of medical need, and is signed by You and Participating Specialty Physician interested in serving as the PCP; (2) the Participating Specialty Physician meets, and agrees to abide by, the Community First requirements for PCP; and (3) the Participating Specialty Physician is willing to accept the coordination of all of Your health care needs.

   If such request is denied, You may Appeal the decision through Community First's established Complaint and Appeals process. Should such request be approved, the new designation shall not be retroactive and shall in no way reduce the amount of compensation owed to the original PCP prior to the date of the new designation.

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

4. **Changing Your PCP**: Community First believes that a strong PCP Member relationship is critical. However, we also realize that there may be a need for a Member to change his/her PCP. If You must change Your PCP, You may do so by calling Community First's Member Services Department. Requests for changes received on or before the 15th of the month will take effect on the first day of the following month. Requests for changes

received after the 15th will take effect the first day of the second month following the change request.

For example, if You request a change on or before August 15th, the change will become effective September 1st. If You request a change on or after August 16th, the change will become effective October 1st.

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 3 of this Part B. Some services, such as hospital confinements, will require Pre-Authorization by Community First. However, You will not need Pre-Authorization for Emergency or Urgent 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. An issuer that uses a preauthorization process for health care services may not require a physician or provider to obtain preauthorization for a particular health care service if the physician or provider meets exemption criteria for certain health care services. Physicians and providers may request a preauthorization renewal process that allows the renewal of an existing preauthorization to be requested at least 60 days before the current authorization expires. Once Community First receives the renewal request, the request will be reviewed, and a determination will be issued. If You have any questions about whether a Covered Service or Supply requires Pre-Authorization, contact Your PCP or Community First's Member Services Department. You can also access Pre-Authorization information and requirements online at: CommunityFirstHealthCoverage.com

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

   a. Covered Services: All Covered Services must be furnished to a Member:

      (1) by a PCP;

      (2) by another Participating Provider;

(3) by a Non-Participating Provider if referred by a PCP and authorized by Community First;

(4) by a Participating Specialty Care Physician approved by Community First's Medical Director to perform the services of a PCP pursuant to a request of a Member 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 from a Specialty Care Physician or prior to undergoing hospitalization, outpatient surgery or diagnostic procedures.

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 Physician 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 is available 24 hours a day, 7 days a week and You should contact him or her if You need after hours care. If Your call is placed after Your PCP's office hours, You will be assisted by an answering service that will notify the physician on call and advise You on how to proceed.

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 assessment and/or treatment within 24 hours, You should contact Your PCP who will direct You to a contracted facility. See Schedule of Copayments.

(2) Urgent Care Outside the Service Area. Community First will cover Urgent Care obtained from a Physician or licensed facility outside our Service Area if the services cannot safely be delayed until You come back to the service area to obtain care through your PCP.

You must obtain the services immediately after the urgent condition occurs, or as soon as possible afterward. Community First has the right to review the services and the circumstances in which You received them. If we decide that some or all of the services do not meet the coverage requirements of this section, You will have to pay for the non-covered services.

Exceptions to these requirements for Covered Services furnished in connection with Emergency Care for medical conditions occurring inside or outside the Service Area are set forth below.

d. Medical Emergency: Services for a Medical Emergency are covered anywhere in the world 24 hours a day. If a Medical Emergency occurs, Members should go to the nearest participating or non-participating medical facility. See Schedule of Copayments.

Necessary Emergency Care services will be provided to Members, including the treatment and stabilization of a Medical Emergency, and any medical screening examination or other 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 performed by Participating or non-Participating Providers. 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 appropriate to the circumstances, but in no case to exceed one hour.

Community First will have Pre-Authorization staff available during regular business hours. 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 rendered by the Member's PCP, not by the Provider who treated You for the Medical Emergency. The Member, or someone acting on the Member's behalf, should contact the Member's PCP within 24 hours, or as soon as reasonably possible, so that he or she may arrange for follow-up care.

Members 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.

e. Clinician-Administered Drugs

For enrollees 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 enrollee'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 enrollee's informed written consent.
    b. A written attestation from the enrollee'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 enrollee's pharmacy choice or if dispensed outside the network.

These rules apply if the enrollee'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 enrollee.
    b. Create a barrier to the enrollee's adherence to their care plan.
    c. Require delivery by another pharmacy due to timeliness or dosage needs.

2. **Member Financial Responsibility.**

When accessing authorized Covered Services from a Participating Provider, You will only owe a Copayment and/or Percentage Copayment to that Provider. It is the Member's responsibility to ensure that the Providers from whom You receive services are contracted with Community First.

All services received from a Non-Participating Provider require pre-authorization except for emergency and urgent care. All out-of-network services require a prior authorization. You will be liable for all charges if services are not pre-authorized. If You receive pre-authorized services from a Non-participating Provider, and that Provider has not agreed to a negotiated rate from Community First, then Community First may pay the Usual and Customary rate for the services provided. If those services are:

- From a non-network facility-based physician in a network facility;
- Emergency care in a non-network facility;
- Medically necessary covered services (other than emergency care) that are not available through a network physician or provider on the request of a network provider;
- Non-Netwokr Diagnostic Imaging Provider ;
- Laboratory Service Provider

You will be responsible for only the copayment or out-of-pocket amounts you would have paid had you been able to receive the services within the Community First provider network.
If You pay up front and seek reimbursement for the pre-authorized services you received from a Non-Participating Provider, You will be reimbursed the Usual and Customary rate less the Copayment and/or Percentage Copayment.

You should ask about the contract status of the Providers from whom you receive treatment if You are referred by your PCP to a Specialty Care Physician and when You receive services at a Participating Hospital, as some facility based physicians or other health care practitioners such as anesthesiologists, pathologists, neonatologists, emergency room physicians, and radiologists may not be included in Community First's network. If medically necessary covered services are not available through network physicians or providers, the Health Maintenance Organization shall fully reimburse the non-network physician or provider at the usual and customary rate or at an agreed rate. **If you receive a bill from any Participating Provider asking you to pay for something other than a Copayment or Percentage Copayment, please notify Community First's Member Services Department immediately.**
A facility-based physician or other health care practitioner may not be included in the Community First Health Plans provider network. That non-network facility-based physician or other health care practitioner may send you a balance bill for amounts not paid by Community First. **If you receive a balance bill, please contact the Community First Member Services Department.**

a. **Premiums.** Members may pay a premium for Plan coverage. The premium amount and payment arrangements are made through Your Employer.

b. **Copayments.** In addition to any payroll deduction Your Employer may impose, 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 Copayments attached to and made a part of this Certificate.

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.

Community First may not impose Copayment charges that exceed fifty percent (50%) of the total cost of providing any single service to Community First's enrollees, nor in the aggregate more than twenty percent (20%) of the total cost to Community First of providing all basic health care services. In any Contract Year, the aggregate amount of a person's Copayments will not exceed an amount equal to two times the total annual premium cost that the Contract Holder (and/or Member) is required to pay. This applies only if the Contract Holder or Member demonstrates that Copayments in that amount have been paid in that year.

c. **Services or Supplies that are not Covered under this Certificate of Group Health Care Coverage.** 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 in the list 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.

Acquired Brain Injury: Cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing and treatment, neurofeedback therapy, and remediation. Post-acute transition services or community reintegration services necessary as a result of and related to an acquired brain injury.

Coverage is subject to the same copayments, and coinsurance applicable to other similar coverage as listed in the Schedule of Benefits and Copayments that is part of the Certificate of Group Health Care Coverage. See Definitions.

Alcohol/Chemical Dependency. Medically necessary care and treatment of Alcohol/Chemical Dependency will be covered the same as any other physical illness and will be subject to the same durational limits, dollar limits and Copayments. Coverage for alcohol/chemical dependency is limited to a lifetime maximum of three separate series of treatments for each covered individual. See Schedule of Benefits and Copayments.

Allergy and treatment. Medically necessary allergy testing to evaluate and determine the cause of allergy and appropriate allergy treatments including injections and serum. See Exclusions and Schedule of Benefits and Copayments.

Ambulance services. Emergency ground or air ambulance transportation when medically necessary.

Amino Acid-Based Elemental Formula. Medically necessary treatment is covered on a basis no less favorable than the basis on which prescription drugs and other medications and related services are covered by the plan, and to the same extent that the plan provides coverage for drugs that are available only on the orders of a physician for the treatment of the following:

(1) immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins
(2) severe food protein-induced enterocolitis syndrome
(3) eosinophilic disorders, as evidenced by the results of a biopsy and
(4) impaired absorption of nutrients caused by disorders affecting the absorption surface, functional length, and mobility of the gastrointestinal tract.

Anesthetics and their administration.

Asthma. Treatment, care and supplies related to asthma, as provided or prescribed by a Participating Physician or other qualified Participating Provider.

Autism Spectrum Disorder: The Plan will cover medically necessary services that are generally recognized services when prescribed by the members PCP or Network specialist. The plan will provide coverage at a minimum from the date of diagnosis only if the diagnosis was in place prior to the child's tenth birthday.
Generally recognized services may include:

(1) evaluation and assessment services;
(2) applied behavior analysis;
(3) behavior training and behavior management;
(4) speech therapy;

(5) occupational therapy;
(6) physical therapy; or
(7) medications or nutritional supplements used to address symptoms of autism spectrum disorder.

An individual providing treatment prescribed (under such statute) must be a health care practitioner who is licensed, certified, or an individual acting under the supervision of a licensed, certified health care practitioner; or registered by an appropriate agency of this state; 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. Autism Spectrum Disorder Copayments/Percentage Copayments and limitations are covered the same as any other illness. See Exclusions.

Biofeedback therapy. Biofeedback therapy is covered when it is reasonable and medically necessary for the individual for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness, and conventional treatments (heat, cold, massage, exercise, support) have not been successful. See Exclusions.

Biomarker testing. Biomarker testing is a laboratory procedure that analyzes body fluids, tissues, or other samples for specific molecules, proteins, or genes.

Blood, Whole Blood, Blood Plasma and Blood Plasma Expanders: Including administration, when prescribed by a Participating Provider and determined to be medically necessary by Community First. For hospital inpatients, whole blood and blood including the cost of blood, blood plasma, and blood plasma expanders.

Breast Cancer Treatment. Diagnosis and treatment including coverage for inpatient care for a Member for a minimum of:

(1) 48 hours following a mastectomy; and
(2) 24 hours following a lymph node dissection for the treatment of breast cancer;

unless the Member and the attending physician determine that a shorter period of inpatient care is appropriate.

Chemotherapy, radiation therapy. Treatment by X-ray, radium or any other radioactive substance, or by chemotherapy.

Chiropractic Care: Services and supplies furnished in connection with

correction, by manual or mechanical means, of subluxation of the spine. 30 visits per plan year per Participant.

Clinical Trials: Medically necessary routine patient care costs incurred 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 a life-threatening disease or condition and is approved by:

(1) the Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
(2) the National Institute of Health;
(3) the United States Food and Drug Administration;
(4) the United States Department of Defense;
(5) The United States Department of Veterans Affairs; or
(6) 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.

Routine patient care costs are any medically necessary health care service for which benefits are provided under the plan without regard to whether the member is participating in a clinical trial. For the purpose of diagnosis, treatment, appropriate management, or ongoing monitoring of a member's disease or condition to guide treatment. 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.

Routine patient care costs do not include:

(1) the cost of an investigational new drug or device that is not approved for any indication by the United States Food and Drug Administration, including a drug or device that is the subject of the clinical trial;
(2) the cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in a clinical trial;
(3) the cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
(4) a cost associated with managing a clinical trial;
(5) the cost of a health care service that is specifically excluded from coverage under a health benefit plan.

Community First will not cover benefits and services that are customarily paid for by the research institution conducting the clinical trial. Community First will not cover benefits and services conducted outside of our service area or the state of Texas unless authorized by Community First.

Dental Treatment.

Dental Services that Must Be Performed in a Hospital Setting. Community First will cover certain services provided to a Member who is unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental, or medical reason as determined by the Member's PCP and the dentist. These services include the hospital or facility, and/or anesthesia charges only. The Dentist, Oral Surgeon and any assisting Dentist or Oral Surgeon charges are not covered.

Injury to Sound Natural Teeth. Restoration and correction of damage caused by external violent accidental injury to healthy, natural teeth occurring while covered under this Certificate for Group Health Care Coverage *and* provided within 24 months of the date of the accident.

Diabetes Care. Covered Services and Supplies include diabetes treatment, equipment, supplies, medications, and self-management training, prescribed or provided by a Participating Physician or other Participating Provider. Community First will not impose a cost-sharing provision for insulin that is included in the formulary if the total amount the enrollee is required to pay exceeds $25 per prescription for a 30-day supply, regardless of the amount or type of insulin needed to fill the enrollee's prescription. This will include at least one insulin from each therapeutic class in the formulary. Coverage is provided for emergency refills of insulin, diabetes equipment, or diabetes supplies dispensed to the enrollee in the same manner as for a nonemergency refill of insulin, diabetes equipment, or diabetes supplies.

Copayments will count towards Your out-of-pocket maximum. *See* Schedule of Benefits and Copayments.

Diagnostic laboratory and radiological services including professional fees. Such diagnostic services include mammography services and therapeutic radiology services.

Durable medical equipment. Rental or purchase that is medically necessary and approved by Community First. Coverage is provided for the initial equipment only and for standard equipment. Special features that are not part of the basic equipment are not covered, such as electric beds and electric wheelchairs. Benefits for rental are limited to, and will not exceed, the purchase price of the equipment. For equipment purchased at Community First's option, this item includes repair if not due to neglect or abuse, and necessary maintenance of purchased equipment not provided under a manufacturer's warranty or a purchase agreement. See Schedule of Benefits and Copayments

for the maximum contract year limitation.

Eye exam. One annual eye exam per plan year, including dilation of the eye by a Doctor of Ophthalmology or a Doctor of Optometry which, within the scope of their license, includes such services as:

(1) external examination of the eye and its structure
(2) determination of refractive status; and
(3) glaucoma screening test

The Member is responsible for any additional charges for services associated with contact lenses, including but not limited to, contact lens eye exams, contact lens fittings and follow up care.

Family Planning and Infertility Services related to the diagnosis of infertility shall be provided as medically necessary and as prescribed and authorized by a participating provider and includes the following services:

(1) counseling
(2) sex education instruction in accordance with medically acceptable standards
(3) contraceptive devices
(4) placement of contraceptive devices
(5) Diagnostic procedures to determine the cause of infertility and some natural curative treatments would include but not be limited to: exploratory lap with flushing of tubes to determine patency, histosalpingogram, Clomid to stimulate ovulation for a non ovulatory person, varicole surgery. Things not considered curative would entail all artificial means of conception such as but not limited to: artificial insemination; egg transfer procedures (transfers include gift & zift procedures which are related to extraction of eggs to fertilize outside of body for re-implantation); and related drug and service therapies to prepare for artificial conception treatment). Coverage includes members currently receiving cancer treatment. This includes surgery, chemotherapy, or radiation, as such services may directly or indirectly cause impaired fertility. See the Schedule of Benefits and Copayments
(6) vasectomies
(7) tubal ligations
(8) infertility drugs – see Schedule of Benefits and Copayments

Fertility Services: Including fertility preservation services include collection and preservation of sperm, unfertilized oocytes, and ovarian tissue.

Foot care. Services and supplies for the care and treatment of diseases of, or injuries to the feet, when prescribed by the PCP and determined to be medically necessary by Community First. Shoe orthotics, insoles, shoe inserts or other supportive devices of the feet are covered only when prescribed as part of a treatment plan for someone with a primary diagnosis of diabetes. Orthopedic shoes are covered only when the shoe is an integral part of a medically necessary leg brace. Covered foot orthotics are limited to two per plan year

and shoes are limited to two pair per plan year. See Exclusions.

Formulas. Dietary formulas are covered services when medically necessary for the treatment of phenylketonuria and other heritable diseases when prescribed by a physician. All other dietary over-the-counter formulas are excluded from coverage. See Section III.D, Exclusions.

Genetic testing and counseling.

Health education. Services including, but not limited to, the following:

(1) Information about Community First's Covered Services, including recommendations on generally accepted medical standards for the use and frequency of such services;
(2) Diabetes self-management training provided by a Participating Provider who is licensed in Texas to provide such services. Self-management training includes, but is not limited to:

    (a) training provided to a Member after the initial diagnosis of diabetes in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies;
    (b) additional training required as a result of a significant change in the Member's symptoms or condition;
    (c) periodic continuing education training when prescribed by a Participating Physician as warranted by the development of new techniques and treatments for diabetes.
    (d) All diabetes self-management training is subject to Medical Director review.

(3) Other disease-specific health education programs provided by or approved by Community First.
(4) Prenatal education materials provided by Community First.
(5) Nutritional counseling and education provided by or approved by Community First.

Hearing Aids (including batteries). Coverage for the cost of a medically necessary hearing air or cochlear implant and related services and supplies for a covered member who is 18 years of age and younger. Coverage includes fitting and dispending services, the provision of earmolds as necessary to maintain optimal fit, treatment for habilitation and rehabilitation, and for cochlear implant, an external speech processor and controller with necessary component and replacement every three years. See Schedule of Copayments and Benefits for limitations. A member'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.

Home Health Care services. Skilled nursing provided by or supervised by a

registered nurse (R.N.). The services must be provided by a participating home health agency; your PCP refers You or arranges the services and is pre-authorized by Community First. Services may include physical, occupational, speech or respiratory therapy; the service of home health aides under the supervision of an RN; medical social services under the supervision of an RN.

Hospice Care services and supplies. Covered if authorized by a Participating Physician as part of a Hospice Care Program for a Member who is Terminally ill.

(1) Hospice care services including pain relief, symptom management and supportive services to terminally ill Members and their immediate families on both an outpatient and inpatient basis.
(2) Counseling Services provided by members of a Hospice Team.

Hospital inpatient services and supplies. Semi-private room and board. This includes general nursing care, meals and special diets when medically necessary, use of operating room and related facilities, intensive care services, x-ray services, laboratory and diagnostic test, drugs, medications, biologicals, anesthesia, oxygen services, special duty nursing when medically necessary, radiation and inhalation therapy, administration of whole blood and blood plasma and short-term rehabilitation therapy services.

For any day on which a PCP authorizes the person's stay in a private room in a Hospital that has no semi-private rooms, Hospital private room and board, including normal daily services and supplies, will be included as Eligible Services and Supplies.

Hospital private room and board, including normal daily services and supplies, may also be included as Eligible Services and Supplies for any day on which:

(1) the person is being isolated in a private room because of the person's communicable disease; or
(2) use of a private room is medically necessary, as determined by Community First, for treatment of the person's Illness or Injury.

Hospital Outpatient Services and Supplies. Covered Services and Supplies in connection with surgical treatment, including operating room and treatment room, medical supplies such as splints and casts, and non-experimental drugs and medications furnished by and administered at the Hospital or facility.

Implantable Devices. A surgically implanted artificial device, determined by Community First to be medically necessary, that corrects a significant functional disorder (e.g., hip or knee joints, penile implants, cochlear implants, and electrical stimulators). See Schedule of Benefits and Copayments for

limitations.

Injectible/ Specialty Medications. Medically necessary injectable drugs administered by a Participating Provider. Some medications are subject to age limitations. Age restrictions do not apply to treat Phenylketonuria and other Heritable Diseases. See Exclusions and Schedule of Benefits and Copayments.

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

Lymphedema Compression Treatment. Items refer to standard and custom fitted gradient compression garments and other items determined by the Secretary that are;
1). Furnished on or after January 1, 2023, to an individual with a diagnosis of lymphedema for the treatment of such condition;
2). Primarily and customarily used to serve a medical purpose and for the treatment of lymphedema, as determined by the Secretary; and
3). Prescribed by a physician (or a physician assistant, nurse practitioner, or clinical nurse specialist).
Two garments at one time (or two sets of garments, if your treatment requires more than one piece) replaced every 6 months.

Maternity care. The maternity benefit offered includes coverage for prenatal services, delivery and postdelivery care for a mother and her newborn child in a health care facility. Complications of pregnancy will be covered the same as any other illness.

The following coverage is provided for a mother and newborn for a minimum of:

(1) 48 hours following an uncomplicated vaginal delivery; and
(2) 96 hours following an uncomplicated delivery by cesarean section unless the Member and her attending physician determine that a shorter period of inpatient care is appropriate. Complications of pregnancy will not be treated differently than any other illness or sickness. Post-delivery care will be provided at the woman's home, health care provider's office or health care facility.

Mental Health Services. Mental health covered under the same terms and conditions applicable to the plan's medical and surgical benefits. Community First is prohibited from imposing quantitative or nonquantitative treatment

limits on Mental Health and Substane Abuse Disorder benefits that are more restrictive than those imposed on benefits for medical or surgical expenses. See Schedule of Benefits and Copayments.

Metastatic Cancer. Coverage for stage-four advanced, metastatic cancer and associated conditions. Prescription step therapy does not apply to these conditions. The health plan will not require the enrollee to:

(1) fail to successfully respond to a different drug; or

(2) prove a history of failure of a different drug.

(b) This section applies only to a drug the use of which is:

(1) consistent with best practices for the treatment of stage-four advanced, metastatic cancer or an associated condition;

(2) supported by peer-reviewed, evidence-based literature; and

(3) approved by the United States Food and Drug Administration.

Ophthalmological services. Covered Services and Supplies needed for the diagnosis and treatment of diseases of, or Injury to, the eye.

Orthotics (excluding foot orthotics/inserts, see foot care). Prescribed by a Participating Provider and determined to be medically necessary by Community First. Repair and replacement is covered unless due to misuse or loss. See Schedule of Benefits and Copayments and Exclusions.

Oxygen. Oxygen and rental of equipment for use of oxygen, when medically necessary and prescribed by a Participating Physician.

Pain Management Services. Medically necessary pain management treatment and related services that are ordered by a participating provider and preauthorized by Community First. Services can be expected to meet or exceed treatment goals and are scientifically proven and evidence-based to improve Your medical condition.

Physicians' services for surgical procedures and for other medical care.

Preventive health services. The following preventive health services are covered. Also covered are evidenced based items or services with a rating of A or B in the current recommendations of the United States Preventive Services Task Force:

(1) Well-baby and well-childcare to include a doctors visit every few months for your newborn, and a visit every year until child is 21 years of age to include:

(a) Physical exam and measurements to include.
- (1) Screening for hearing loss, hypothyroidism, sickle cell disease, and phenylketonuria (PKU), includes the cost of the test kit.
- (2) Gonorrhea preventative medication for eyes
- (3) Any newborn screening tests, include the cost of the test kit

(b) Vision and hearing screenings, including hearing loss screening in newborns;
(c) Oral health risk assessments;
(d) Developmental assessments to identify any development problems;
(e) Screenings for hemoglobin level, lead, tuberculin;
(g) Screenings and counseling to prevent, detect and treat common problems such as:
(1) obesity to help children maintain a healthy weight
(2) depression among adolescent children; and
(3) anemia

(2) Periodic adult health evaluations.

(3) Pediatric and adult immunizations in accordance with Community First's clinical guidelines and/or recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Community First does not require any documentation certifying an enrollee's COVID-19 vaccination or post-transmission recovery as a condition for obtaining coverage or receiving benefits under the plan.

(4) Annual well-woman exam including, but not limited to, periodic screening for breast (mammography and other breast imaging) and cervical cancer for women 18 years of age or older. A conventional pap smear screening or a screening using liquid-based cytology methods alone or in combination with a test for the detection of the human papilloma virus. An ovarian cancer blood test (CA-125) as well as any other test or screening approved by the United States Food and Drug Administration for the detection of ovarian cancer. Females 35 years of age or older include coverage for mammography and diagnostic imagin. Diagnostic imaging means an imaging examination using mammography, ultrasound imaging, or magnetic resonance imaging that is designed to evaluate:

a) a subjective or objective abnormality detected by a physician or patient in a breast;

b) an abonormality seen by a physician on a screening mammography;
c) an abnormality previously identified by a physician as probably benign in a breast for which follow-up imaging is recommended by a physician;
d) an individual with a personal history of breast cancer or dense breast tissue.

(5) Promote Healthy Pregnancy. Screenings including but not limited to; iron deficiency, hepatitis B, Rh incompatibility. Counseling to help pregnant women to quit smoking and avoid alcohol use and support breast-feeding.

(6) Annual diagnostic testing for the detection of prostate cancer. Coverage is provided for (a) a physical examination for the detection of prostate cancer, and (b) a prostate-specific antigen test used for the detection of prostate cancer for each male who is: (1) at least 50 years of age and asymptomatic; or (2) at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

(7) For qualified individuals, medically accepted bone mass measurement for the detection of low bone mass and to determine the risk of osteoporosis and fractures associated with osteoporosis. Qualified individual means:
(a) postmenopausal woman who is not receiving estrogen replacement therapy;
(b) an individual with:
(1) vertebral abnormalities;
(2) primary hyperparathyroidism; or
(3) a history of bone fractures; or
(c) an individual who is:
(1) receiving long-term glucocorticoid therapy; or
(2) being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

(8) Colorectal Cancer Screening for members over age 45 for an annual fecal occult blood test, a flexible signoidoscopy performed once every 5 years, and a colonoscopy performed once every 10 years. Medically necessary screenings for colorectal cancer. Multi-target Stool DNA Testing for colorectal Cancer Screening such as Cologuard. Cologuard is intended for the qualitative detection of colorectal neoplasia associated DNA markers and for the presence of occult hemoglobin in human stool. Coverage is provided for a follow-up colonoscopy if the results of the initial colonoscopy, test, or procedure are abnormal.

(9) Medically necessary screening for cardiovascular disease. Coverage includes all colorectal cancer examinations, preventive services, and laboratory tests assigned a grade of “A” or “B” by the United States Preventive Services Task Force for average-risk individuals, including

the services that may be assigned a grade "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, procedure are abnormal.

(10) Screening for cardiovascular disease for a male older than 45 years of age and younger than 76 or females older than 55 years of age and younger than 76 who is diabetic or has an intermediate or higher risk of developing coronary heart disease. Screening tests performed every 5 years to include (1) computed tomography (CT) scanning measuring artery calcification or (2) ultrasonography measuring carotid intima-media thickness and plaque. Community First will pay $200 dollars every 5 years towards the screening.

(11) Obesity screening and prevention to include referrals for dietary counseling for adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease.

Prosthesis. An external or removable artificial device that replaces a body part (e.g., arm or leg) and is determined by Community First to be medically necessary. This benefit includes repair and replacement when due to growth. See Schedule of Benefits and Copayments.

Reconstructive Surgery After Mastectomy. Surgery to provide coverage for (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to achieve a symmetrical appearance; and (3) prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

Reconstructive Surgery for Craniofacial Abnormalities in a Child younger than 18 years of age. Surgery determined by Community First to be medically necessary to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease. See Exclusions.

Rehabilitative services. Including physical, occupational, hearing and speech therapy for loss due to Illness or Injury when ordered by a Participating Physician. Rehabilitative services and therapies that are medically necessary in the opinion of the physician may not be denied, limited, or terminated if they meet or exceed treatment goals for the person needing such services.

For a physically disabled person, treatment goals should include improvement or maintenance of functioning or prevention of or slowing of further deterioration. Covered Services for speech or hearing therapy are limited to therapy that is provided by a qualified speech therapist or audiologist for loss or impairment of speech or hearing.

Renal dialysis. Services and supplies furnished in connection with dialysis for

renal disease.

Respiratory therapy.

Sexually transmitted diseases (STD). Education, diagnosis, and treatment for STDs, including HIV, AIDS, and AIDS-related illnesses.

Skilled Nursing Facility services. Covered Services and Supplies are subject to the conditions set forth below:

(1) If You were not admitted to a Skilled Nursing Facility, You would need acute care hospitalization;

(2) The skilled nursing services are of a temporary nature and will lead to rehabilitation and increased ability to function;

(3) Your PCP or attending specialist refers You and certifies that the Member needs 24-hour-a-day nursing care.

See Schedule of Benefits and Copayments.

Smoking Cessation service or supply furnished to assist with smoking cessation program. See Schedule of Copayments.

Speech and Hearing. Therapy for developmental delay of speech is considered educational in nature and is limited to $500 per Contract Year. Rehabilitative Services for loss of speech or hearing due to Illness or Injury are covered under the Rehabilitative Services benefit.

Supplies. Prescribed by a Participating Provider and determined to be medically necessary and appropriate by Community First. Medical supplies are non-reusable, disposable, and are not useful in the absence of Illness or Injury.

To be considered "medically necessary or appropriate", a medical supply must be determined by Community First to meet all these conditions and must not be listed under Exclusions. The supply(ies):

(1) must be part of a Participating Provider's treatment plan;
(2) must be based on current treatment protocols;
(3) must be obtained from a Participating Provider;
(4) must be required such that its omission would adversely affect the Member's health;
(5) must be recognized as safe and effective for its intended use.
(6) must be used in a manner that is consistent with generally accepted United States medical standards or guidelines.

Examples of medical supplies may include, but not be limited to, diabetic supplies, ostomy supplies, Jobst stockings, sterile dressings, and urinary catheters. See non-Covered Supplies under Exclusions.

Telemedicine services Services provided through Telehealth Services and Telemedicine Medical Services is covered on the same basis and to the same extent that the plan provides coverage for the service or procedure in an in-person setting.

Transplant services. Covered medical services including evaluation and supplies for medically necessary and appropriate transplant services including:

(1) Heart transplant
(2) Lung transplant
(3) Heart/Lung transplant
(4) Kidney transplant
(5) Kidney/pancreas transplant
(6) Liver transplant
(7) Liver/small bowel transplant
(8) Pancreas transplant
(9) Small bowel transplant
(9) Corneal transplant
(10) Bone marrow transplant for aplastic anemia, leukemia, severe combined immuno-deficiency disease, and Wiskott Aldrich syndrome.

Donor expenses are covered. The cost of artificial organs are excluded from coverage. Services or procedures considered experimental and/or investigational under current medical plan guidelines also are excluded. *See* Section III.D, Exclusions.
Community First will not require that a Member travel out-of-state to receive transplant services unless the informed consent of the Member has been obtained, which explains the benefits and detriments of in-state and out-of-state options. Furthermore, Community First will not cover a human organ transplant, or post-transplant care if;

1. The operation can not be 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.

If the Member satisfies medical criteria developed by Community First for receiving transplant services, Community First will provide a written authorization for care to a transplant facility selected by Community First from a list of facilities it has approved. If, after referral, either Community First or the medical staff of the referral facility determines that the Member does not satisfy its respective criteria for the services involved, Community First's obligation is limited to paying for Covered Services provided prior to such determination according to the Schedule of Copayments.

Wigs are covered when determined to be medically necessary.

C. LIMITATIONS

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

1. *Major Disaster or Epidemic*. Community First will consistently make a good faith effort to provide or arrange for Covered Services, taking into account existing conditions and events. If there is a major disaster or an epidemic, Community First will provide or arrange for Covered Services to the extent possible or practical. Neither Community First nor any Participating Provider will have any liability or obligation on account of delay or failure to provide or arrange for Covered Services.

2. *Circumstances Beyond the Control of Community First or Participating Providers*. Due to circumstances not within the control of Community First or Participating Providers, there may be a delay in providing or arranging for Covered Services, or it may not be practical or possible to do so. Community First nor any Participating Provider will have any liability or obligation on account of delay or failure to provide or arrange for Covered Services if a good faith effort has been made to do so. Some examples of such circumstances are: complete or partial destruction of facilities because of war, riot, civil insurrection; natural disasters, the disability of a significant number of Participating Providers; and other similar causes.

3. *Continuity of Treatment in the Event of the Termination of a PCP*. Community First will notify You no less than thirty (30) days in advance if a Participating Physician or other provider treating You is going to be leaving the Community First network, unless circumstances do not allow for such advance notice. If the Physician or other provider is treating You under a "special circumstance" and the treating Physician or provider makes the request, then Community First will continue to compensate the Physician or other provider, on Your behalf, for up to ninety (90) days, for up to nine (9) months in the case of a Terminally Ill Person or, in the case of a Member who is past the 24th week of pregnancy, for delivery of the child, immediate postpartum care, and the follow-up checkup within the first six (6) weeks of delivery. "Special circumstance" means a condition such that Your Physician or provider reasonably believes discontinuation of care could cause harm to You. Examples include:

    a. A person who has a disability;
    b. A person with an acute condition;
    c. A person with a Life-Threatening Illness;
    d. A person who is past the 24th week of pregnancy.

3. *Non-Participating Provider and Out-of-Area Services and Benefits*. Only Emergency Care services are covered outside the Community First's network and/or Service Area, unless medically necessary Covered Services are not available through Community First's network of

Participating Providers, or in the case of Court-Ordered Dependent Coverage. If medically necessary Covered Services are not available through Community First's Participating Providers, Community First will allow, upon the request of a Participating Provider and within the time appropriate to the circumstances (but in no event to exceed five Working Days after receipt of reasonably requested documentation), a referral to a Non-Participating Provider. Before Community First denies such referral, You may request a review by a specialist of the same or similar specialty as the type of Physician or Provider to whom a referral is requested.

4. Community FIrst will provide an explanation of benefits to the member 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:

a statement of the billing prohibition

the total amount the physician or provider may bill the enrollee under the enrollee's health plan, including an itemization of copayments, coinsurance, deductibles, and other amounts included in the total
for an explanation of benefits provided to the physician or provider, information advising the physician or provider of the availability of mediation or arbitration

D. EXCLUSIONS.

All services and benefits for care and conditions within each of the following classifications shall be excluded from coverage:

Abortion services. Unless determined to be medically necessary by a Participating Provider to preserve the life of the mother.

Artificial Internal Organs and animal organs.

Alternative Treatments that includes but not limited to acupressure, acupuncture, aromatherapy, hypnotism, massage therapy, rolfing, art therapy, music therapy, dance therapy and horseback therapy.

Allergy testing, treatment, and sera for food allergies.

Allowable cost of Covered Services. Coverage normally provided for a Covered Service may not be applied toward the cost of a non-Covered Service or Supply.

Ambulance Services. Transport services for non-emergency conditions unless pre-authorized.

Biofeedback therapy. Excluded for the treatment of ordinary tension and muscle contraction headaches or psychosomatic conditions.

Charges for broken appointments.

Charges for completion of any forms.

Charges made by the Employer or a close relative. Services or supplies furnished by:

(1) the Employer; or
(2) You, Your spouse, or a child, brother, sister, or parent of You or Your spouse.

Chelation therapy except when used in the treatment of heavy metal poisoning.

Chemical Dependency aftercare services including, but not limited to, AA/NA, support, or education groups, and/or other services that primarily focus on relapse prevention to the Member who completed treatment and/or their family members.

Clothing, shoes, and diapers, unless specifically covered by this Certificate (e.g., correctional shoes or inserts associated with diabetes are covered).

Corrective appliances and artificial aids. Including, but not limited to, communication devices and eyeglasses or contact lenses of any type (unless covered by a Rider to the Group Contract), except for treatment of keratoconus and initial replacements for loss of the natural lens.

Cosmetic surgery except for specifically stated covered services. Services and supplies including cosmetic, furnished mainly to change a person's appearance are excluded. This includes surgery performed to treat a mental, psychoneurotic or personality disorder through change in appearance.

Custodial Care. Services or supplies furnished in connection with Custodial Care.

Diagnostic tests to establish paternity of a child and tests to determine sex of an unborn child.

Dental care, oral surgery or treatment of teeth or periodontium. Services and supplies not covered unless the services are received in connection with an Injury to sound natural teeth except for an Injury resulting from biting or chewing. *See* Section III.B, Covered Services and Supplies.

Dental braces, dental implants or any treatment related to the preparation or fitting of dentures are not covered, unless covered by a Rider to the Group Contract. Oral appliances and devices to treat bruxism, or as part of an orthodontia care plan are not covered, unless covered by a Rider to the Group Contract.

Community First will not exclude a member from coverage who is unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental, or medical reason as determined by the Member's PCP and the

dentist.

Educational Testing and Therapy, motor or language skills or services that are educational in nature or are for vocational testing or training.

Environmental consultations and modifications. Consultations of an environmental engineer, air conditioners, humidifiers, dehumidifiers, purifiers, elevators, and chair lifts.

Experimental or Investigational Services and Supplies. Including new and emerging health care technologies, that are determined by Community First to be Experimental or Investigational.

Community First may, however, deem an Experimental or Investigational service or supply covered for treating a Life-Threatening Illness or condition if it is determined by Community First, through an Ombudsman Program, that the Experimental or Investigational service or supply at the time of the determination:

(1) is proved to be safe with promising efficacy; and
(2) is provided in a clinically controlled research setting; and
(3) uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

See IX. A. 8. Process for Requesting Independent Review of an Adverse Determination of Your right to appeal an Adverse Determination that Community First determined is experimental or investigational.

Eye Surgery. Services and supplies furnished in connection with eye surgery such as radial keratotomy and lasik, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).

Foot care. Routine foot care, treatment of flat feet and treatment of subluxations of the feet are excluded. Orthopedic shoes are not covered, except as part of an integral part of a medically necessary leg brace. This does not include treatment of fractures or other acute injuries.

Home and automobile modifications or improvements even when necessary to accommodate installation of Covered Services or to facilitate entrance or exit.

Hospital private room unless determined to be medically necessary by Community First.

Infertility drugs. Drug therapy for infertility which involves:

(1) non-FDA approved indications;
(2) non-standard dosages, length of treatment, or cycles of therapy; or
(3) in-vitro fertilization procedures.

Infertility Diagnosis and Treatment. Services or supplies furnished in connection with any procedures which involve harvesting, storage and/or manipulation of eggs and sperm for in-vitro fertilization. Other procedures excluded, but are not limited to:

(1) In-vitro fertilization
(2) Artificial insemination
(3) Gamete or zygote intrafallopian transfer and similar procedures
(4) Reversal of voluntary induced sterility
(5) Surrogate parent services and fertilizations
(6) Donor egg or sperm
(7) Embryo transfer
(8) Embryo freezing

Infertility benefits excluded from coverage include transsexual surgery, gender reassignment, and any services or supplies used in any procedures performed in preparation for or immediately after any of the above-referenced procedures.

Injectable Medications which have not been proven safe and effective for a specific disease or approved for a mode of treatment by the Food and Drug Administration and the National Institute of Health.

Medical record charges. Charges associated with copying or transferring medical records.

Military Service-Connected Disabilities. Services and supplies furnished in connection with military service-connected disabilities for which the Member is legally entitled to services and for which facilities are reasonably available to the Member.

Obesity. Services including surgical or invasive procedures or complications arising from these services are excluded. Excluded services includes, but is not limited to: liposuction, gastric bypass, jejunal bypass, balloon procedures, gastric banding procedures, exercise programs, exercise or other equipment, food supplements, appetite suppressants and other medications furnished in connection with any weight loss program.

Over-the-counter medications and supplies. Any care, treatment, service, supply or item that is available without a Physician's recommendation or written prescription, including a dietary formula, is excluded unless expressly covered by this Certificate of Group Health Care Coverage (e.g., over-the-counter diabetic supplies are covered, and Copayments will count towards Your out-of-pocket maximum, as are dietary formulas necessary for the treatment of Phenylketonuria and other Heritable Diseases). Examples of over-the-counter items not covered: band-aids, tape, gauze bandages, ACE bandages, elastic joint supports, TED hose, paper towels, etc.

Personal comfort items. Including but not limited to telephone, newborn infant photographs, meals for guests of the patient, and other articles which are not

determined to be medically necessary or appropriate for the specific treatment of the Illness or Injury.

Physical examinations provided solely for the purpose of travel, employment, or school.

Prescription Medications. Unless (i) furnished by a Hospital during a Hospital Inpatient Stay, (ii) specifically listed in the "Covered Services" section above, or (iii) such drugs are covered by a Rider to the Group Contract. See Schedule of Benefits and Copayments. Community First does not require an enrollee to use an affiliated pharmacy or DME provider resulting in reduced cost-sharing.

Public Facility. Services and supplies furnished in a federal, state, or governmental entity, including care and treatment provided in a non-participating Hospital owned or operated by any federal, state, or other governmental entity, except to the extent required by state or local laws.

Reconstructive Surgery for Craniofacial Abnormalities for anyone 18 years of age or older.

Recreational, educational and sleep therapy, including any related diagnostic services.

Reduction Mammoplasty for cosmetic purposes, except for post-mastectomy reduction of the unaffected breast to achieve a symmetrical appearance.

School-based therapy services.

Services and supplies. Services and supplies that meet the following conditions:

a. Unnecessary services and supplies that are not medically necessary or appropriate for the diagnosis and/or treatment of an Illness or Injury. Examples are rubber sheets, incontinent pads, diapers, non-sterile rubber gloves, emesis basins, body powder, etc.

b. Required by a court decree regarding a divorce action, a motor vehicle violation or other judgment not directly related to this Coverage if they would not be covered in the absence of such a decree.

c. Related to preservation and/or storage of body parts, fluids, or tissues, except for autologous blood and related collection and storage costs in connection with covered non-Experimental services and supplies.

d. Not furnished or authorized by a PCP.

e. Furnished for Cosmetic Surgery except what is listed under Covered Services.

f. Over-the-counter supplies.

g. Received from a Nurse which do not require the skill and training of a Nurse.

Sex changes. All services, medications and/or supplies furnished in conjunction with the sex change process. This includes hormonal medications required before and after surgery.

Sex therapy, sex counseling and sexual dysfunction or inadequacies that do not have a physiological or organic basis.

Thermograms and thermography measuring the temperature variations at the body surface.

Temporomandibular Joint (TMJ). Any service or supply furnished in connection with the medical/surgical treatment of the temporomandibular joint.

Vocational rehabilitation. Education or training for the purpose of gaining employment.

Voluntary sterilization reversal. Reversal of a previous Surgical Procedure intended to induce permanent infertility.

Work Related Injury or Illness. Services and supplies for any work-related injury if any other source of coverage or reimbursement which is in force and in effect for the services. Sources of coverage or reimbursement available to You may include Your employer, a work-related benefit plan maintained by Your employer, and any Workers' Compensation, occupational disease or similar program under local, state, or federal law.

IV. RIGHT OF SUBROGATION AND REIMBURSEMENT UNDER THE GROUP HEALTH CARE COVERAGE

A. Sometimes another person or entity may be liable to You for medical services covered by Community First under this Certificate. For example, if a Member 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 Member for medical expenses incurred because of the injuries. If Community First pays or provides benefits for Member under this Group Health Care Coverage, Community First is subrogated to all rights of recovery which Member 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 Member's rights in its own name or the name of Member, 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 Member agrees to reimburse Community First as described in these provisions in return for Community First providing services, supplies, or benefits for a Member'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 Member 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 only if the covered individual or the covered individual's immediate family did not pay the premiums for the coverage.
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, judgment or in any other way) with respect to such Illness or Injury, the Member 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 Member 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 Members for Basic Health Care Services covered under Worker's Compensation benefits, Community First will seek reimbursement from the financially responsible party. The Member will cooperate with Community First to ensure that Community First is reimbursed for the actual cost paid for any benefits provided to the Member. The Member 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. Member agrees to cooperate with Community First in order to protect Community First's subrogation and reimbursement rights. Member agrees to promptly furnish to Community First all information which Member has concerning Member'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 Member 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 Member 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 Member 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 Member's claim against any Party for damages or claims or causes of action that the Member 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 Member agrees to cooperate with such designated person, agency, or organization the same as if dealing with Community First itself.

V. GENERAL RULES FOR COORDINATION OF BENEFITS OF THE GROUP CONTRACT WITH OTHER BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health care or vision coverage under more than one plan. Plan is defined below.
The order of benefit determination rules governs the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accord with its plan terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plan's equal 100 percent of the total allowable expense.

A. DEFINITIONS

1. **Plan**

(a) A "plan" is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
(1) Plan includes: group, blanket, or franchise accident and health insurance policies, excluding disability income protection coverage; individual and group health maintenance organization evidences of coverage; individual accident and health insurance policies; individual and group preferred provider benefit plans and exclusive provider benefit plans; group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care; medical care components of individual and group long-term care contracts; limited benefit coverage that is not issued to supplement individual or group in-force policies; uninsured arrangements of group or group-type coverage; the medical benefits coverage in automobile insurance contracts; and Medicare or other governmental benefits, as permitted by law.

(2) Plan does not include: disability income protection coverage; the Texas Health Insurance Pool; workers' compensation insurance coverage; hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage; supplemental benefit coverage; accident only coverage; specified accident coverage; school accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis; benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; a state plan under Medicaid; a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan; or other nongovernmental plan; or an individual accident and health insurance plan that is designed to fully integrate with other policies. Each contract for coverage under (a)(1) or (a)(2) is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

2. **Separate Plan, Primary or Secondary**

(b) "This plan" means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies, and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits. The order of benefit determination rules determines whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan. When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits equal 100 percent of the total allowable expense.

3. **Allowable Expense**

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

The following are examples of expenses that are not allowable expenses:
(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.
(2) If a person is covered by two or more plans that do not have negotiated fees and compute their benefit payments based on the usual and customary fees, allowed amounts, or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.
(3) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense**.**
(4) If a person is covered by one plan that does not have negotiated fees and that calculates its benefits or services based on usual and customary fees, allowed amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another plan that provides its benefits or services based on negotiated fees, the primary plan's payment arrangement must be the allowable expense for all plans. However, if the health care provider or physician has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement_and if the health care provider's or physician's contract permits, the negotiated fee or payment must be the allowable expense used by the secondary plan to determine its benefits.
(5) The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, prior authorization of admissions, and preferred health care provider and physician arrangements.
(d) "Allowed amount" is the amount of a billed charge that a carrier determines to be covered for services provided by a nonpreferred health care provider or physician. The allowed amount includes both the carrier's payment and any applicable copayment or percentage copayment amounts for which the insured is responsible.
(e) "Closed panel plan" is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of health care providers and physicians that have contracted with or are employed by the plan, and that excludes coverage for services provided by other health care providers and physicians, except in cases of emergency or referral by a panel member.
(f) "Custodial parent" is the parent with the right to designate the primary residence of a child by a court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the plan year, excluding any temporary visitation.

4. **Claim Determination Rules**

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

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

(b) Except as provided in (c), a plan that does not contain a COB provision that is consistent with this plan is always primary unless the provisions of both plans state that the complying plan is primary.

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

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

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

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

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

(h) Each plan determines its order of benefits using the first of the following rules that apply.

(1) Nondependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, contract holder, subscriber, or retiree, is the primary plan, and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent, then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, conract holder, subscriber, or retiree is the secondary plan and the other plan is the primary plan. An example includes a retired employee.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court order stating otherwise, plans covering a dependent child must determine the order of benefits using the following rules that apply.
(A) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
(i) The plan of the parent whose birthday falls earlier in the plan year is the primary plan; or (ii) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
(B) For a dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:
(i) If a court order states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.
(ii) If a court order states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of (h)(2)(A) must determine the order of benefits.
(iii) If a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of (h)(2)(A) must determine the order of benefits.
(iv) If there is no court order allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(I) The plan covering the custodial parent;
(II) The plan covering the spouse of the custodial parent;
(III) The plan covering the noncustodial parent; then
(IV) the plan covering the spouse of the noncustodial parent.

(C) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of (h)(2)(A) or (h)(2)(B) must determine the order of benefits as if those individuals were the parents of the child.
(D) For a dependent child who has coverage under either or both parents' plans and has his or her own coverage as a dependent under a spouse's plan, (h)(5) applies.
(E) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits must be determined by applying the birthday rule in (h)(2)(A) to the dependent child's parent(s) and the dependent's spouse.
(3) Active, Retired, or Laid-off Employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan that covers that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the plan that covers the same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee does not have

this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree is the primary plan, and the COBRA, state, or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The plan that has covered the person as an employee, member, contract holder, subscriber, or retiree longer is the primary plan, and the plan that has covered the person the shorter period is the secondary plan.

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

B. EFFECT ON THE BENEFITS OF THIS PLAN

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

(b) If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB must not apply between that plan and other closed panel plans.

C. COMPLIANCE WITH FEDERAL AND STATE LAWS CONCERNING CONFIDENTIAL INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. Community First will comply with federal and state law concerning confidential information for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Each person claiming benefits under

this plan must give Community First any facts it needs to apply those rules and determine benefits.

D. FACILITY OF PAYMENT

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

E. RIGHT OF RECOVERY

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

VI. COORDINATING BENEFITS OF THE GROUP CONTRACT WITH MEDICARE

A. WHEN COMMUNITY FIRST IS THE PRIMARY PAYER

1. **Active employees age 65 or older (Employer with 20 or more Employees).** If you are age 65 or older and are an Eligible Employee who has chosen to receive Group Health Care Coverage through Community First, and Your Employer has 20 or more Employees, Community First will be the primary payer for Your health care coverage and will determine Your benefits under this Certificate *before Medicare* pays benefits.

2. **Spouses aged 65 and older of active employees (Employer with 20 or more Employees).** If You are an Eligible Employee of an Employer with 20 or more employees, your spouse is age 65 or older, and You have enrolled Your spouse for Dependent coverage under this Certificate of Group Health Care Coverage, Community First will be the primary payer for Your spouse's health care coverage and will determine Your spouse's benefits under this Certificate *before* Medicare pays benefits.

3. **Members under age 65 and eligible for Medicare because of a disability (Enrolled through an Employer with 100 or More Employees).** If You are a Community First Member (Employee or Dependent), are eligible for Medicare because of a disability, and you are enrolled through an Employer with 100 or more Employees, Community First will be the primary payer for Your health

care coverage and will determine Your benefits under this Certificate *before* Medicare pays benefits.

4. **Members who are Eligible for Medicare Only Because of Permanent Kidney Failure.** If You are a Community First Member (Employee or Dependent) and are eligible for Medicare Part A because of permanent kidney failure, Community First is the primary payor for the first 30 months of treatment, after which Medicare Part A becomes the primary payor and Community First is the secondary payor. If you choose to participate in Medicare Part B, the same order of benefit determination will apply as Medicare Part A, unless you are a retiree over age 65.

B. WHEN MEDICARE IS THE PRIMARY PAYER.

1. **Active employees aged 65 or older (Employer with less than 20 Employees).** If you are age 65 or older and are an Eligible Employee who has chosen to receive Group Health Care Coverage through Community First, and Your Employer has less than 20 Employees, Medicare will be the primary payer for You and Your Dependents' health care coverage and will determine Your benefits under Medicare *before* Community First determines benefits under this Certificate.

2. **Eligible Retirees.** If You are an Eligible Retiree, Medicare will be the primary payer for You and Your Dependents' health care coverage and will determine Your benefits under Medicare *before* Community First determines benefits under this Certificate.

3. **Members under age 65 and eligible for Medicare because of a disability (Enrolled through an Employer with less than 100 Employees).** If You are a Community First Member (Employee or Dependent), are eligible for Medicare because of a disability, and you are enrolled through an Employer with less than 100 Employees, Medicare will be the primary payer for You and Your Dependents' health care coverage and will determine Your benefits under Medicare *before* Community First determines benefits under this Certificate.

VII. CLAIM RULES

These rules apply if a charge is made to a Member for any service or supply with respect to which benefits would be provided under the Group Health Care 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 approved 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, then submit a copy of the paid bill along with a completed claim form to Community First's Member Services Department requesting reimbursement (Claim forms may be obtained from the Member Services Department). Include all of the following information on Your request:

1. The patient's name, address and the identification number and Group number and Your relationship to the Subscriber from Your identification card.

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 Certificate or applicable law, then Community First will pay the bill or reimburse Member 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.

B. PROOF OF LOSS

Community First must be given written proof of the loss for which claim is made under the Coverage. This proof must cover the occurrence, character and extent of that loss. It must be furnished to Community First within sixty (60) days after the date of the loss or, if unable to submit within 60 days, then as soon as reasonably possible but no later than 6 months from the rendition of services. 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 MEMBER

All benefits for allowed charges for a Covered Service or Supply with respect to which benefits would be provided under the Group Health Care 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 Certificate and are the obligation of Community First, reimbursement for those charges will be paid to You.

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

1. No later than fifteen days after receipt of claim, Community First shall:

    a. Acknowledge receipt of claim;

    b. Commence investigation of claim; and

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

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

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

    b. Notify claimant in writing of the reasons Community First needs additional time.

3. No later than the 45th day after 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 claimant that claim will be paid, claim will be paid no later than five Working Days after notice was made.

5. All claims must be submitted to Community First within 60 calendar days from the date expenses are 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 person 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 one year after the end of the time within which proof of loss is required.

VIII. INCONTESTABILITY OF COVERAGE

This section limits Community First's use of Your statements in contesting Your Coverage under the Group Health Care 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.

We may increase the premium for Your coverage to the appropriate level if we determine that You made a material misrepresentation of Your health status on the application.

Community First must provide the Group Contract Holder 60 days prior written notice of any premium rate change.

IX. GENERAL INFORMATION

A. MEMBER COMPLAINT/APPEALS PROCESS

1. **General.** Members are required to submit all Complaints through Community First's internal Complaints and Appeals process, which we have outlined for You below.

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

   Community First will not retaliate against any Participating Physician or Provider, including termination of or refusal to renew a contract, simply because a Participating Physician or 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 P. O. Box 149104, Austin, Texas 78714-9104.

2. **Where to File a Complaint**. Complaints/Appeals should be directed to Community First's Member Services Department at 1-800-434-2347 or 210-227-2347 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:

Step	Action
1.	You, or someone acting on Your behalf, notifies Community First orally or in writing of a Complaint.
2.	Upon receipt of a written Complaint, we will send You a letter acknowledging receipt of Your Complaint within five Working 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.

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

3. Community First will investigate the Complaint and send You or Your designated representative a letter explaining the resolution of Your Complaint. 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.

4. 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 business day from the date the Complaint is received by Community First per Texas Insurance Code - INS § 843.252.

4. **Member Appeal Process**

Appeals will be handled in the following manner:

Step	**Action**
1.	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.
2.	Community First will send You a letter acknowledging receipt of Your Complaint Appeal within five Working Days of receiving your written request for Appeal.
3.	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, Physicians or other Providers, and Members. No individual serving on the Panel may have previously been involved in the disputed decision that is the subject of the Appeal.

All Physicians or other Providers serving on the Panel must have experience in the area of care that is in dispute and must be independent of the Physician(s) or 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.

4. No later than five Working Days before the hearing, unless You agree otherwise, Community First shall provide You or Your designated representative:

   a. any documentation that Community First staff will present to the Panel;

   b. the specialization of any Physicians or Providers consulted during the investigation; and

   c. 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:

   a. Appear in person before the Appeals Panel;

   b. Present alternative expert testimony; and

   c. 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.

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

6. Community First will complete the 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.

7 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 Certificate of Group Health Coverage shall be arbitrated and 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 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 and judgment may be entered upon it in accordance with applicable law in any federal or Texas court having jurisdiction. Please note enrollees have a right to pursue legal action and cannot be required to agree to mandatory binding arbitration as arbitration is voluntary

6. **Maintenance of Records.** Community First will maintain a record of each Complaint and/or Appeal as well as any proceedings and any actions taken on a Complaint and/or Appeal for three years from the date of receipt of a Complaint. You may obtain a copy of the record on Your 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 a Member 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.

A Complainant (You, your authorized representative, a provider of record acting on your behalf) may appeal an Adverse Determination orally or in writing. Appeals of Adverse Determinations will be handled in the following manner:

a. Within five Working 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 needed 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, denials of continued stays for hospital patients and denial of prescription drugs or intravenous infusions for which the member is currently receiving benefits, and denials due to step therapy protocols, 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 typically manages the medical condition, procedure, or treatment under review. Please note that if Community First does not deny a step therapy exception request before 72 hours after the health benefit plan receives the request, the request is considered granted. If the prescribing provider believes death or serious harm is probable, the step therapy exception request is considered granted if the plan does not deny the request before 24 hours.

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.

d. 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 days after we receive the oral or written Appeal. Community First shall provide notice of an adverse determination for a concurrent review of the provision of prescription drugs or intravenous infusions for which the patient is receiving health benefits under no later than the 30th day before the date on which the provision of

prescription drugs or intravenous infusions will be discontinued.

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. Community First will provide to You, Your designated representative and Your provider of record with the prescribed form with the initial notice of adverse determination. The form must be completed and returned to Community First, including the medical release section signed by You or the Members legal guardian in order to begin the Independent Review process.

c. In a circumstance involving a Life-Threatening Condition (regardless of the prescription drug status) and those involving prescription drugs or intravenous infusions are entitled to an immediate Appeal to an Independent Review Organization for denial of prescription drugs or intravenous infusions 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.

The IRO must make its determination and notify You, Your designated representative, Your provider of record, Community First and the Texas Department of Insurance by the 15th day after the date the IRO receives the information necessary to make the determination or by the 20th day after the date the IRO receives the request. In the event of a life-threatening condition, the determination must be made no later than the 3rd day after the date the IRO receives the information necessary to make the determination or the 3rd day after the date the IRO receives the request that the determination has been made.

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, if the requirement of exhausting the Appeal process places Your health in serious jeopardy.

d. 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 members within 30 calendar days of receiving notice of the members selection of a PCP. The ID card will include all necessary information to allow You to access all services under the Group Health Care Coverage.

Identification cards issued by Community First, in connection with the Group Health Care 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 Group Health Care Coverage. Any person who receives services, supplies, or other benefits to which the person is not entitled by the terms of the Group Health Care Coverage and of the Group 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 any Member permits another person to use the Member's ID Card, Community First may:

1. invalidate that Member's ID Card; and

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

C. CONFIDENTIAL NATURE OF MEDICAL RECORDS

Any information from a Member's medical records received from Providers or Hospitals incident to the physician-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 Member, except as is reasonably necessary in connection with the administration of the Group Health Care Coverage or as permitted by law. Each Member agrees that Participating Providers or Consulting Physicians 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 a Member under the Group Health Care Coverage are personal to the Member 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 Members under the Contract and is solely responsible to Members for Hospital supplies and services.

The relationship between Community First and any Participating Physician or other Participating Provider is that of an independent contractor. No Participating Physician or other 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 Physician or other Participating Provider. Each Participating Physician or other Participating Provider will maintain the provider-patient relationship with Members under the Group Contract and is solely responsible to Members for supplies and services furnished to Members.

Neither the Contract Holder nor any Member under the Group Contract is the agent or representative of Community First. Any Member under the Group Contract will not be liable for any acts or omissions of Community First, its agents or employees, or of any Hospital, Physician, or other health care provider with which Community First, its agents or employees make arrangements for furnishing supplies and services to Members.

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

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

1. the Member 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 Member 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 Members for Cause" part of the "WHEN YOUR COVERAGE ENDS" section of the Certificate of Group Health Care Coverage), Community First may give written notice to the Member that the person

is no longer a Member for the Group Health Care Coverage. The procedures for receiving and resolving complaints described above are available to Members.

F. NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under the Group 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 Certificate.

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

G. WHEN YOUR COVERAGE ENDS

1. **Employee and Dependent Coverage.**

a. Your Employee Coverage or Your Dependent Coverage will end when the first of these occurs:

(1) Your membership in the Covered Classes for the Coverage ends because Your employment ends (see" End of Employment" section below).

(2) The Group Contract ends.

(3) You fail to pay, when due, any contribution required for Your Employee Coverage. Failure to contribute for Dependent Coverage will not cause Your Employee Coverage to end.

(4) You no longer reside, live or work within the Service Area.

(5) 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 Employees and their Qualified Dependents) and choose not to continue the Group Health Care Coverage.

(6) You fail to enroll in Parts A and B of Medicare, if required by the Employer (for retired Eligible Employees and their Qualified Dependents).

(7) The coverage is Dependent Coverage and Your Employee Coverage ends.

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 unmarried 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. End of Employment: For purposes of Coverage under the Group Contract, Your employment ends when You are no longer considered to be employed by the Employer. But, for Coverage purposes, the Contract Holder may consider You as still employed and in the Covered Classes during certain types of absences from work. The Contract Holder decides whether You are to be considered as still employed during those types of absences and for how long. In making such a determination, the Contract Holder must not discriminate among persons in like situations.

You may be considered as still employed up to any time limit on Your type of absence. When so considered, Your Eligible Employee Coverage and Dependent Coverage will be continued only while You are paying contributions for such coverage at the time and in the amounts, if any, required by the Contract Holder (whether or not those Coverages would otherwise be Non-contributory Coverages). But the Coverages will not be continued after they would end for a reason other than end of employment. The types of absences and the time limits are those set forth below:

Eligible Types of Absences

From Full-time Work	**Time Limit**
Disability or retirement	Same as under the Employer's Health Benefits Plan
Leave of absence or temporary layoff	Same as under the Employer's Health Benefits Plan for reasons other than disability

d. Cancellation and Non-Renewal of Coverage: If any of the following conditions exist, Community First will give written notice to the Member that the person is no longer a Member for the Group Health Care Coverage:

(1) *Nonpayment of Amounts Due Under the Contract.* Community First may cancel Your coverage, after providing You with at

least a 30 day written notice, if You fail to pay the amounts due, such as failure to pay any Copayment or to make any reimbursement to Community First required under the Group Health Care Coverage. Community First is not required to provide written notice of cancellation for failure to pay premium, and You may be held responsible for the cost of services received after the premium due date.

(2) *Fraud or Intentional Material Misrepresentation.* If You furnish incorrect or incomplete information in a statement made for the purpose of effecting coverage under the Group Health Care Coverage, Your coverage may be cancelled after not less than 15 days written notice. This condition is subject to the provisions of the section entitled "INCONTESTABILITY OF COVERAGE."

(3) *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 not less than 15 days' written notice.

(4) *Misconduct Detrimental to Safe Plan Operations.* Coverage may be cancelled immediately if a Member engages in any misconduct that is detrimental to safe plan operations and the delivery of services.

(5) *Failure to Meet Eligibility Requirements.* If a Member fails to meet eligibility requirements other than the requirement that he or she reside, live, or work in Community First's Service Area, coverage may be cancelled immediately, subject to continuation of coverage provisions.

(6) *Failure to Reside, Live or Work in Community First's Service Area.* If a Member neither resides, lives or works in Community First's Service Area, coverage may be canceled after a 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 Member such written notice of termination of Coverage:

(a) that person will cease to be a Member 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 Appeals Process established by Community First.

(7) *Discontinuance of a particular type of Group Health Care Coverage.* If Community First discontinues a particular type of Group Health Care Coverage in the Service Area, but only if coverage is discontinued uniformly without regard to Health Status Related Factors of Members and Dependents of Members, who may become eligible for coverage, coverage may be cancelled after 90 days written notice from Community First, in which case Community First must offer any other Group Health Care Coverage offered by Community First in the Service Area.

(8) *Discontinuance of all Group Health Care Coverage.* Community First may terminate coverage by discontinuing all Group Health Care Coverage in the Service Area, but only if coverage is discontinued without regard to Health Status-Related Factors of Members and Dependents of Members who may become eligible for coverage. Coverage may be cancelled after 180 days written notice to the Commissioner and to Members.

H. CONTINUATION PRIVILEGE

1. **Continued Coverage for an Incapacitated Child**: Your Dependent Coverage for a child will not end just because the child has reached a certain age if both a. and b. below are true:

   a. The child is then mentally or physically incapable of earning a living. Community First must receive proof of this within the next 31 days; and

   b. The child otherwise meets the definition of Qualified Dependent.

   If these two conditions are met, the age limit will not cause the child to stop being a Qualified Dependent under the Coverage. This will apply as long as the

child remains incapacitated and dependent unless coverage is otherwise terminated with the terms of the Group Contract.

2. **Continued Coverage at You or Your Dependent's Option**: You or Your Dependent may be eligible for continued coverage upon the occurrence of certain events as described below.

a. Continued Coverage under COBRA. A Member may be eligible to continue coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) with the same benefits as provided under the Group Contract upon the occurrence of a qualifying event. Qualifying events are listed below, along with the length of time that COBRA coverage is available.

YOUR BENEFITS

DEPENDENTS BENEFITS

Qualifying Event	Length of Time COBRA Coverage is Available
Termination of Your Employment (unless due to gross misconduct)	18 months (29 months for a person who qualifies for Social Security disability benefits)
Reduction in Your work hours	18 months (29 months for a person who qualifies for Social Security disability benefits)
You become entitled to Medicare	36 months
Your death	36 months
Your divorce or legal separation	36 months
Dependent child loses eligibility	36 months

The continuation of coverage periods shown above include any periods that the Member was covered under any other continuation of coverage. The continuation of coverage may be terminated sooner than the indicated length of time when:

- the plan ends;

- the Member fails to timely pay the premium;

- the Member first becomes eligible for Medicare;

- in the case of a Member who is disabled when the continuation coverage begins, the Member becomes ineligible for disability benefits under the Social Security Act; provided, however, this will apply only if the Member becomes ineligible after such continuation coverage has been in effect for at least 18 months; or

- the Member becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any such pre-existing condition of the Member.

Election for continuation of coverage under COBRA must be made within (60 days of the later of: (i) the occurrence of a qualifying event, or (ii) the date You or Your Dependent receives the appropriate COBRA election forms that must be provided by the Employer or Contract Holder.

b. Continued Coverage under State Law. A Member may be eligible for continued coverage under the requirements set forth below if their coverage under the Group Contract has been terminated for any reason, except involuntary termination for cause, or if they have completed continuation of coverage as provided under COBRA. The Member must have been continuously insured under the Group Contract for at least three consecutive months immediately prior to termination.

(1) If the Member has completed continuation of coverage as provided under COBRA, such continuation, under State Law, must be offered to the Member not less than thirty (30) days prior to the expiration of COBRA;

(2) Such coverage continuation must be requested in writing by the member within 60days following the later of (a) the date the group coverage would otherwise terminate, or (b) the date the Member is given notice of the right of continuation by the Employer or Group Contract Holder;

(3) The Member must make the first payment no later than the 45th day after the initial election for coverage and on the due date of each payment thereafter. Following the first payment made after the initial election for coverage the payment of any other premium shall be considered timely if made by the 30th day after the date on which payment is due. The Member will pay the Employer or Contract Holder the amount of contribution

required by the Contract Holder or Employer plus two percent (2%) of the group rate for the coverage being continued on the due date of each payment;

(4) Maximum continuation period for a Member not eligible for continuation under COBRA is nine months after the date the election to continue coverage is made or for any Member eligible for continuation coverage under COBRA, six additional months following any period of continuation provided under statute unless (a) the date on which failure to make timely payments would terminate coverage; (b) the date on which the Member is covered for similar services and benefits by another health plan; or (c) the date on which group coverage terminates in its entirety;

(5) Not less than 30 days before the end of the continuation period, Community First will notify the Member that the Member may be eligible for coverage under the Texas Health Insurance Pool and Community First will provide the address for applying to the Pool to such Member.

A member who did not elect continuation coverage during the election period, or whose elected continuation coverage lapsed or was canceled without reinstatement, is eligible for Pool coverage. Eligiblity for the Pool is subject to a 180-day exclusion.

The 180 day exclusion does not apply to a Member eligible for benefits under the continuation of coverage, who did not elect continuation during the election period, or whose elected continuation coverage lasped or was canceled without reinstatement, following a period of continuation coverage under COBRA.

c. Continued Coverage for Dependents. A Dependent may be eligible for continued coverage if the Dependent's previous eligibility for coverage hereunder ceases because of the severance of the family relationship or the retirement or death of the employee; and the family member or the Dependent has been a member of the group for a period of at least one year or is an infant under one year of age. A Member electing such continued coverage must pay premiums for the coverage directly to the Contract Holder. The Member will have the option of paying the premiums in monthly installments. The premium for continuation of coverage shall be no more than the premium charged under the Group Contract for the Member had the family relationship not been severed.

An Eligible Employee must give written notice to the Contract Holder within 15 days of any severance of the family relationship that might activate the continuation coverage option under this section and, upon receiving this notice, the Contract Holder shall immediately give written notice to each affected Dependent of the continuation option; however, such written notice may be given by the Eligible Employee's Dependent. On receipt of notice of the death or retirement of an Eligible Employee, the Contract Holder will immediately give written notice the Eligible Employee's Dependents of the coverage continuation option. Within 60 days from the date of the severance of the family relationship or the retirement or death of the Eligible Employee, the Dependent must give written notice to the Contract Holder of the desire to continue coverage.

Coverage under the plan will remain in effect during the 60-day period if plan premiums are paid. Such continued coverage shall continue until: (1) the Member fails to make a premium payment in the time required to make that payment; (2) the Member becomes eligible for substantially similar coverage under another health benefit plan; or (3) a period of three years has elapsed since the severance of the family relationship or the retirement or death of the Eligible Employee.

X. 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 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 interrlationships 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 Employee. For the purposes of eligibility, an Adopted Child must be enrolled, at the option of the Eligible Employee, within either:

1. thirty-one (31) days after the Eligible Employee 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 a Member are not medically necessary or are experimental or investigational or not appropriate.

After Hours Care: Health care services provided to a Member for an illness or an injury that occurs after normal provider's normal office hours.

Appeal: A request, orally or in writing, for reconsideration of a decision reached under the Community First formal Complaint and Appeals process.

Appeals Panel or Panel: A Panel, composed of equal numbers of Community First Staff, Physicians or other providers, and Members, which advises Community First on the resolution of a dispute.

Associated Company: Employers that are the Contract Holder's subsidiaries or affiliates and are reported in writing to Community First for inclusion under the Group Contract.

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 enrollee 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 enrollee's health benefit plan.

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 Physician 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 Employee, 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. Also included is an unmarried grandchild of Yours who is less than 26 years old and is living with you in your household.

Community First: Community First Health Plans, Inc., a health maintenance organization.

Complainant: A Physician, provider, Member, or other person designated to act on behalf of a Member, 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 Member, and does not include a Provider's or Member's oral or written dissatisfaction or disagreement with an Adverse Determination.

Contract Year: The twelve (12) month period, commencing with the effective date of the Certificate of Group Health Care Coverage, during which coverage is in effect.

Contributory Coverage, Non-contributory Coverage: Contributory Coverage is coverage for which the Contract Holder requires Employee contributions. Non-contributory Coverage is coverage for which the Contract Holder does not require Employee contributions.

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 a Member, in addition to premium, in connection with certain Covered Services and Supplies. A Copayment may be a set dollar amount or a percentage of the cost of the service.

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.

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 Group Health Care Coverage.

Covered Classes: All who live, work or reside in the Service Area but are not covered under the Employer's Health Benefits Plan.

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 a Member;

2. services related to performing or assisting a Member 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 Certificate of Group Health Care Coverage, or another person who is a Dependent under eligibility rules that are set by the Employer and agreed to in writing by Community First;
- is listed by You on the enrollment form;
- for whom the required premium has been paid, and
- is a Court-ordered Dependant
- 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 by 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 a member 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; and glucon emergency kits.

Durable Medical Equipment: Equipment prescribed by the attending physician 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 Employee: An Employee who works on a full-time basis and usually works at least thirty (30) hours a week. This term includes a sole proprietor, a partner, and an independent contractor, if the sole proprietor, partner, or independent contractor is included as an "employee" under a health benefit plan of Contract Holder. The term does not include:

1. an employee who works on a part-time, temporary, seasonal, or substitute basis; or

2. an employee who is covered under:

    a. another health benefit plan;
    b. a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et. Seq.);
    c. the Medicaid program if the employee elects not to be covered;
    d. another federal program, including the CHAMPUS / TRICARE program or Medicare program, if the employee elects not to be covered; or
    e. a benefit plan established in another country if the employee elects not to be covered.

Eligible Retiree: A former Employee who meets eligibility criteria that have been set by the Employer and approved in writing by Community First.

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.

Employee Coverage: Coverage that applies to an Eligible Employee or Eligible Retiree.

Employer: Collectively, all Associated Companies.

Employer's Other Health Benefits Coverage: The health plan(s) of the Employer providing health care expense coverage, other than the Group Health Care Coverage. This does not include Medicare Part A or Part B.

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 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 Physician: A radiologist, anesthesiologist, pathologist, emergency department physician 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 Members.

Freestanding Emergency Medical Care Facility. A facility, structurally separate and distinct from a hospital that receives an individual and provides emergency care.

Grandchildren: Certain Grandchildren are included in the definition of Children (see Definition of Children).

Group Enrollment Period: A period of at least thirty-one (31) days each year, set by the Contract Holder and agreed to by Community First, during which an Eligible Employee, may:

1. Elect coverage under the Employer's Health Benefits Plan or the Group Health Care Coverage; or
2. Elect to change from the Group Health Care Coverage to coverage under the Employer's Health Benefit Plan; or
3. Elect to change from coverage under the Employer's Health Benefits Plan to the Group Health Care Coverage.

Group Health Care Coverage: The services that are included in this Certificate of Group Health Care Coverage. Also referred to as "Coverage."

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 a Member: 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 intellectual or developmental disability or death.

Home Health Care: A program, prescribed in writing by a Participating Physician 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 Physicians and with 24-hour a day nursing and Physician 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 a 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 Article 21.58C of the Texas Insurance Code.

Initial Enrollment Period: The initial period of enrollment after a potential Member first becomes an Eligible Employee 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 a Member.

Individual Treatment Plan: A plan with specific attainable goals and objectives appropriate both to the Member and the treatment modality of the program.

Life-Threatening Condition: A disease or other medical condition with respect to which death is probable unless the course of the disease is interrupted. A Member or the Member's provider of record shall determine the existence of a Life-Threatening Condition on the basis that a prudent lay person 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 Physician who is retained by Community First to coordinate and supervise the delivery of health care services for Members through Participating Physicians and 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.

Member: An Employee who is covered under the Group Health Care Coverage described in this Certificate~~;~~ or a Dependent with respect to whom an Employee is covered for Dependent Coverage described in this Certificate.

Non-Participating Provider: A Physician, 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.

Ombudsman Program: Independent medical review program that provides case review for new and emerging technologies/therapies including, but not limited to, issues pertaining to the experimental/investigational status of an intervention, clinical trials and research studies, and other clinical information, for the purpose of assisting Community First in determining Medical Necessity and appropriateness.

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 Member's responsibility each Contract Year. The specific Out-of-Pocket maximum Copayment that applies under this Certificate of Group Health Care Coverage is listed in the attached Schedule of Copayments. Community First will assist the Member 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 a Member's Out-of-Pocket as set forth in the attached Schedule of Copayments.

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 Physician: A Physician who is either a Primary Care Physician (PCP) or a Specialty Care Physician and who has contracted with Community First to provide services to Members.

Participating Provider: A Physician, 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 Members.

Phenylketonuria: An inherited condition that may cause severe intellectual disability if not treated.

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

Pre-Authorization: The verbal or written approval by Community First, or its designee, obtained prior to admitting a Member to a Facility or providing certain other Covered Services to a Member when approval is required for such services. Pre-authorization is not the same as a Referral, and a Member who has been referred to another Physician or Provider by the Member's PCP may still need to obtain Pre-authorization prior to certain services being rendered by the Referral Physician or Provider.

Prescription Medication and/or Supplies: This means only:

1. a medicinal substance that, by law, can be dispensed only by prescription;
2. other items that require a prescription order to be dispensed.

Primary Care Physician (PCP): A Participating Physician (generally an internal medicine, general medicine, pediatrics or family practice physician) who is chosen by or for a Member to:

1. provide primary medical care to the Member;
2. maintain the continuity of the Member's medical care and initiate referrals to Non-Participating Physicians and/or other 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 Physician of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology.

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 a Member's PCP or other treating provider for a patient to be evaluated or treated by another Physician or 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 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 Group Contract, to Members who live, reside or work within that geographic area. The Service Area applicable to Members is shown as Attachment A to Your Certificate of Group Health Care Coverage.

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 from its patients 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 Physician or registered graduate nurse (R.N.); or, if full-time supervision by a Physician is not provided, it has the services of a Physician 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.

Special Enrollment Period: A period outside of the Initial Enrollment Period and the Group Enrollment Period during which an Employee or Dependent can enroll in the Plan. The Special Enrollment Period for both Employees 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 Employee through marriage, birth, adoption or placement for adoption.
3. A court order requiring the Employee to cover a spouse or child.

Specialty Care Physician: A Participating Physician who provides certain specialty medical care to Members. Under special circumstances a Specialty Care Physician may function as a PCP if approved by the Medical Director. Members who are referred to Specialty Care Physicians may still need to obtain Pre-authorization to receive certain services from the Specialty Care Physician and should work with his/her PCP and Specialty Care Physician in order to obtain Pre-authorization when required.

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 Physician or another Provider authorized to act under Physician delegation and supervision for purposes of patient assessment by a

Provider, diagnosis or consultation by a Physician, 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 Physician.

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 Physician 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 orretrospective 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 Employee or a Member.

COMMUNITY FIRST HEALTH PLANS, INC.

ATTACHMENT A

Service Area

The approved Service Area for Community First Health Plans, Inc., includes all of the following Texas counties: Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina, and Wilson. See Community First's Provider Directory for a Service Area Map and locations for all health care delivery sites. Please visit our website at CommunityFirstHealthCoverage.com.