Member Plan Document

2020 Virtual Lonestar Plan #00006

IMPORTANT INFORMATION ABOUT YOUR COVERAGE

DISCLOSURE OF GUARANTY FUND NONPARTICIPATION: This contract is not covered by an insurance guaranty fund or other solvency protection arrangement because this contract is a contract under which the risk is borne by the policyholder.

Texas Freelancers Association

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SECTION 1 - WELCOME

Lonestar is a self-funded benefit plan offered through the Texas Freelancers Association Benefits Trust (TFA or Association) administered by Decent Inc.

TFA is pleased to provide you with this Member Plan Document (MPD), which describes the health benefits available to you and your eligible covered family members. It includes information regarding:

- who is eligible;
- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

This MPD is designed to meet your information needs. It supersedes any previous printed or electronic MPD for this plan.

IMPORTANT

A health care service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in Section 13, *Glossary*.) The fact that a Physician or other Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorder, disease or its symptoms, does not make the procedure or treatment a Covered Health Service under the Plan.

This arrangement shall renew the health benefit plan, at the employer's option, unless:

1. a contribution has not been paid as required by the terms of the plan;
2. the employer has committed fraud or has intentionally misrepresented a material fact;
3. the employer has not complied with the terms of the health benefit plan document;
4. the health benefit plan is ceasing to offer any coverage in a geographic area; or
    a. there has been a failure to meet the terms of an applicable collective bargaining agreement or other agreement requiring or authorizing contributions to the health benefit plan, including a failure to renew the agreement or to employ employees covered by the agreement.
    b. The TFA may refuse to renew the coverage of a participating member or dependent for fraud or intentional misrepresentation of a material fact by that person.
    c. The TFA may not cancel a health benefit plan except for a reason specified for refusal to renew

An arrangement may not cancel the coverage of a participating employee or dependent except for a reason specified for refusal to renew.

The TFA may elect to refuse to renew all health benefit plans delivered or issued for delivery by the Associated Services Agreement in this state. The arrangement shall notify: (1) the commissioner of the election not later than the 180th day before the date coverage under the first health benefit plan terminates; and (2) each affected employer not later than the 180th day before the date on which coverage terminates for that employer. (b) A multiple employer welfare arrangement that elects under this section to refuse to renew all health benefit plans may not write a health benefit plan in this state before the fifth anniversary of the date notice is delivered to the commissioner. (c) The TFA may elect to discontinue a health benefit plan only if the arrangement: (1) provides notice to each employer of the discontinuation before the 90th day preceding the date of the discontinuation of the plan; (2) offers to each employer the option to purchase coverage under another health benefit plan offered by the arrangement; and

A multiple employer welfare arrangement may require an employer to meet minimum contribution or participation requirements as a condition of issuance and renewal of coverage in accordance with the terms of this plan document. (b) The minimum contribution and participation requirements are stated in the plan document in the section titled ***Eligibility for the Lonestar Plan*** and will be applied uniformly to each employer offered or issued coverage by the Texas Freelancer Association in Texas.

Decent Inc. is the administering firm for Lonestar. Decent Inc.'s goal is to give you the tools you need to make wise health care decisions. Decent Inc. also helps TFA to administer claims. although Decent Inc. will assist you in many ways, it does not guarantee any benefits. The Texas Freelancers Association benefits trust, as administered by Decent, is ultimately responsible for paying benefits described in this MPD.

Please read this MPD thoroughly to learn how the Lonestar plan works. If you have questions, contact Decent or call (866) Heart-us toll-free.

PLEASE NOTE

Your provider does not have a copy of your MPD and is not responsible for knowing or communicating your benefits

NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

The claims administrator on behalf of itself and its affiliated companies and Decent comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Decent Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

SECTION 2 - INTRODUCTION

What this section includes:

- **Who's eligible for coverage under the Plan**
- **The factors that impact your cost for coverage**
- **Instructions and time frames for selecting coverage for yourself and your eligible Dependents**
- **When coverage begins**
- **When you can make coverage changes under the Plan**

Eligibility for the Texas Freelancers Association

You are eligible to enroll in health coverage offered by the Texas Freelancers Association (TFA) if you are a regular full-time Freelancer. This means you currently work AT LEAST 20 hours per week for yourself. This can take the form of a sole proprietor, LLC, or other limited liability company. Association Member as defined in Section 13, *Glossary*.

Eligibility for this Plan

As a Member, you are eligible for coverage in the Lonestar Plan if you can demonstrate that you meet the following criteria:

1. You are an active member of the Texas Freelancer Association
2. You work at least 20 hours per week or 80 hours per month, and can demonstrate that you have earned income from the trade or business that at least equals the working owner's cost of coverage for the working owner and any covered beneficiaries in the group health plan
3. You must live in the Austin Plan Service Area
4. You are able to demonstrate a history of performing knowledge-based independent freelance work in specific technical, creative, and professional fields served by TFABT. Examples include:
    - **BUSINESS**: Accountant, Business Analyst, Consultant, Data Analyst, Financial Analyst, Insurance Agent or Broker, Lawyer, Market Researcher, Marketer, Real Estate Agent or Broker

- **CREATIVE**: Actor, Architect, Artist, Designer, Illustrator, Musician, Photographer, Videographer, Translator, Writer
- **HEALTH**: Licensed Healthcare Professional
- **TECHNICAL**: Data Scientist, Developer, IT Professional, QA Tester, Scientist

5. Your eligible **Dependents** may also participate in the Lonestar Plan. An eligible Dependent is considered to be a:
    a. Subscriber's spouse – an individual to whom the Subscriber is legally married. This includes a ceremonially married spouse or an informally married spouse whose marriage is memorialized by a valid marriage license or Declaration of Informal Marriage filed with the appropriate governmental authority prior to the date of the spouse's enrollment in the Program;
    b. Subscriber's child who is under age 26, including a natural child, a stepchild, a foster child, a legally adopted child, or a child in which member has entered in to suit seeking adoption of the child.
    c. A child who is related to the Subscriber by blood or marriage and was claimed as the Subscriber's Dependent on his/her federal income tax return for the year prior to enrolling the child and for each subsequent year in which the child is enrolled (unless the child is born in the year first enrolled or the Subscriber has a qualifying reason for not claiming the child); or
    d. a child age 26 or over who (i) is certified by an approved practitioner to be mentally or physically incapacitated from gainful employment and (ii) either earns less than the monthly wage standard for enrolling in CHIP in Texas for a family of one at the time of application or reevaluation or earns more than this wage standard for a period of six months or longer in any calendar year and demonstrates that he/she

       is dependent on the Subscriber for care or support and either lives with the Subscriber or has care provided by the Subscriber on a regular basis.
    e. A child, who is at least 26 years of age and who is unmarried on the date of and following the expiration of the child's continuation coverage under COBRA ceases to be a Dependent and may continue coverage as a Subscriber.
    f. A Former COBRA Unmarried Child may enroll a newly acquired dependent child within 31 days of the child's date of birth or placement for adoption, or a child in which member has entered in to suit seeking adoption of the child. The Former COBRA Unmarried Child may not enroll any other dependents.

The Subscriber's Dependents may not enroll in an Association health plan unless the Subscriber is also enrolled in an Association health plan. The Subscriber and Dependents must be enrolled in the same health plan unless the Subscriber and/or Dependents have different Medicare eligibility status. If the Subscriber and his/her Dependent are both eligible to enroll in an Association health plan as the Subscriber, he/she may each be enrolled as the Subscriber or be covered as a Dependent of the other person's plan, but not both. In addition, if you and your spouse are both Subscribers under an Association health plan, only one parent may enroll your child as a Dependent on this Plan.

IMPORTANT

If you wish to change your benefit elections following your marriage or the birth or adoption of a child, placement for adoption of a child or other family status change, you must contact your Decent or make the change through Decent Online, within 31 days of the event.

Cost of Coverage

The Subscriber pays 100% of the cost of the Plan. The Subscriber contribution amount may depend on age, smoking status, zip code, and whether the Subscriber chooses to enroll any Dependents. The Subscriber's contributions are paid directly to the Plan Administrator, Decent Inc.

You can obtain current contribution rates by logging on to www.decent.com.

How to Select Coverage

Login into www.decent.com and follow the sign-up process as directed.

When Coverage Begins

If you sign up during the designated Open Enrollment period – Your coverage will begin on the first day of the new plan year. Open Enrollment period will happen annually, usually in November, and last no less than 31 days

If you are enrolling at any time other than Open Enrollment period, your coverage will begin on the first of the month following at least a one month waiting period. For example: If you enroll on May 15th, your coverage will begin on July 1st.

This applies to Subscribers and Dependents alike.

If Dependent information is received on or before the Subscriber's first day of eligibility, coverage will be effective on the first day of eligibility. If the Subscriber's Dependent information is received after the first day of eligibility, the Dependents will have

their own waiting period. For example: If Dependent information is received on April 7th, the Dependent's coverage will begin
on June 1st.

For eligible Dependents acquired after a Subscriber's eligibility date, or as addressed in the *Changing Your Coverage* subsection below, coverage will begin as follows:

1. coverage for a spouse or Dependent stepchild that the Subscriber acquires via marriage becomes effective the first of the month following the date of the marriage, provided the Subscriber notifies Decent Inc. or makes the change through Decent Online within 31 days of the date of the marriage;
2. a newborn natural child is covered at birth for 31 days without enrollment and an adopted child is covered on the date the member enters into suit in which the member seeks to adopt the child for 31 days without enrollment. However, the Subscriber must enroll the child within 31 days to continue coverage beyond 31 days;
3. an eligible newborn who is not the Subscriber's natural child and meets the definition of Dependent of the Subscriber is covered retroactively to the date of birth, provided that the Subscriber notifies Decent Inc. Or makes the change through Decent Online within 31 days of the birth; and
4. Coverage for an eligible Dependent who is the subject of a National Medical Support Notice is effective automatically for the first 31 days after the notice of medical support is received. However, the Subscriber must enroll the child within 31 days to continue coverage beyond 31 days.

If You Are Hospitalized When Your Coverage Begins

If you are an Inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, the Plan will pay Benefits for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

You should notify Decent Inc. within 48 hours of the day your coverage begins, or as soon as is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network Providers.

Changing Your Coverage

You may make coverage changes during the Plan Year only if you experience a Qualifying Life Event (QLE), or during Annual Enrollment. The change in coverage must be consistent with the QLE (e.g., you cover your spouse following your marriage or your child following an adoption). The following are considered QLEs for purposes of the Plan:

- change in marital status;
- change in Dependent status;
- change in employment status;

- significant cost of Benefits or coverage change imposed by a third party;
- loss of coverage due to the exhaustion of COBRA benefits, provided you were paying for premiums on a timely basis;
- change of address that results in loss of coverage eligibility;
- change in Medicare, Medicaid, or Children's Health Insurance Program (CHIP) status; or
- an applicable National Medical Support Notice.

If you wish to change your elections, you must make the change through Decent Online, within 31 days of the Qualifying Life Event. If the change in benefits election is based on a change in Medicare, Medicaid or CHIP status, you have 60 days. Otherwise, you may not make a change until the next Annual Enrollment.

Any adopted child is covered on the date the member enters into suit in which the member seeks to adopt the child even if the legal adoption is not yet final. If the Subscriber does not legally adopt the child, no provision will be made for continuing coverage (such as COBRA coverage) for the child.

Any changes based on a Qualifying Life Event are effective on the first day of the month following the date of the QLE (except when a child is newborn, adopted or subject to a National Medical Support Order, as previously stated in this section).

CHANGE IN COVERAGE DUE TO QUALIFYING LIFE EVENT - EXAMPLE

Jane is married and has two children who are eligible Dependents. At Annual Enrollment, she elects not to participate in the Association's health coverage, because her husband, Tom, has family coverage under his Association's medical plan. In October, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to Tom's change in employment status, Jane can elect family medical coverage under the Association's health coverage outside of Annual Enrollment.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- **Selecting a Primary Care Physician (PCP)**
- **Accessing Benefits**
- **Network and Non-Network Benefits**
- **Eligible Expenses**
- **Deductibles**
- **Copayment**
- **Coinsurance**
- **Out-of-Pocket Maximum**

Selecting a Primary Care Physician (PCP)

As a Member in this Plan, you are required to select a **Virtual Primary Care Physician** (PCP) in order to obtain Network Benefits. Your PCP will be responsible for your care. You and each of your covered Dependents must select a PCP during enrollment.

If you are the custodial parent of an enrolled Dependent child, you must select a PCP for that child. You may select different PCP's for each person or one PCP for the whole family. Your PCP should be your first point of contact when you need medical care. You may change your PCP selection at any time by contacting Decent Inc. at (866) HEARTUS toll-free or by logging onto www.decent.com.

If you do not select a PCP at the time you elect coverage under this Plan as a new Member, you will be given a 60-day grace period from the effective date of your coverage in which to select a PCP. After 60 days, we will assign you to the closest PCP to your home address.

During the grace period and before you select a PCP, Network Benefits will apply when you visit any Network PCP and any Network Specialists with a valid Referral from a Network PCP. Once you select a PCP, the grace period ends, and all services must be coordinated through your PCP. If, after you select a PCP, you receive services from a Provider you were not referred to by your PCP, Non-Network Benefits apply.

You may select any PCP who is accepting new patients. You may designate a pediatrician as the PCP for a covered Dependent child. For Network obstetrical or gynecological care, you do not need a referral from a PCP, and you may seek care directly from any Network obstetrician or gynecologist.

If your PCP leaves the Network, Decent Inc. will notify you and give you a 60-day grace period to select another PCP. During the grace period and before you select a PCP, Network Benefits will apply when you visit any Network PCP and any Network Specialists with a Referral from a PCP. Non-Network Benefits will apply to any direct visits to a Network Specialist without a Referral from a PCP. Once you select a PCP, the grace period ends, and all services must be coordinated through your PCP. If after you select a PCP, you receive services without going through your designated PCP, Non-Network benefits apply.

You can obtain a list of In Network providers by contacting Decent at (866) HEARTUS toll-free or logging onto www.decent.com.

Please note that Prior Approval is required for certain Covered Health Services even if you have a Referral from your PCP to seek care from another Network Provider. See Section 4, *Prior Approval*, for the list of services.

Accessing Benefits

You can choose to receive Network Benefits or Non-Network Benefits. Generally, when you receive Covered Health Services from a Network Provider, you pay less than you would if you receive the same care from a Non-Network Provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network Provider.

If you receive care from Non-Network Providers, the Plan generally pays Benefits at a lower level. You may also be required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to any Out-of- Pocket Maximum. You may want to ask the Non-Network Provider about his/her billed charges before you receive care.

Emergency Health Services received at a Non-Network Hospital are covered at the Network level until your Physician determines that it is medically appropriate to transfer you to a Network Hospital.

Network Benefits apply to Covered Health Services that are provided by a Network PCP or other Network Provider with a Referral from your PCP or OB/Gyn. Additionally, you will receive Network Benefits when seeking immediate care with a Network PCP that is not your designated PCP per Section 5, Table 2 below: *Other practitioner office visit /Specialist office visit*

For Facility services, these are Benefits for Covered Health Services that are provided at a Network Facility. Note: When you receive Inpatient services in a Facility from a Specialist Physician, Decent Inc. will confirm a Referral was received from your PCP before paying Network Benefits. If a Referral is not in place, Non-Network Benefits will be paid for the Inpatient Stay.

Emergency Health Services are always paid at the Network Benefit level regardless of whether services are received at a Network or Non-Network Hospital until your Physician determines that it is medically appropriate to transfer you to a Network Hospital. For more information on this benefit, go to Section 6, *Details for Covered Health Services*.

Network Benefits apply when Covered Health Services are provided by or referred by your PCP. If care from another Network Physician is needed, your PCP should provide you with a Referral. The Referral must be received by Decent Inc. before the

services are rendered. You are ultimately responsible to confirm that the Referral is in place before you receive any service by contacting Decent Inc. at (866) HEARTUS toll-free or logging onto www.decent.com.

Referrals are valid for 1 year and the first visit must be used within 90 days.

Non-Network Benefits apply to Covered Health Services that are provided by a Non-Network Provider, Non-Network Facility, or Network Provider without a Referral from your PCP.

Referrals from your PCP are required for the highest level of benefits.

Member can see their selected Primary Care Provider without a referral and no co-pay.

A member can see an in-network specialist provider and receive in-network benefits if the primary care doctor has provided a referral.

If the member seeks care from an out of network provider but, has a referral from their primary care physician - the claim will be paid as out of network but will be allowed. Unless member has sought prior approval from Decent, in which case Decent will apply in-network level benefits.

If the member seeks care from an out of network provider without a referral from the PCP and has not received an approval from Decent, Inc., the plan will not pay.

IMPORTANT

If you see a Network Specialist Physician without a Referral from your PCP, you will receive Non- Network Benefits. Non-Network Benefits will apply to all related services received without the required Referral, including any Inpatient Hospital Stay. You do not need a Referral to see a Network obstetrician/ gynecologist.

A written Referral does not ensure that Benefits will be paid for all related services you receive. The services must also be Covered Health Services as defined by the Plan.

When Covered Health Services from Non-Network Providers will be Paid as Network Benefits

If specific Covered Health Services are not available from a Network Provider in your area, you may be eligible to receive Network Benefits from a Non-Network Provider. In such rare instances, your PCP will notify Decent Inc., and they will work with you and your PCP to refer you to a Non-Network Provider and coordinate care through this Provider.

The Plan allows such Referrals only when there is no Network Provider to provide the necessary medical care within a reasonable radius of the Member's eligible county.

When you receive Covered Health Services on this basis, the Plan will pay Network Benefits for those Covered Health Services, even if one or more of those Covered Health Services is received from a Non-Network Provider.

Network Benefits also apply to Covered Health Services that are provided on a non-emergent basis at a Network Facility by a Non-Network Emergency Care Physician, assistant surgeon, surgical assistant, laboratory technician, radiologist, anesthesiologist, pathologist, or consulting Physician. However Covered Health Services provided on this basis will be reimbursed as set forth under Eligible Expenses as described in Section 13, *Glossary*.

As a result, you may be responsible for the difference between the amount billed by the Provider and the amount Decent Inc. determines to be an Eligible Expense for reimbursement.

LOOKING FOR A NETWORK PROVIDER?

In addition to other helpful information, Lonestar's dedicated website contains a directory of Network health care professionals and Facilities. While Network status may change from time to time, www.decent.com has the most current source of Network information.

Network Providers

Decent or its affiliates arrange for health care Providers to participate in the Network. Keep in mind, a Provider's Network status may change so the most up-to-date source of Network Providers is the Lonestar dedicated website. To verify a Provider's status or request a Provider directory, you can call (866) HEARTUS toll-free or log onto **www.decent.com**. Network Providers are independent practitioners and are not employees of Decent. Decent's credentialing process confirms only public information about the Providers' licenses and other credentials but does not assure the quality of the services provided.

Coverage While Traveling Abroad

The Plan pays Benefits for a Member while traveling outside the United States. Emergency services received outside the United States will be paid at the Network benefit level. Eligible Expenses for non-Emergency services incurred while outside the United States are reimbursed at the Non-Network Benefit level. Any care received must be a Covered Health Service for Benefits to apply. **You must pay the Provider at the time treatment is received and obtain appropriate documentation of services received and the cost of these services including itemized bills, receipts and any medical narrative.** This information should be included when you submit your claim to Decent as described in Section 8, *Claims Procedures*. If you have any questions about Benefits while traveling abroad, or before you travel, please call Decent at (866) HEARTUS toll-free. To obtain an international claims form, go to **www.decent.com**

Eligible Expenses

(sometimes known as the Allowable Amount)

Eligible Expenses are charges for Covered Health Services that are provided while the Plan is in effect, determined as described below.

For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the Provider bills. For Non-Network Covered Health Services, you may be responsible for paying, directly to the non-Network Provider, any difference between the amount the Provider bills you and the amount Decent Inc. will pay for Eligible Expenses.

TFA has delegated to Decent Inc. the discretion to determine whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan, according to guidelines established by the Plan and/or Decent Inc. Decent has the discretion to interpret all terms and conditions under the Plan, as described under *Interpretation of the Plan*, *Other Important Information*.

Eligible Expenses are the amount Decent Inc. determines that TFA will pay for Benefits. Eligible Expense determinations are subject to Decent Inc.'s reimbursement policy guidelines, as described under the definition of Eligible Expenses in Section 13, *Glossary*.

For Network Benefits, Eligible Expenses are based on the following:

When Covered Health Services are received from a Network Provider, Eligible Expenses are Decent Inc.'s contracted fee(s) with that Provider.

When Covered Health Services are received from a non-Network Provider as a result of an Emergency or as arranged by Decent Inc., Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

When Covered Health Services are received from a non-Network Provider, Eligible Expenses are determined, based on rates Decent negotiates with the provider on your behalf or comparable rates to those that the provider receives from Medicare.

Non-Network Providers may bill you for any difference between the Provider's billed charges and the Eligible Expense described above (which is sometimes referred to as "balance billing).

Deductibles

A Deductible is the amount you pay annually in covered services before you TFA will pay for benefits. This plan only has a deductible for pharmacy benefits meaning you do not need to meet a deductible before the plan will start paying claims. It does mean that you have LARGE copays for certain services, including inpatient and surgical services. Those co-pays do count toward your out of pocket maximum.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services.

The Copay is a flat dollar amount and is paid at the time of service or when billed by the Provider. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

Copays do not count toward the deductible. However, Copays count toward the Out-of-Pocket Maximum.

Coinsurance

Coinsurance is a fixed percentage of costs that you are responsible for paying for certain Covered Health Services

The payments you make as Coinsurance apply to your Out-of Pocket Maximum.

Out-of-Pocket Maximums

The most you have to spend for covered services in a calendar year. After you reach this amount, Decent pays 100% for covered services.

The out-of-pocket maximum doesn't include your monthly premiums. It also doesn't include anything you spend for services your plan doesn't cover.

There is no out of pocket maximum for non-covered or out of network services.

SECTION 4 - PRIOR APPROVAL

Before receiving these services from a Network Provider, you may want to contact Decent Inc. to verify that the Hospital, Physician and other Providers are current Network Providers and that they have obtained the required Prior Approval.

Network Facilities and Network Providers cannot bill you for services they fail to prior authorize as required. To check the status of a Prior Approval, you may contact Decent Inc. by calling (866) HEARTUS toll-free.

When you choose to receive certain Covered Health Services from Non-Network Providers, you are responsible for obtaining Prior Approval before you receive these services. Note that your obligation to obtain Prior Approval is also applicable when a Non-Network Provider intends to admit you to a Network Facility or refers you to other Network Providers.

To obtain Prior Approval, call (866) HEARTUS toll-free. Once you have obtained the Approval, please review the documentation carefully so that you understand what services have been authorized and what Providers are authorized to deliver the services that are subject to the Approval.

It is recommended that you confirm with Decent Inc. that all Covered Health Services listed below have been approved as required.

The Plan requires Prior Approval for certain Covered Health Services. In general, Network Providers are responsible for obtaining Prior Approval before they provide these services to you. Covered Health Services for which Prior Approval is required are identified below and in Section 6, *Details for Covered Health Services*, within each Covered Health Service category.

Prior Approvals are valid for 90 days once issued. After 90 days a member or their physician will need to obtain a new approval.

Covered Health Services that Require Prior Approval

Please note that Prior Approval may be required even if you have a Referral from your PCP.

Network Covered Health Services

Network Providers are responsible for obtaining Prior Approval from Decent Inc. before they provide most services to you.

However, there are some Network Benefits for which you are responsible for obtaining Prior Approval from Decent Inc.

The Network services that require **you** to request Decent Inc. Approval are:

- Ambulance – non-emergent air;
- Congenital Heart Disease surgeries
- Transplants

For reductions in Benefits that apply if you do not obtain Prior Approval from Decent Inc, as applicable, see below under *Reduction in Benefits if Prior Approval is Not Obtained* as well as Section 6, *Details for Covered Health Services*.

Non-Network Covered Health Services

When you choose to receive certain Covered Health Services from Non-Network Providers, you are responsible for obtaining Prior Approval from Decent Inc. before you receive these services. In many cases, your Non-Network Benefits will be reduced if Decent Inc. has not provided Prior Approval, as described below under *Reduction in Benefits if Prior Approval is Not Obtained*.

The Non-Network services that require **you** to request Approval are:

- Ambulance – non-emergent air;
- Congenital Heart Disease surgeries;
- Durable Medical Equipment that will cost more than $1,000 to purchase or rent, including diabetes equipment for the management and treatment of diabetes;
- Genetic Testing – BRCA (breast cancer gene);
- Home health care;
- Hospice care - Inpatient;
- Hospital Inpatient Stay - all scheduled admissions. ***Note:*** For Hospital Inpatient Stays:
- the length of the Inpatient Stay must have Prior Approval. The Provider may request additional days to be authorized, if needed; and
- the transfer to another Hospital or to or from a specialty unit in a Hospital requires another Prior Approval; lab, x-ray and diagnostics – outpatient - sleep studies;
- Mental Health Services - Inpatient Stay - all scheduled admissions (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility);
- Neurobiological Disorders - Autism Spectrum Disorder Services - Inpatient Stay - all scheduled admissions (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), Intensive Behavioral Therapy, including Applied Behavior Analysis (ABA);
- Orthognathic surgery performed on an Inpatient basis;

- Pregnancy services for an Inpatient Stay that exceeds the number of hours allowed as described in Section 6, *Details for Covered Health Services*;
- Private Duty Nursing;
- Prosthetic devices that will cost more than $1,000 to purchase or rent;
- Reconstructive Procedures, including breast reduction surgery;
- Serious Mental Illness - Inpatient Stay - all scheduled admissions (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility);
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services;
- Substance Use Disorder Services - Inpatient Stay - all scheduled admissions (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility);
- Surgery – outpatient
- Sleep apnea surgeries;
- Therapeutic treatments – outpatient - all outpatient therapeutic treatments; and transplants.

For reductions in Benefits that apply if you do not obtain Prior Approval from Decent Inc., see below under *Reduction in Benefits if Prior Approval is Not Obtained* as well as Section 6, *Details for Covered Health Services*.

Note: If you are admitted to a Non-Network Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility as a result of an Emergency, you or your representative must notify Decent Inc. within 48 hours after the admission.

Reduction in Benefits if Prior Approval is Not Obtained

If you do not obtain Prior Approval from Decent Inc. For these Non-Network services, Benefits will not be covered:

- Scheduled admissions (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), Intensive Behavioral Therapy, including Applied Behavior Analysis (ABA);
- Hospitalization/Day Treatment and services at a Residential Treatment Facility and Outpatient treatment for transcranial magnetic stimulation; and
- Inpatient stays for any reason; such as Substance Use Disorder Services, Mental Health, and Partial inpatient services.

EXAMPLES:

Non covered service example: Bariatric Surgery. Even if you have a referral, Decent still does not consider this a covered benefit. A patient is responsible for provider's full billed charges. Does not count towards annual out of pocket max.

If you seek care from an in-network specialist without a referral from your PCP, the provider will bill Decent directly, however, out-of-network benefits will apply. Any amount paid by you will not accumulate toward your out of pocket maximum.

If you seek care from an out of network specialist with a referral from your PCP and Prior Approval from Decent, the provider will bill Decent directly and the highest level of in-network benefits will apply. Out of Pocket amounts count toward your out of pocket max.

SECTION 5 - SCHEDULE OF BENEFITS AND COVERAGE

Important Questions	Answers	Why This Matters:
What is the Medical deductible?	$0 for Medical Services	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. Pharmacy Deductible is $5,500/Individual or $11,000/family	The Pharmacy deductible applies primarily to specialty prescriptions. You do not need to meet this deductible to obtain generic or brand name preferred prescriptions. See Comments in Medical Deductible for more information about deductibles.
What is the out-of-pocket limit for this plan?	$8,150/Individual or $16,300/family for in-network services only	The out-of-pocket limit is the most you could pay in a year for covered in-network services only. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. There is no out-of-pocket limit for out of network services.
What is not included in the out-of-pocket limit?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.decent.com or call 1-866-HeartUs for a list of participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral. before you see the specialist.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Selected Direct Primary care to treat an injury or illness	$0 Copay	Not covered	None
	Non- Selected Primary care visit to treat an injury or illness	$50 Copay	Not covered	Referral required if seeking in-network benefits from a non-selected primary care provider
	Specialist visit including Chiropractic Care	$85 Copay	Not covered	Referral required if seeking in-network benefits.
	Preventive care/screening/ immunization	No Copay – 100% covered	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work, Allergy Testing)	$50 Copay	Not covered	Pre-Authorization is required for some imaging services. If proper pre-authorization is not obtained, services will not be covered.
	Imaging (CT/PET scans, MRIs)	$200 Copay	Not covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage	Preferred generic drugs	$5 Copay	Not covered	Applies to formulary preferred generic only.
	Preferred brand drugs	$25 Copay	Not covered	Applies to formulary preferred brand only
	Non-preferred brand drugs	$200 Copay	Not covered	Applies to formulary non-preferred brand.
	Specialty drugs	50% after deductible	Not covered	Subject to Pharmacy deductible. Other restrictions apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$1000 Copay	Not covered	Pre-Authorization may be required for some outpatient surgical procedures. If proper pre-authorization is not obtained, services will not be covered.
	Physician/surgeon fees	$300 Copay	Not covered	Pre-Authorization may be required for some outpatient surgical procedures. If proper pre-authorization is not obtained, services will not be covered.
If you need immediate medical attention	Emergency room care	$1000 Copay	$2000 Copay	Copay waived if admitted. If traveling and you need Emergency care outside of the health plan service area in-network benefits will be applied.
	Emergency medical transportation	$1000 Copay	$1000 Copay	None
	Urgent care	$100 Copay	$300 Copay	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$3000 Copay	Not covered	Pre-Authorization may be required for some hospital stays. If proper pre-authorization is not obtained, services will not be covered. Copay is per day for a maximum of two days.
	Physician/surgeon fees	$300 Copay	Not covered	Pre-Authorization may be required for some hospital stays. If proper pre-authorization is not obtained, services will not be covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient Office Visit	$50 Copay	Not covered	Pre-Authorization may be required for some mental health,or substance abuse services. If proper pre-authorization is not obtained, services will not be covered. Copay is per day for a maximum of two days.
	Inpatient services	$3,000 Copay	Not covered	
If you are pregnant	Pre and Postnatal Office Visit	$25 Copay	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional/facility services	$1500 Copay	Not covered	
If you need help recovering or have other special health needs	Private-duty nursing	$85 Copay	Not covered	96 hours per year. Pre-Authorization may be required. If proper pre-authorization is not obtained, services will not be covered.
	Rehabilitative Services	$85 Copay	Not covered	Pre-Authorization may be required. If proper pre-authorization is not obtained, services will not be covered. Limit does not apply to Autism
	Habilitation services	$85 Copay	Not covered	
	In-Home Skilled nursing care	$85 Copay	Not covered	100 days per year. Pre-Authorization may be required. If proper pre-authorization is not obtained, services will not be covered.
	Durable medical equipment	50% coinsurance not subject to deductible	Not covered	Pre-Authorization may be required. If proper pre-authorization is not obtained, services will not be covered.
	Hospice services	$3,000 Copay not subject to deductible	Not covered	Pre-Authorization is required. If proper pre-authorization is not obtained, services will not be covered. Copay is per day for a maximum of two days.
	Home Health Care	$85 Copay	Not covered	Pre-Authorization may be required. If proper pre-authorization is not obtained, services will not be covered. Limited to 100 visits per year.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Child and Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Eye Exams & Eye wear (Child and Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- **Chiropractic care – limited to 35 visits per year**

Hospital Admissions for Mental Health, Substance Abuse, or other Severe Behavioral Health Diagnosis require approval from Decent Inc.

You must obtain Prior Approval from Decent Inc., to receive full Benefits before receiving certain Covered Health Services from a Non-Network Provider.

There is no Out-of-Pocket Maximum for Non-Network Benefits. If Prior approval is obtained and In-Network level benefits are approved for out of network providers, those services will count toward your out of pocket maximum.

Certain services will be paid at 50% coinsurance up to the allowable covered amount. There is, however, no upper limit on how much you will owe if you go out of network and do not receive prior approval. This does not apply to urgent, emergent, and out of area care.

In general, if you visit a Network Provider, that Provider is responsible for obtaining Prior Approval from Decent Inc. before you receive certain Covered Health Services.

SECTION 6 - DETAILS FOR COVERED HEALTH SERVICES

This section supplements *Schedule of Benefits and Coverage*.

This section provides more details of Covered Health Services and the Benefits for them. These details provide any additional limitations that may apply, as well as identify the Covered Health Services for which you must obtain Prior Approval from Decent Inc. Health care services that are not covered are described in Section 7, *Exclusions: What the Medical Plan Will Not Cover*.

All Covered Health Services must be determined by the Plan to be Medically Necessary. Capitalized terms are defined in Section 13, *Glossary*, and may help you to understand the Benefits in this section.

Acquired Brain Injury

This plan includes coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing and treatment, neurofeedback therapy, and remediation required for and related to treatment of an acquired brain injury. Including but not limited to:

- Post-acute transition services,
- Community reintegration services,
- Including outpatient day treatment services
- Other post-acute care treatment services necessary as a result of and related to an acquired brain injury.

This plan does not include any annual or lifetime limitation on the number of days of acute care treatment covered under the plan, any post-acute care treatment covered under the plan and does not limit the number of days of covered post-acute care, including any therapy or treatment or rehabilitation, testing, remediation, or other like care that is determined to be medically necessary as a result of and related to an acquired brain injury. The treating physician shall determine whether treatment or care is medically necessary for purposes of this subsection in consultation with the treatment or care provider, the insured or enrollee, and, if appropriate, members of the insured's or enrollee's family. The determination is subject to review.

Additionally, to ensure that appropriate post-acute care treatment is provided, this plan includes coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered under the plan who:

- Has incurred an acquired brain injury;
- Has been unresponsive to treatment; and
- Becomes responsive to treatment at a later date.
- A determination of whether expenses, are reasonable may include consideration of factors including:
- Cost;

- The time that has expired since the previous evaluation;
- Any difference in the expertise of the physician or practitioner performing the evaluation;
- Changes in technology; and
- Advances in medicine.

Allergy Treatment

The Plan pays for Benefits for allergy treatment, including injections, testing and antigens/serum, received in a Physician's office or other Outpatient Facility when no other health service is received

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 13, *Glossary*, for the definition of Emergency and Emergency Health Services.

Ambulance service by air is covered in an Emergency if ground transportation is impossible or would seriously jeopardize your life or health. If special circumstances exist, the Plan may pay Network Benefits for Emergency air transportation to a Hospital that is not the closest Facility to provide Emergency Health Services.

The Plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as the Plan determines appropriate) between Facilities when the transport is requested by a Physician and is:

1. From a Non-Network Hospital to a Network Hospital;
2. To a Hospital that provides a higher level of Medically Necessary care that was not available at the original Hospital;
3. To a more Cost-Effective acute care Facility; or
4. From an acute Facility to a sub-acute setting.

In most cases, Decent Inc. will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency air ambulance services, please remember that you must obtain Prior Approval from Decent Inc. as soon as possible prior to the transport. if Approval from Decent Inc. is not obtained, you will be responsible for paying all charges and no Benefits will be paid.

Autism Spectrum Disorder Services

The Plan pays Benefits for behavioral services for Autism Spectrum Disorders including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA).

This health plan provides coverage to a member who is diagnosed with autism spectrum disorder, only if the diagnosis is in
place prior the member's 10th birthday.

The plan covers all generally recognized services prescribed in relation to autism spectrum disorder by the enrollee's primary care physician in the treatment plan recommended by that physician.

An individual providing treatment prescribed under this subsection must be a health care practitioner who is licensed, certified, or registered by an appropriate agency of this state; whose professional credential is recognized and accepted by an appropriate agency of the United States.

Generally recognized services may include:

- Evaluation and assessment services;
- Applied behavior analysis;
- Behavior training and behavior management;
- Speech therapy;
- Occupational therapy;
- Physical therapy;
- Medications or nutritional supplements used to address symptoms of autism spectrum disorder.

Bariatric Surgery

Bariatric surgery is not a covered service.

Cancer Screenings

Colorectal Cancer Screening

This plan provides coverage for screening medical procedures to each member in the plan who is 50 years of age or older and at normal risk for developing colon cancer coverage for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Coverage for screening is covered as preventive services free of charge. You may get a screening via a fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years; or a colonoscopy performed every 10 years.

Detection of Human Papillomavirus, Ovarian Cancer, And Cervical Cancer

This plan provides coverage for diagnostic medical procedures to each woman 18 years of age for an annual medically recognized diagnostic examination for the early detection of ovarian cancer and cervical cancer.

(1) A CA 125 blood test; and

(2) A conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

(c) A screening test must be performed in accordance with the guidelines adopted by:

(1) The American College of Obstetricians and Gynecologists; or

(2) Another similar national organization of medical professionals recognized by the commissioner.

Prostate Cancer

This plan provides coverage to each male enrolled in the plan coverage an annual medically recognized diagnostic examination for the detection of prostate cancer.

(1) A physical examination for the detection of prostate cancer; and

(2) A prostate-specific antigen test used for the detection of prostate cancer for each male who:

(A) Is at least 50 years of age and is asymptomatic; or

(B) Is at least 40 years of age and has a family history of prostate cancer or another prostate cancer risk factor.

Clinical Trials

This plan will provide benefits for routine patient care costs to an enrollee 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 Institutes 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 means the costs of any medically necessary health care service for which benefits are provided under a health benefit plan, without regard to whether the enrollee is participating in a clinical trial. Clinical Trial Routine patient care costs do not include:

(1) The cost of an investigational new drug or device that is not approved for any indication by the 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; or
(5) The cost of a health care service that is specifically excluded from coverage under a health benefit plan.

This plan will not reimburse the research institution conducting the clinical trial for the cost of routine patient care provided through the research institution unless the research institution, and each health care professional providing routine patient care through the research institution, agrees to accept reimbursement under the health benefit plan, at the rates that are established under the plan, as payment in full for the routine patient care provided in connection with the clinical trial.

This plan does not provide benefits for routine patient care services provided outside of the plan's health care provider network unless out-of-network benefits are otherwise provided under the plan.

The benefits available under this chapter are subject to a deductible, coinsurance, or copayment requirement comparable to other deductible, coinsurance, or copayment requirements applicable under the health benefit plan.

Congenital Heart Disease (CHD) Services

The Plan pays Benefits for Congenital Heart Disease (CHD) services ordered by a Physician. Benefits include, but are not limited to, the Facility charge and the charge for supplies and equipment.

Please remember that you must obtain Prior Approval from Decent Inc. when surgery for CHD will result in an Inpatient Hospital Stay. For Non- Network Benefits, if Approval from Decent Inc. is not obtained, Benefits for Covered Health Services for the Inpatient Stay will be reduced.

Dental Services

Accident-Related

Dental services are covered by the Plan when all of the following are true:

1. Treatment is necessary because of accidental damage caused by physical trauma to sound and natural teeth (i.e., teeth with no major restorations and no periodontal involvement) and/or dental work that was in place at the time of the injury, including, but not limited to, crowns, veneers, bridges and implants;
2. The dental damage did not occur as a result of normal activities of daily living or extraordinary use of the teeth;
3. Dental services are performed by a doctor of dental surgery or a doctor of medical dentistry;
4. The dental damage is severe enough that initial contact with a physician or dentist occurred within 72 hours of the accident. (you may request an extension of this time period provided that you do so within 60 days of the dental damage and if extenuating circumstances exist due to the severity of the accident that caused the dental damage); and
5. The dental services for final treatment to repair the accidental dental damage must be completed within 24 months of the accident.

The Plan provides Benefits for only the following treatment of accidental dental damage:

- Emergency examination
- Necessary diagnostic X-rays;
- Endodontic (root canal) treatment;
- Temporary splinting of teeth;
- Prefabricated post and core;
- Simple minimal restorative procedures (fillings);
- Extractions;
- Post-traumatic crowns if such are the only clinically acceptable treatments
- Restoration or replacement of dental work that was in place at the time of the Injury, including, but not limited to, crowns, veneers, bridges and implants;
- Replacement of lost teeth due to the Injury; and
- Temporary repairs immediately following the Injury that will allow any of the above permanent repairs to be performed.

Alternate Benefit for Accident-Related Dental Services

If you require new dental work, such as crowns or implants, or repair/replacement of dental work that was in place at the time of the Injury, as described above, the Plan will pay benefits for the most Cost-Effective procedure(s) recommended by the treating Provider. However, if you choose to have a more costly procedure(s), the Plan may reimburse you for a portion of your costs, up to a maximum of the amount of the more Cost-Effective procedure. When you submit your claim, you must include an estimate from the Provider for the more Cost-Effective procedure(s) in addition to receipts for the alternate procedure(s) actually performed. You will receive a maximum reimbursement of the amount estimated for the more Cost- Effective procedure(s).

Medical Condition-Related

The Plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- medical transplant procedures;
- initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system);
- treatment or correction of a Congenital Anomaly when provided to an eligible Dependent child; and
- direct treatment of cancer or cleft palate.

The Plan also provides Benefits for Covered Health Services for oral surgery for the following:

- excision of neoplasms, including benign, malignant and premalignant lesions, tumors and non-odontogenic cysts;
- incision and drainage of cellulitis;
- surgical procedures involving sinuses, salivary glands and ducts;
- removal of teeth if integral to a medical procedure prior to radiation therapy of the head and neck, but not the dental reconstruction for the replacement of the extracted teeth;
- replacement of natural teeth lost as a result of radiation therapy performed while you are a Member in the Plan;
- reconstruction after tumor removal (including bone grafting and dental implants if necessary, to stabilize a maxillofacial prosthesis such as an obturator); and
- removal of broken teeth if necessary, to reduce jaw fracture.

Dental Anesthesia

The Plan provides Benefits for dental anesthesia for a Member whose dentist provides documentation that states he or she cannot undergo local anesthesia because of a documented physical, mental or medical reason.

Charges for the dental procedure itself, including, but not limited to, the professional fees of the dentist, are not covered.

Diabetes Services

The Plan pays Benefits for the Covered Health Services identified below.

All supplies, including medications, and equipment for the control of diabetes will be dispensed as written, including brand name products, unless substitution is approved by the physician or practitioner who issues the written order for the supplies or equipment.

Covered Diabetes Services	
Diabetic Eye Examinations/Foot Care	Benefits under this section include, but are not limited to, medical eye examinations (dilated retinal examinations) and preventive foot care for Members with diabetes.
Diabetes Self-Management Training Programs	Benefits are provided for Outpatient self-management training, including, but not limited to: ● training after the initial diagnosis of diabetes regarding the care and management of diabetes, nutritional counseling and proper use of diabetes equipment and supplies; ● training after a significant diagnosed change in symptoms or condition requiring change in self-management regime; and ● periodic training warranted by the development of new techniques and treatment for diabetes. These services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals.
Diabetic Self-Management Items	Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Member. All supplies, including medications, and equipment for the control of diabetes will be dispensed as written, including brand name products, unless substitution is approved by the physician or practitioner who issues the written order for the supplies or equipment. Covered diabetes equipment is specifically defined as: (1) blood glucose monitors, including those designed to be used by or adapted for the legally blind; (2) test strips specified for use with a corresponding glucose monitor; (3) lancets and lancet devices; (4) visual reading strips and urine testing strips and tablets which test for glucose, ketones and protein; (5) insulin and insulin analog preparations; (6) injection aids, including devices used to assist with insulin injection and needleless systems; (7) insulin syringes; (8) biohazard disposal containers; (9) insulin pumps, both external and implantable, and associated appurtenances, which include: (A) insulin infusion devices; (B) batteries; (C) skin preparation items; (D) adhesive supplies; (E) infusion sets;

	(F) insulin cartridges; (G) durable and disposable devices to assist in the injection of insulin; and (H) other required disposable supplies; (10) repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer's warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump; (11) prescription medications which bear the legend "Caution: Federal Law prohibits dispensing without a prescription" and medications available without a prescription for controlling the blood sugar level; (12) podiatric appliances, including up to two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes; and (13) glucagon emergency kits. (b) As new or improved treatment and monitoring equipment or supplies become available and are approved by the United States Food and Drug Administration, such equipment or supplies shall be covered if determined to be medically necessary and appropriate by a treating physician or other practitioner through a written order. (c) All supplies, including medications, and equipment for the control of diabetes shall be dispensed as written, including brand name products, unless substitution is approved by ***Note:*** Insulin and insulin analogs, prescriptive and non-prescriptive oral agents for controlling blood sugar levels are covered under the Lonestar Prescription Drug Program administered by Costco.

Please remember, to receive Non-Network Benefits you must obtain Prior Approval from Decent Inc. before obtaining any Durable Medical Equipment for the management and treatment of diabetes if the retail purchase cost or cumulative retail rental cost of a single item will exceed $1,000. To receive Network Benefits, you must purchase or rent the DME from the vendor Decent Inc. identifies or purchase it directly from the prescribing Network Physician. If Approval from Decent Inc. is not obtained, you will be responsible for paying all charges and no Benefits will be paid.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that is:

1. ordered or provided by a Physician for Outpatient use;
2. not consumable or disposable;
3. used for medical purposes with respect to treatment of a Sickness, Injury or disability or their symptoms;
4. durable enough to withstand repeated use;
5. not implantable within the body (except as noted below); and
6. appropriate for use, and primarily used, within the home.

If more than one piece of DME can meet your functional needs, your coverage will provide the most appropriate model of orthotic device that adequately meets the needs of the enrollee as determined by the enrollees treating physician, or podiatrist and prosthetist, or orthotist. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include, but are not limited to:

- Continuous positive airway pressure device (CPAP or BIPAP);
- Equipment to administer oxygen (e.g., respirator);

- Equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- Delivery pumps for tube feedings;
- Negative pressure wound therapy pumps (e.g., wound vacuums);
- Burn garments;
- Insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section;
- Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service.

The Plan also covers batteries, tubings, nasal cannulas, connectors and masks used in connection with DME.

Cochlear implants and components such as an external speech processor and controller with replacement every three years are covered under the Durable Medical Equipment benefit provision.

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period.

Note: DME is different from prosthetic and Orthotic devices – see *Prosthetic and Orthotic Devices* in this section.

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every three Calendar Years.

Replacements may be covered when the DME is damaged beyond repair due to normal wear and tear, when repair costs
exceed new purchase price or when a replacement piece of DME is required due to the Member's growth or other physical change or a change in the Member's abilities or medical condition occurs sooner than the three-year timeframe. Repairs, including, but not limited to, the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device.
Requests for repairs may be made at any time and are not subject to the three-year timeline for replacement

Emergency Room Services - Outpatient

The Plan's Emergency Room services Benefit pays for Outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

If you are admitted as an Inpatient to a Hospital directly from the Emergency room, the Benefits for an Inpatient Stay in a Network Hospital will apply instead.

Network Benefits will be paid for an Emergency admission to a Non-Network Hospital as long as Decent Inc. is notified within 48 hours after you are admitted to a Non-Network Hospital. If you continue your stay in a Non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Non-Network Benefits will apply.

Emergency room Benefits may be available when you seek such services to treat a condition you reasonably believe is an Emergency even if, once diagnosed, the condition is not determined by the Plan to have been an Emergency.

Please remember that you or your representative must notify Decent Inc. Within 48 hours after you are Admitted to a Non-Network Hospital as a result of an Emergency. If Decent Inc. Is not notified, Benefits for the Inpatient Hospital Stay Benefits will be paid at the Non-Network level.

Family Planning and Infertility Services

The Plan pays Benefits for voluntary family planning services and supplies. Coverage is provided for contraceptive counseling, elective sterilization procedures (tubal ligation or vasectomy), contraceptives drugs administered by a Provider (e.g., Depo-Provera, Norplant) and contraceptive devices (e.g., diaphragm, intrauterine device (IUD)), including fitting and removal.

Note: Oral contraceptives are covered under the Lonestar Prescription Drug Program administered by Costco.

Coverage for infertility services includes only diagnostic laboratory and X-ray procedures, therapeutic injections and surgical treatment necessary for the diagnosis and treatment of involuntary infertility (i.e., infertility that is not a result of voluntary sterilization).

For services specifically excluded, refer to Section 7, *Exclusions: What the Medical Plan Will Not Cover*, under the heading
Reproduction/Infertility.

Habilitation and Rehabilitation Services - Outpatient Therapy

The Plan provides short-term Outpatient Habilitation services and rehabilitation services for the following types of therapy up to the benefits outlined in Table 2.:

- Physical therapy;
- Occupational therapy;
- Speech therapy;
- Chiropractic care
- Post-cochlear implant aural therapy;
- Cognitive rehabilitation therapy following a traumatic brain Injury or cerebral vascular accident;
- Pulmonary rehabilitation; and
- Cardiac rehabilitation.

Benefits provided under this section include “Habilitation” services, which are health care services that help a person keep, learn or improve skills and functioning for daily living prescribed by a Member’s treating Physician pursuant to a treatment plan to develop a function not previously developed as a result of a disabling condition, or a disorder resulting from Sickness, Injury, trauma or other event or condition suffered by the Member prior to the development by that Member of one or more functional life skills such as walking or talking. Benefits for Habilitation services do not apply to Educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not Habilitation services.

To be Covered Health Services, all Habilitation services or rehabilitation services must be performed by a licensed therapy Provider under the direction of a Physician (when required by state law) and must be provided in a Physician's office or on an Outpatient basis at a Hospital or Alternate Facility. -p
Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of Habilitation services, are described under *Durable Medical Equipment* and *Prosthetic Devices* in this section.

Except as described below under *Developmental Delay Services*, the Plan will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when:

1. The speech impediment or dysfunction results from a Congenital Anomaly or Injury or Sickness, including, but not limited to, stroke, cancer or Autism Spectrum Disorder;
2. Needed following the placement of a cochlear implant; or used to treat stuttering, stammering, or other articulation disorders not related to an underlying medical condition.

Developmental Delay Services

The Plan provides Benefits for rehabilitation and Habilitation services for Dependent children with developmental delay that are determined to be necessary to, and provided in accordance with, an individualized family service plan issued by the Interagency Council on Early Childhood Intervention. Covered Health Services include:

- Occupational therapy evaluations and services;
- Physical therapy evaluations and services; and
- Speech therapy evaluations and services.

These services are not subject to any limitations or rehabilitation goal requirements shown in this section.

Hearing Aids

The Plan pays Benefits for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits available for Hearing aids are included in the DME section. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Hearing aid batteries are not included in the hearing aid Benefit limit. Hearing aid batteries are covered at 100% up to maximum of $1 per battery. You must submit a receipt with a completed hearing aid battery claim form located under the *Publications and Forms* section at www.decent.com

Benefits do not include dispensing fees or repairs to a hearing aid, even if the hearing aid purchase was a Covered Health Service under the Plan.

This plan provides coverage for the full cost of a medically necessary hearing aid or cochlear implant and related services and supplies for a covered individual who is 18 years of age or younger.

(1) Coverage will include:

(A) Fitting and dispensing services and the provision of ear molds as necessary to maintain optimal fit of hearing aids;

(B) Any treatment related to hearing aids and cochlear implants, including **coverage for habilitation and rehabilitation as necessary for educational gain; and**

(C) For a cochlear implant, an external speech processor and controller with necessary components replacement every three years; and

(2) Is limited to:

(A) One hearing aid in each ear every three years; and

(B) One cochlear implant in each ear with internal replacement as medically or audiologically necessary.

(c) Coverage requirements:

(1) May not be less favorable than coverage for physical illness generally under the plan; and

(2) Must be subject to durational limits and coinsurance factors no less favorable than coverage provided for physical illness generally under the plan.

(d) Coverage required under this section is subject to any provision that applies generally to coverage provided for durable medical equipment benefits under the plan, including a provision relating to deductibles, coinsurance, or prior authorization.

Note: Limited coverage of bone anchored hearing aids is provided as described under *Prosthetic Devices* in this section.

Hearing Tests

This plan provides each covered child coverage for:

(1) A screening test for hearing loss from birth through the date the child is 30 days of age, and

(2) Necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months of age.

High-Tech Radiology

CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

The Plan pays Benefits for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an Outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include, but are not limited to:

- The Facility charge and the charge for supplies and equipment; and
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under Physician Fees for Surgical and Medical Services.

Home Health Care

Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be:

- ordered by a Physician;
- provided by or supervised by a registered nurse (R.N.) or licensed vocational nurse (L.V.N.), or provided by either a home health aide or licensed practical nurse (L.P.N.) and supervised by a registered nurse, in your home;
- not considered Custodial Care, as defined in Section 13, *Glossary*; and
- provided on a part-time or Intermittent Skilled Nursing Care schedule when Skilled Care is required. Refer to Section 13, *Glossary*, for the definition of Skilled Care.
- Decent Inc. will decide if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be Skilled Care simply because there is not an available caregiver.

Covered Health Services for home health care include, but are not limited to:

- physical, occupational (when consisting of traditional physical therapy modalities), speech and respiratory therapy services provided by a licensed therapist; and
- supplies and equipment routinely provided by a Home Health Agency.

For services specifically excluded, refer to Section 7, *Exclusions: What the Medical Plan Will Not Cover*, under the heading
Types of Care.

Benefits under this section are provided for home infusion therapy, which is the administration of fluids, nutrition or medication (including, but not limited to, all additives, and chemotherapy) by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting. There is no coverage for home infusion therapy unless it is performed by a Network Provider.

Home infusion therapy includes, but is not limited to:

- Drug and intravenous solutions;
- Pharmacy compounding and dispensing services;
- All equipment and ancillary supplies necessitated by the defined therapy;
- Delivery services;
- Patient and family education; and
- Nursing services.

Non-Network Benefits for home health care are limited to **35 visits per Calendar Year**. One visit equal four hours of Skilled Care services. Home health care visits from both Network and Non- Network Providers apply to this limit.

Please remember, to receive Non-Network Benefits you must obtain Prior Approval from Decent Inc. before receiving services. If Approval from Decent Inc. is not obtained, you will be responsible for paying all charges and no Benefits will be paid.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill Member. Hospice care can be provided on an Inpatient or Outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill Member and short-term grief (bereavement) counseling for immediate family members while the Member is receiving Hospice care. Benefits are available only when Hospice care is received from a licensed Hospice, which can include a Hospital.

Benefits for Outpatient Hospice care include, but are not limited to:

- Part-time or intermittent nursing care by a registered nurse (R.N.) or licensed vocational nurse (L.V.N.); and
- Part-time or intermittent home health aide services that consist primarily of caring for the Member.
- Benefits for Inpatient Hospice care include, but are not limited to:
- All usual nursing care by a registered nurse (R.N.) or licensed vocational nurse (L.V.N.); and
- Room and board and all routine services, supplies and equipment provided by the Hospice Facility.
- Benefits for Inpatient or Outpatient Hospice care include, but are not limited to:
- Physical, occupational (when consisting of traditional physical therapy modalities), speech, and respiratory therapy services provided by a licensed therapist; and
- Counseling services by licensed social workers and pastoral counselors routinely provided by the Hospice agency, including bereavement counseling.

For services specifically excluded, refer to Section 7, Exclusions: What the Medical Plan Will Not Cover, under the heading Types of Care.

Please remember, to receive Non-Network Benefits you must obtain Prior Approval from Decent Inc. before receiving services. If Approval from Decent Inc. is not obtained, you will be responsible for paying all charges and no Benefits will be paid.

Hospital - Inpatient Stay

Hospital - Inpatient Stay Benefits are available for:

- Non-Physician services and supplies received during an Inpatient Stay;
- Room and board in a Semi-private Room; and
- Physician services for radiologists, anesthesiologists, pathologists, assistant surgeons, surgical assistants, consulting Physicians and Emergency room Physicians.

Note: The Plan will pay the difference in cost between a Semi-private Room and a private room only when a Semi-private Room is not available or if a private room is Medically Necessary according to generally accepted medical practice.

Benefits for a Hospital - Inpatient Stay are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Room Services* and *Surgery - Outpatient, Scopic Procedures - Diagnostic and Therapeutic*, and Therapeutic Treatments - Outpatient, respectively.

For scheduled admissions, please remember you must obtain Prior Approval from Decent Inc. before you are admitted. If Approval from Decent Inc. is not obtained, Benefits will be subject to out of network benefits.

For Emergency admissions (also termed non-scheduled admissions) please remember that you or your representative must notify Decent Inc. within 48 hours after you are admitted to a Non-Network Hospital as a result of an Emergency. If Decent Inc. is not notified, Benefits for the Inpatient Hospital Stay will be subject to out of network benefits.

Lab, X-Ray and Diagnostics - Outpatient

Covered Health Services for Sickness and Injury-related diagnostic purposes, received on an Outpatient basis at a Hospital or Alternate Facility include, but are not limited to:

- Lab and radiology/X-ray;
- Mammography; and
- Bone density screening
- Benefits under this section include, but are not limited to:
- The Facility charge and the charge for supplies and equipment; and
- Physician services for radiologists, anesthesiologists and pathologists.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section.

Mammography: This plan provides coverage to a female who is 35 years of age or older for an annual screening, by all forms of low-dose mammography including digital mammography or breast tomosynthesis, for the presence of occult breast cancer and is subject to the same dollar limits, deductibles, and coinsurance factors as coverage for other radiological examinations under the plan.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *High-Tech Radiology - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section.

Please remember, to receive Non-Network Benefits for sleep studies, you must obtain Prior Approval from Decent Inc. before scheduled services are received. If Approval from Decent Inc. is not obtained, you will be responsible for paying all charges and no Benefits will be paid.

Medical Supplies

The Plan pays Benefits for medical or disposable supplies when the supplies are prescribed by a Physician. Covered Health Services include, but are not limited to:

- Urinary catheters;
- Wound care or dressing supplies given by a provider during treatment for covered health services; and
- Medical-grade compression stockings when considered medically necessary. The stockings must be prescribed by a physician, individually measured and fitted to the patient.

Coverage also includes disposable supplies necessary for the effective use of Durable Medical Equipment and diabetic supplies for which Benefits are provided as described under *Durable Medical Equipment* and *Diabetes Services* in this section.

Mental Health Services

The Plan pays Benefits for Mental Health Services for the treatment of Mental Illness received on an Inpatient or Outpatient basis in a Hospital, an Alternate Facility or in a Provider's office.

Benefits and reimbursement for mental health services will be the same to those for physical health services. This includes deductibles, coinsurance, or another out-of-pocket expense or annual or lifetime limit, or another financial requirement.

Services must be received from a Mental Health Provider as defined in Section 13, *Glossary*.

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

- Individual or group psychotherapy;
- Psychodynamic therapy;
- Mental health counseling;
- Electroconvulsive treatment;
- Diagnostic evaluations and assessment;
- Treatment planning;
- Treatment and/or procedures;
- Referral services;
- Psychotropic drugs, including their administration;
- Medication management;
- Individual, family, therapeutic group and provider-based case management services;
- Crisis intervention;
- Services at a residential treatment facility;
- Psychological testing and assessment;
- Partial hospitalization/day treatment; and
- Intensive outpatient treatment.

Note: The Plan will pay the difference in cost between a Semi-private Room and a private room only when a Semi-private Room is not available or if a private room is Medically Necessary according to generally accepted medical practice.

Serious Mental Illness Services

The Plan pays Benefits for Covered Health Services received on an Inpatient or Outpatient basis in a Hospital, an Alternate Facility or in a Provider's office.

Services must be received from a Physician or a Mental Health Provider as defined in Section 13, *Glossary*.

Covered Health Services also include transcranial magnetic stimulation (TMS) provided on an Outpatient basis for an adult patient with a major depressive disorder that is a Serious Mental Illness that has not been responsive to other Medically Necessary treatments.

Decent, will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

Note: The Plan will pay the difference in cost between a Semi-private Room and a private room only when a Semi-private Room is not available or if a private room is Medically Necessary according to generally accepted medical practice.

You are encouraged to contact Decent for coordination of care.

Please remember for services to be covered, you must obtain Prior Approval to receive Inpatient Benefits. When you obtain Prior Approval, Decent will work with you to determine the appropriate setting for your treatment. Please refer to Section 4, *Prior Approval*, for the specific services that require Prior Approval. Please call (866) HEARTUS toll-free. Without Prior Approval Covered Health Services for the Inpatient Stay will be subject to Out of Network Benefits

For Emergency admissions (also termed non-scheduled admissions) please remember that you or your representative must notify Decent within 48 hours after you are admitted to a Non-Network Facility as a result of an Emergency. If not notified, Benefits for the Inpatient Hospital Stay will be subject to Out of Network Benefits and Benefits will be paid at the Non-Network level.

Nutritional Counseling

The Plan will pay for Covered Health Services for medical education services provided in a Physician's office or Inpatient setting by an appropriately licensed or health care professional when:

- Medical education services are required for a disease in which patient self-management is an important component of treatment; and
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.
- Some examples of such medical conditions include, but are not limited to:
    - Diabetes;
    - Coronary artery disease;
    - Congestive heart failure;
    - Severe obstructive airway disease;
    - Gout (a form of arthritis);
    - Renal failure;
    - Phenylketonuria (a genetic disorder diagnosed at infancy); and
    - Hyperlipidemia (excess of fatty substances in the blood).

Nutritional counseling services include, but are not limited to, the education, counseling, or training of a Member regarding diet, regulation or management of diet or the assessment or management of nutrition.

In addition, the Plan provides Benefits for dietary or nutritional evaluations for Members with developmental delay that are determined to be medically necessary.

Orally Administered Anticancer Medication

Also known as Oral Chemotherapy - This health plan provides coverage for a prescribed, orally administered anticancer medication that is used to kill or slow the growth of cancerous cells on a basis no less favorable than intravenously administered or injected cancer medications that are covered as medical benefits by the plan. A prior approval is required for an orally administered anticancer medication. If an orally administered anticancer medication is approved, the cost to the covered individual may not exceed the coinsurance or copayment that would be applied to a chemotherapy or other cancer treatment visit.

Ostomy Supplies

Benefits for ostomy supplies include, but are not limited to:

- pouches, face plates and belts;
- irrigation sleeves, bags and ostomy irrigation catheters;
- skin barriers; and
- deodorants, filters, lubricants, tape, appliance cleaners, adhesive and adhesive remover.

Pharmaceutical Products - Outpatient

The Plan pays for Pharmaceutical Products that are administered on an Outpatient basis in a Hospital, Alternate Facility or Physician's office. The Plan also pays for Pharmaceutical Products that are administered in a Member's home but only by a Network Provider. Examples of what would be included under this category are antibiotic injections in the Physician's office, inhaled medication in an Urgent Care Center for treatment of an asthma attack or Medically Necessary growth hormone therapy.

Benefits under this section are provided only for Pharmaceutical Products that, due to their characteristics (as determined by Decent Inc.), must typically be administered or directly supervised by a qualified Provider or licensed/certified health professional, unless approved for self-administration by the United States Food and Drug Administration (FDA).

Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy under the Lonestar Prescription Drug Program administered by Costco. Additional information is located at **www.decent.com**

Physician Fees

for Surgical and Medical Services

The Plan pays Benefits for Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility, or for Physician house calls.

Physician's Services

Sickness and Injury

Benefits are paid by the Plan for Covered Health Services for the evaluation, diagnosis and treatment of a Sickness or Injury. Benefits under this section include, but are not limited to, allergy injections and hearing exams in case of Injury or Sickness.

Benefits are available for Genetic Testing that is determined to be Medically Necessary following genetic counseling when ordered by the Physician and authorized in advance by Decent Inc.

Covered Health Services also include Visits, Telehealth and Telemedicine services, such as the use of electronic media for diagnosis, consultation, treatment, transfer of medical data and medical education.

Benefits under this section include lab, radiology/ X-ray or other diagnostic services performed in the Physician's office.

Benefits for high-tech radiology such as CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services performed in the Physician's office are described under *High-Tech Radiology - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section.

Benefits for preventive services are described under *Preventive Care Services* in this section.

Please remember, to receive Non-Network Benefits for Genetic Testing – BRCA (breast cancer gene) you must obtain Prior Approval from Decent Inc. If Approval from Decent Inc. is not obtained, you will be responsible for paying all charges and no Benefits will be paid.

Please Note

Your Physician does not have a copy of your MPD and is not responsible for knowing or communicating your Benefits.

Pregnancy - Maternity Services

The Plan provides Benefits for Covered Health Services related to Pregnancy. Covered Health Services include, but are not limited to, all maternity-related medical services for prenatal care, postnatal care, delivery services provided by the delivering Physician, laboratory tests, sonograms, stress tests, amniocentesis and expenses for the Hospital – Inpatient Stay, including

assistant surgeon or anesthesiologist fees if required. Benefits to treat any related Complications of Pregnancy will be paid at the same level as Benefits for any other medical condition, Sickness or Injury.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following an uncomplicated vaginal delivery; or
- 96 hours for the mother and newborn child following an uncomplicated cesarean section delivery.

Please remember Prior Approval must be obtained as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be longer than the timeframes indicated above.
Note: If the newborn remains hospitalized after the mother is released, in order to ensure that a penalty is not applied, you should obtain separate Prior Approval for the child and arrange to have the child admitted to the Hospital in his or her own name for treatment by a Physician or other Provider for the non-routine services.

These are federally mandated requirements under the Newborns' and Mothers' Health Protection Act of 1996 which apply to this Plan. The Hospital or other Provider is not required to get Approval for the time periods stated above. Approval are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Members in the immediate family. Covered Health Services include related tests and treatment.

Preventive Care Services

The Plan pays Benefits for Preventive care services provided on an Outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

Evidence-based items or services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;

Immunizations that have a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the federal Health Resources and Services Administration; and with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the federal Health Resources and Services Administration.

Early detection of cardiovascular disease for a member who is:

(A) a male older than 45 years of age and younger than 76 years of age; or
(B) a female older than 55 years of age and younger than 76 years of age; and
(2) who:
(A) is diabetic; or
(B) has a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm, that is intermediate or higher.

For one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five years, performed by a laboratory that is certified by a national organization recognized by the commissioner by rule for the purposes of this section:

(1) computed tomography (CT) scanning measuring coronary artery calcification; or
(2) ultrasonography measuring carotid intima-media thickness and plaque.

Preventive Services that are currently rated as A or B according to the United States Preventive Services Task Force (USPSTF) are listed in *Addendum - List of Covered Preventive Care Services*. This list is subject to change according to the guidelines and recommendation provided by USPSTF as determined by the Plan. Coverage is subject to guidelines based on age, dosage, and frequency.

Breastfeeding

The Plan provides Benefits for lactation support and counseling sessions for female Members in conjunction with childbirth. To be considered Covered Health Services, services must be received from a Network Provider and/or Facility.

You may purchase a breast pump from a Network DME Provider or Physician. You may also purchase a breast pump at a retail location and submit a claim as described in Section 8, *Claims Procedures*. Benefits for breast pumps are provided at 100% of Eligible Expenses.

The earliest date that a breast pump can be purchased for a delivery is 30 days prior to the estimated delivery date. You or your Provider should indicate on your claim the estimated date

Breast pumps are covered under the Plan as long as they are purchased within the duration of breastfeeding.

Note: Rental of breast pumps and any shipping costs related to purchase of a breast pump are not Covered Health Services under this Benefit.

For questions about your preventive care Benefits under this Plan call (866) HEARTUS toll-free.

Private Duty Nursing - Outpatient

The Plan covers Private Duty Nursing care when ordered and provided under the direction of a Physician and given on an Outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or Licensed Practical Nurse (L.P.N.).

Benefits are available when Skilled Care is needed, and nursing intervention is required at least every two to three hours and when one or more of the following is true:

- The Member's condition makes him or her homebound; or
- The Member's condition plus the geographic distance make it unreasonable for him or her to obtain the needed Services in an Outpatient Facility or Physician's office; or
- The Member's condition makes him or her technology dependent;
- Services are needed on a continuous basis (e.g., suctioning or hemodynamic monitoring) to assure immediate intervention if required; or
- The services are more Cost-Effective in the home than an alternative setting.

The Member's treatment plan should be reviewed periodically (no less than every 30 days, or as determined by the PCP) and updated by the Physician.

Benefits are provided for the time devoted to providing the Member with services that are Medically Necessary.

Benefits are limited to 96 hours per Calendar Year.

Please remember, to receive Benefits you must obtain Prior Approval from Decent Inc. before receiving services. If Approval from Decent Inc. is not obtained, you will be responsible for paying all charges and no Benefits will be paid.

Prosthetic and Orthotic Devices

Benefits are paid by the Plan for prosthetic devices and appliances that replace a limb or body part or help an impaired limb or body part work. Examples include, but are not limited to:

- Artificial arms, legs, feet and hands;
- Artificial face, eyes, ears and nose; and
- Breast prosthesis following mastectomy as required by the women's health and cancer rights act of 1998, including mastectomy bras and lymphedema stockings for the arm.
- Benefits under this section are also provided for bone anchored hearing aids only for members who have either of the following:
- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Examples of orthotic are

- Cranial remolding orthotics (e.g., cranial helmets);
- Braces that stabilize an injured body part, including, but not limited to, necessary adjustments to shoes to accommodate braces.

Braces that straighten or change the shape of a body part are excluded from coverage.

Dental braces are also excluded from coverage; and equipment for the treatment of chronic or acute respiratory failure or conditions.

Note: Procedures related to covered bone anchored hearing aids are also covered by the Plan under *Hospital - Inpatient Stay* or *Surgery - Outpatient* in this section.

Benefits under this section are provided only for external prosthetic and orthotic devices and do not include any device that is fully implanted into the body.

If more than one device can meet your functional needs, coverage must be provided for the most appropriate model of orthotic device that adequately meets the needs of the enrollee as determined by the enrollees treating physician, or podiatrist and prosthetist, or orthotist.

The device must be ordered or provided either by a Physician or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan may pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Replacements are covered when the prosthetic device is damaged beyond repair due to normal wear and tear, or when a
replacement prosthetic device is required due to the Member’s growth or other physical change or a change in the Member's
abilities or medical condition.

Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

Note: Prosthetic and Orthotic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

Please remember, you must obtain Prior Approval from Decent Inc. before obtaining any prosthetic device that exceeds $1,000 in cost per device. If Approval from Decent Inc. is not obtained, you will be responsible for paying all charges and no Benefits will be paid.

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part, not primarily changing or improving

physical appearance of a healthy organ or body part. Reconstructive procedures include surgery or other procedures that are associated with an Injury, Sickness or Congenital Anomaly.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. This plan provides coverage for inpatient care 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 member's attending physician determine that a shorter period of inpatient care is appropriate.

Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. Other services required by the Women's Health and Cancer Rights Act of 1998, including, but not limited to, breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service.

When the purpose of a procedure is to improve the appearance of a healthy body part, it is a Cosmetic Procedure and it is excluded from coverage under the Plan. For Members age 19 and over, procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 13, *Glossary*.

The fact that a Member may suffer negative psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery to address the condition (or other procedures done to relieve such consequences or behavior) as a covered reconstructive procedure.

For Members under the age of 19, reconstructive procedures that improve the function of, or attempt to create a normal appearance of, an abnormal structure caused by a Congenital Anomaly, development deformity, trauma, tumor, infection or disease are not considered Cosmetic Procedures and are Covered Health Services under the Plan.

For scheduled admissions for Reconstructive Procedures, you must obtain Prior Approval from Decent Inc. before you are admitted. If Approval from Decent Inc. is not obtained, Benefits will be subject to Out of Network Benefits

For a non-scheduled Reconstructive Procedure, please remember that you or your representative must notify Decent Inc. within 48 hours after you are admitted to a Non- Network Hospital. If Decent Inc. is not notified, Benefits for the Inpatient Hospital Stay will be subject to Out of Network Benefits and Benefits will be paid at the Non-Network level.

Scopic Procedures

Outpatient Diagnostic and Therapeutic

The Plan pays Benefits for diagnostic and therapeutic scopic procedures and related services received on an Outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are minimally invasive medical examinations that enable visualization, performance of biopsies and polyp removal. Examples of diagnostic scopic procedures include, but are not limited to, colonoscopy, sigmoidoscopy, and endoscopy. Therapeutic scopic procedures are usually surgical in nature. Examples of therapeutic scopic procedures include, but are not limited to, bronchoscopy and esophagoscopy.

Benefits under this section include, but are not limited to:

- The Facility charge and the charge for supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include, but are not limited to, arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

The Plan pays Benefits for Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits include, but are not limited to:

- Non-Physician services and supplies received during the Inpatient Stay;
- Room and board in a Semi-private Room; and
- Physician services for radiologists, anesthesiologists and pathologists.

Note: The Plan will pay the difference in cost between a Semi-private Room and a private room only when a Semi-private Room is not available or if a private room is Medically Necessary according to generally accepted medical practice.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under Physician Fees for Surgical and Medical Services.

The Plan will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if:

- The initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost-Effective alternative to an Inpatient Stay in a Hospital; and
- The Skilled Care services to be provided are not primarily Custodial Care.
- Skilled Care will be covered up to 100 days per year.

You are expected to improve to a predictable level of recovery. Your Provider will be required to submit a treatment plan that outlines goal-directed rehabilitation services. Benefits can be denied or shortened for Members who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 13, *Glossary*.

For scheduled admissions, please remember, you must obtain Prior Approval from Decent Inc. before you are admitted. If Approval from Decent Inc. is not obtained, you will be responsible for paying all charges and no Benefits will be paid.

For Emergency admissions (also termed non-scheduled admissions) please remember that you or your representative must notify Decent Inc. within 48 hours after you are admitted to a Non-Network Facility as a result of an Emergency. If Decent Inc. is not notified, you will be responsible for paying all charges and no Benefits will be paid.

Substance Use Disorder Services

The Plan pays Benefits for Substance Use Disorder Services (also known as substance-related and addictive disorders services) received on an Inpatient or Outpatient basis in a Hospital, an Alternate Facility or in a Provider's office.

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

- Diagnostic evaluations and assessment;
- Treatment planning;
- Treatment and/or procedures;
- Referral services;
- Medication management;
- Individual, family, therapeutic group and provider-based case management services;
- Crisis intervention;
- Detoxification (sub-acute/non-medical);
- Services at a residential treatment facility;
- Partial hospitalization/day treatment; and
- Intensive outpatient treatment.

The Decent, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

Note: The Plan will pay the difference in cost between a Semi-private Room and a private room only when a Semi-private Room is not available or if a private room is Medically Necessary according to generally accepted medical practice.

You are encouraged to contact the Decent for Referrals to Providers and coordination of care. Inpatient Substance Use Disorder Services must be authorized and overseen by the Decent or PCP.

Surgery - Outpatient

The Plan provides Benefits for surgery and related services received on an Outpatient basis at a Hospital or Alternate Facility or in a Physician's office. Decent has a high quality and efficient network of providers. You must use an in-network provider. Please visit www.decent.com for a listing of providers available in your area.

Covered Health Services under this section include, but are not limited to:

- Surgery and related services;
- The facility charge and the charge for supplies and equipment;
- Certain surgical scopic procedures (examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy); and
- Physician services for radiologists, anesthesiologists and pathologists.

Examples of surgical procedures performed in a Physician's office include, but are not limited to, mole removal and ear wax removal.

Temporomandibular Joint (TMJ) Services and Orthognathic Surgery

The Plan pays Benefits for diagnostic and surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes, but is not limited to, necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect, or pathology.

Covered diagnostic treatment includes, but is not limited to, examination, radiographs and applicable imaging studies and consultation.

Benefits are provided for surgical treatment if:

- There is clearly demonstrated radiographic evidence of significant joint abnormality;
- Non-surgical treatment has failed to adequately resolve the symptoms; and

- Pain or dysfunction is moderate or severe.

Benefits for surgical services include, but are not limited to, arthroscopy, arthroplasty, arthrotomy and open or closed reduction of dislocations. Benefits also include oral surgery to reduce a dislocation of, excisions of and injection of the temporomandibular joint.

The Plan also provides Benefits for orthognathic surgery.

Benefits for an Inpatient Stay in a Hospital and Hospital-based Physician services are described in this section under *Hospital – Inpatient Stay* and *Physician Fees for Surgical and Medical Services*, respectively.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an Outpatient basis at a Hospital or Alternate Facility, including, but not limited to, dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an Outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered health care professionals when:

- Education is required for a disease in which patient self-management is an important component of therapeutic treatment; and
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered health services under this section include, but are not limited to:

- The facility charge and the charge for related supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other physician services are described in this section under *physician fees for surgical and medical services*.

Benefits are paid described under *Physician's Office Services* when these services are performed in a Physician's office.

Please remember, to receive Non-Network Benefits you must obtain Prior Approval from Decent Inc. for all outpatient therapeutic treatments before scheduled services are received or, for non-scheduled services, within 48 hours or as soon as is reasonably possible. If Approval from Decent Inc. is not obtained, you will be responsible for paying all charges and no Benefits will be paid.

Transplant Services

The Plan pays Benefits for transplant services only if Inpatient Facility services (including, but not limited to, evaluation for transplant, organ procurement and donor searches) for transplant procedures are ordered by a Physician and approval by Decent. Benefits are available to the donor and the recipient when the recipient is covered under this Plan. If the recipient is not a Member in this Plan but the donor is a Member in this Plan, then the recipient's plan is the Primary Plan and this Plan is the Secondary Plan for the donor's expenses in all cases, regardless of coordination of benefits rules to the contrary. The transplant must meet the definition of a Covered Health Service and cannot be Experimental or Investigational, or Unproven. Examples of transplants for which Benefits are available include, but are not limited to:

- Heart;
- Heart/lung;
- Lung;
- Kidney;

- Kidney/pancreas;
- Liver;
- Liver/kidney;
- Liver/intestinal;
- Pancreas;
- Intestinal; and
- Bone marrow (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a covered health service.

Benefits are also available for corneal transplants. However, you are not required to obtain Prior Approval from Decent Inc. for a cornea transplant.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan or through the donor's coverage under this Plan with the recipient's plan being the Primary Plan and this Plan being the Secondary Plan.

The Plan has specific guidelines regarding Benefits for transplant services. Contact Decent, Inc. Www.decent.com or at (866) HEARTUS toll-free for information about these guidelines.

Urgent Care Center Services

The Plan provides Benefits for professional services received at an Urgent Care Center, as defined in Section 13, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury* earlier in this section. No PCP Referral is required to receive services at an Urgent Care Facility.

SUPPORT IN THE EVENT OF SERIOUS ILLNESS

If you or a covered family member has cancer or needs an organ or bone marrow transplant, Decent Inc. can put you in touch with quality treatment centers around the country.
Please call Decent Inc. at (866) HEARTUS toll-free.

Vision Examinations

The Plan pays Benefits for: vision screenings, which could be performed as part of an annual physical examination in a Provider's office (vision screenings do not include refractive examinations to detect vision impairment);

SECTION 7 - EXCLUSIONS

WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:

- **Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6, *Details for Covered Health Services.***

When Benefits are limited within any of the Covered Health Services categories described in Section 6, *Details for Covered Health Services*, those limits are reflected in the corresponding Covered Health Service category in Section 5, *Schedule of Benefits and Coverage*. Additional limits may apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 5, *Schedule of Benefits and Coverage*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed the Benefit limits.

Please note that in listing services or examples, when the MPD says "this includes," or "including, but not limited to," it is not the Plan's intent to limit the items to that specific list. When the Plan does intend to limit a list of services or examples, the MPD specifically states that the list is limited to or covers only the specific items listed.

The Plan does not pay Benefits for the excluded services, treatments or supplies even if they are recommended or prescribed by a Provider, are the only available treatment for your condition or are determined by the Plan to be Medically Necessary. You are solely responsible for payment of charges for all services and supplies excluded by the Plan and described in this section.

The following services, treatments and supplies are excluded from coverage under the Plan:

Alternative Treatments

- Acupressure.
- Acupuncture.
- Aromatherapy.
- Hypnotism.
- Massage therapy except as described under *rehabilitation services - outpatient therapy* in section 6, *details for covered health services*.
- Rolfing (holistic tissue massage).
- Art therapy, music therapy, dance therapy, horseback therapy, wilderness experience therapy and other forms of alternative treatment as defined by the national center for complementary and alternative medicine (nccam) of the national institutes of health. This exclusion does not apply to chiropractic treatment and non-manipulative osteopathic care for which benefits are provided as described in section 6, *details for covered health services.*

Dental

Dental care, including, but not limited to, endodontics, periodontal surgery and restorative treatment, except as identified under *Dental Services* in Section 6, *Details for Covered Health Services.*

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. An example of what is not covered is treatment of dental caries resulting from dry mouth due to radiation treatment or medication.

- Diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include, but are not limited to:
- Extractions (including, but not limited to, wisdom teeth);
- Restoration and replacement of teeth;
- Medical or surgical treatments of dental conditions; and
- Services to improve dental clinical outcomes.

This exclusion does not apply to dental services for which Benefits are provided as described under *Dental Services* in Section 6, *Details for Covered Health Services*.

- Dental implants, bone grafts, and other implant-related procedures.
- This exclusion does not apply to dental services for which benefits are provided as described under *dental services* in section 6, *details for covered health services*.
- Dental braces (orthodontics).
- Dental x-rays, supplies and appliances and all associated expenses, including, but not limited to, hospitalizations and anesthesia.
- This exclusion does not apply to:
    - Dental care (oral examination, x-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition; or
    - Hospitalization and anesthesia for certain members who cannot undergo local
    - Anesthesia
    - For which benefits are available under the plan, as described in section 6, *details for covered health services*.

- Treatment of malpositioned or supernumerary (extra) teeth, even if part of a congenital anomaly.

Devices, Appliances and Prosthetics

- Devices used specifically as safety items or to affect performance in sports-related activities.
- orthotic appliances and devices that straighten or re-shape a body part, except as described under *Durable Medical Equipment (DME)* in Section 6, *Details for Covered Health Services*:

Examples of excluded orthotic appliances and devices include, but are not limited to, foot orthotics or any orthotic braces available over-the-counter. This exclusion does not include podiatric appliances for the prevention of complications associated with diabetes as described under *Diabetes Services* in Section 6, *Details for Covered Health Services*.

The following items are excluded, even if prescribed by a Physician:

- Blood pressure cuff/monitor;
- Enuresis alarm;
- Non-wearable external defibrillator;
- Trusses; and
- Ultrasonic nebulizers.
- The repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect.
- The replacement of lost or stolen prosthetic devices.
- Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which benefits are provided as described under *durable medical equipment* in section 6, *details for covered health services*.
- Oral appliances for snoring.

Drugs

Outpatient prescription medications are covered under the Lonestar Prescription Drug Program administered by Costco. Medical Plan does not cover pharmacy - Your Pharmacy claims will be administered by Costco on your behalf.

- Prescription drugs for Outpatient use that are filled by a prescription order or refill or
- self-injectable medications, except as described under *Pharmaceutical Products* in Section 6, *Details for Covered Health Services*.
- growth hormone therapy that is not Medically Necessary.
- non-injectable medications given in a Physician's office except as required in an Emergency and consumed in the Physician's office.
- over-the-counter drugs and treatments and, prescription medications with over the counter equivalents

(This exclusion does not apply to medications which, due to their characteristics, as determined by the Plan, must typically be administered or directly supervised by a qualified Provider or licensed/certified health professional in an Outpatient setting). ***Note:*** Insulin is an Outpatient prescription medication covered under the Lonestar Prescription Drug Program administered by Costco.

Educational Services

Services that are Educational in nature, as defined in Section 13, *Glossary*.

This exclusion does not apply to Diabetes Self-Management Training Programs for which Benefits are provided as described under *Diabetes Services* in Section 6, *Details for Covered Health Services*.

Experimental or Investigational or Unproven Services

Experimental or Investigational Services or Unproven Services, as described in Section 13, *Glossary*.

This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.

This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Details for Covered Health Services*.

Foot Care

- Routine foot care services that include, but are not limited to:
- Cutting or removal of corns and calluses;
- Nail trimming or cutting; and
- Debriding (removal of dead skin or underlying tissue).

This exclusion does not apply to foot care for severe systemic disease or preventive foot care for Members with diabetes for which Benefits are provided as described under *Diabetes Services* in Section 6, *Details for Covered Health Services*.

- Hygienic and preventive maintenance foot care, except for Members who are at risk of neurological or vascular disease arising from diseases such as diabetes. Examples include, but are not limited to:
- Cleaning and soaking the feet; and
- Applying skin creams in order to maintain skin tone; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot.
- Treatment of flat feet.
- Treatment of subluxation of the foot.
- Arch supports.
- Shoe inserts, shoes (standard or custom), lifts and wedges and shoe orthotics.

This exclusion does not include podiatric appliances for the prevention of complications associated with diabetes as described under *Diabetes Services* in Section 6, *Details for Covered Health Services.*

Medical Supplies and Equipment

- Prescribed or non-prescribed medical and disposable supplies. Examples of excluded supplies include, but are not limited to, compression stockings, ace bandages and wound care or dressing supplies purchased over the counter.

This exclusion does not apply to:

- Ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 6,
  Details for Covered Health Services;
- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Details for Covered Health Services*;
- Urinary catheters;
- Wound care or dressing supplies given by a Provider during treatment for Covered Health Services;
- Medical-grade compression stockings when considered Medically Necessary. The
- Stockings must be prescribed by a Physician, individually measured and fitted to the patient; and
- Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 6, *Details for Covered Health Services*.
- Batteries, tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment.
- The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect.
- The replacement of lost or stolen Durable Medical Equipment.

Mental Health/Substance Use Disorder Services

In addition to all other exclusions listed in this Section 7, *Exclusions*, the exclusions listed directly below apply to services described under *Mental Health Services*, *Neurobiological Disorders - Autism Spectrum Disorder Services*, *Serious Mental Illness Services* and/or *Substance Use Disorder Services* in Section 6, *Details for Covered Health Services*.

- Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless tied to an appropriate behavioral health diagnosis in the ICD-10.
- Health services or supplies that do not meet the definition of a Covered Health Service - see the definition in Section 13, *Glossary*.
- Mental Health Services as treatments for R-, T- and Z-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
- Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep- wake disorders, sexual dysfunction disorders, feeding disorders, communication disorders, motor disorders, binge eating disorders, neurological disorders and other disorders with known physical bases.
- Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorders.
- Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.
- Treatment for intellectual disability as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
- Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- Methadone treatment, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction. ***Note:*** These may be covered under the Lonestar Prescription Drug Program administered by Costco. For more information on covered prescription medications for the Lonestar Prescription Drug Program through Costco.
- Gambling disorders.
- Substance-induced sexual dysfunction disorders and substance-induced sleep disorders.
- Services, supplies and related expenses that the Plan determines to be Educational in nature, unless expressly covered under the Plan.
- Any treatments or other specialized services designed for Autism Spectrum Disorder that are not supported by credible research demonstrating that the treatments or services have a measurable and beneficial health outcome and therefore are considered to be Educational in nature, or to be Experimental or Investigational or Unproven Services.
- Services for any family, marital or other relational disorder or condition, except in the case of Marriage and Family Therapy/Counseling, as defined in Section 13, *Glossary,* as required under a Member's Physician-directed treatment plan for a specific disease or condition.
- Self-treatment by a provider as a part of their training; treatment by an individual or facility outside the scope of licensed or otherwise authorized scope of practice.
- Medical Social Services provided as mental health or substance-related and addictive disorder treatment. This exclusion does not apply to Medical Social Services provided as part of Physician-ordered treatment provided for home health care, Hospice care or Private Duty Nursing or provided while you are confined in a Skilled Nursing or Inpatient Rehabilitation Facility.
- Vocational counseling.

Nutrition

- Nutritional or cosmetic therapy using high doses or mega quantities of vitamins, minerals or elements, and other nutrition-based therapy.
- Nutritional counseling for either individuals or groups, except as identified under *diabetes services*, under *Developmental delay services* and under *nutritional counseling* in section 6, *details for covered health services*.
- Enteral formulas and other nutritional and electrolyte formulas, including, but not limited to, infant formula and donor breast milk (infant formula available over-the-counter is always excluded) and home infusion therapy for over-the-counter fluids that do not require a prescription, including, but not limited to, standard nutritional formulations used for enteral nutrition therapy.
- Motility of the gastrointestinal tract.
- Food of any kind. Examples include, but are not limited to:
    - High-protein, low-protein or low-carbohydrate foods;

- Foods to control weight, treat obesity (including, but not limited to, liquid diets), lower cholesterol or control diabetes;
- Oral vitamins and minerals;
- Meals you can order from a menu, for an additional charge, during an inpatient stay; and
- Other dietary, nutritional and electrolyte supplements.

- Health education classes unless offered by decent inc. Or its affiliates, including, but not limited to, asthma, smoking cessation, and weight control classes.

This exclusion does not apply to:

- Enteral feedings or other nutritional formulas that are the only source or the majority of nutrition or that are specifically created to treat inborn errors of metabolism or heritable diseases such as phenylketonuria (PKU);
- Medically Necessary Physician ordered and medically necessary amino acid-based elemental formulas, regardless of the formula delivery method, that are used for the diagnosis and treatment of:
  (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 absorptive surface, functional length, and motility of the gastrointestinal tract.
- Any medically necessary services associated with the administration of the formula
- Severe food protein-induced enterocolitis syndrome;
- Eosinophilic disorders, as evidenced by a biopsy; or
- Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

Personal Care, Comfort or Convenience

Inclusive of but not limited to:

- Television.
- Telephone.
- Beauty/barber service.
- Guest service.
- Health club membership and programs.
- Breast pumps except as benefits are provided under the federal health resources and services administration (hrsa) requirement as described under *preventive care services* in section 6, *details for covered health services.*
- Rental of breast pumps is always excluded.
- Air conditioners;
- Air purifiers and filters;
- Batteries and battery chargers, except as described under *hearing aids, treatment of diabetes,* and under *durable medical equipment* in section 6, *details for covered health services*
- Dehumidifiers and humidifiers;
- Ergonomically correct chairs;
- Non-hospital beds, comfort beds, motorized beds and mattresses;
- Car seats;
- Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners;
- Exercise equipment and treadmills;
- Hot tubs, jacuzzis, saunas and whirlpools;
- Medical alert systems;
- Music devices;
- Personal computers;
- Pillows;
- Power-operated vehicles;
- Radios;
- Strollers;
- Safety equipment;

- Vehicle modifications such as van lifts;
- Video players;
- Home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides); and
- Personal hygiene protection (for example, adult diapers).

Physical Appearance

- Cosmetic Procedures, as defined in Section 13, *Glossary*, are excluded from coverage. Examples include, but are not limited to:
    - Scar removal or revision procedures;
    - Breast enhancement procedures; and
    - Removal or replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure.
- Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, spa treatments, and diversion or general motivational programs
- Weight loss programs whether or not they are under medical supervision or determined to be Medically Necessary, even if for morbid obesity.
- Wigs regardless of the reason for the hair loss.
- Treatment of benign gynecomastia.

Procedures and Treatments

- Biofeedback. Except in the case where a member has an acquired brain injury diagnosis. Biofeedback falls within the definition of "neurofeedback therapy" and coverage is required, however, a member must receive authorization for biofeedback, or coverage for the procedure will be denied.
- Tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
- Hair removal or treatments for hair loss by any means.
- Procedures and treatments for skin wrinkles or any procedure or treatment to improve the appearance of the skin, including, but not limited to, face lifts
- Treatment for spider veins.
- Skin abrasion procedures performed as a treatment for acne.
- Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea and approved by pcp.
- Rehabilitation services and chiropractic treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including, but not limited to, routine, long-term or maintenance/preventive treatment.
- Speech therapy, except as described under *developmental delay services* or under *rehabilitation services – Outpatient therapy* in section 6, *details for covered health services*.
- A procedure or surgery to remove fatty tissue and/or hanging skin on any part of the body including, but not limited to, panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy, even if hanging skin is due to weight loss or to bariatric surgery.
- Psychosurgery (lobotomy).
- Stand-alone multi-disciplinary smoking cessation programs. These programs usually include services by health care providers specializing in smoking cessation, such as a psychologist or social worker, and also usually include intensive psychological support, behavior modification techniques and medications to control cravings.
- Chelation therapy, except to treat heavy metal poisoning.
- Services provided by a chiropractor to treat a condition unrelated to an identifiable neuromusculoskeletal condition, such as asthma or allergies, or services that do not meet the definition of chiropractic treatment shown in section 13, *glossary*.
- Therapy treatments or procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
- Gender reassignment surgery and related services.
- Non-surgical bariatric treatment, even if for morbid obesity.
- Bariatric surgery

- Oral appliances and devices used to treat tmj pain disorders or dysfunction of the joint, jaw, jaw muscles and nerves.
- The following services for the diagnosis and treatment of tmj outside of the covered services definition as outlined in detail in the *covered services section above.*
- Health care services performed at a diagnostic facility (hospital or alternate facility) without a written order from a provider.
- Health care services which are self-directed to a free-standing or hospital-based imaging facility
- Health care services performed at a diagnostic facility (hospital or alternate facility), when ordered by a provider affiliated with the diagnostic facility and when that provider is not actively involved in your medical care either prior to ordering the service or after the service is received. This exclusion does not apply to mammography testing or bone density screening.
- Breast reduction surgery that is determined to be a cosmetic procedure. *(this exclusion does not apply to breast reduction surgery that the plan determines is for the treatment of a physiologic functional impairment or is coverage required by the women's health and cancer rights act of 1998 for which benefits are described under reconstructive procedures in section 6, details for covered health services.)*

Providers

- Health care services performed by a Provider who is your family member by birth or marriage, including, but not limited to, your spouse, brother, sister, parent or child.
- Health care services that a Provider performs on himself or herself.
- Health care services performed by a Provider who has your same legal residence.
- Health care services performed by an unlicensed Provider or a Provider who is providing health care services outside of the scope of his/her license.

Reproduction/Infertility

- Health services and associated expenses for infertility treatments, including, but not limited to, artificial insemination, intra-fallopian transfer or other assisted reproductive technology, regardless of the reason for the treatment. Also excluded are any services or supplies used in any procedure in preparation for or performed as a direct result of and immediately after any of the excluded procedures.

This exclusion does not apply to services required to treat or correct underlying causes of infertility.

Note: If a Pregnancy results from excluded infertility treatment, Pregnancy and newborn services will be covered as described under *Pregnancy - Maternity* Services in Section 5, *Schedule of Benefits and Coverage* and Section 6, *Details for Covered Health Services*.

- Storage and retrieval of all reproductive materials (examples include, but are not limited to, eggs, sperm, testicular tissue and ovarian tissue).
- In vitro fertilization regardless of the reason for treatment. Also excluded are any services or supplies used in any procedure in preparation for or performed as a direct result of and immediately after in vitro fertilization
- Surrogate parenting, donor eggs, donor sperm and host uterus.
- The reversal of voluntary sterilization.
- Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes.
- Selective reduction surgery for multiple gestations.
- Services provided by a labor aide (doula).
- Parenting, pre-natal or birthing classes. (this exclusion does not apply to breastfeeding counseling as mandated by the affordable care act.)

Services Provided under Another Plan

Services for which coverage is available:

- Under another plan, except for Eligible Expenses payable as described in Section 9, *Coordination of Benefits (COB)*.
- Under workers' compensation

- Through automobile coverage or similar plan if applicable to an injury sustained in an auto accident or is covered by other persons liability insurance. Additionally, this plan cannot subrogate against its own insured for a claim arising from the very same risk for which the insured is covered.
- While on active military duty.
- For treatment of military service-related disabilities when you are legally entitled to other coverage, and Facilities are reasonably accessible, as determined by the Plan.

Transplants

- Health services for organ and tissue transplants, except as identified under *Transplant Services* in Section 6*, Details for Covered Health Services*, unless the Plan determines the transplant to be appropriate according to the Plan's transplant guidelines.
- Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (for example, a device that supports the heart while the patient waits for a suitable donor heart to become available).

Types of Care

- Custodial Care as defined in Section 13, *Glossary*, or maintenance care.
- Domiciliary Care, as defined in Section 13, *Glossary.*
- Multidisciplinary pain management programs provided on an Inpatient basis for acute pain or for exacerbation of chronic pain.
- Private Duty Nursing received on an Inpatient basis.
- Home health care, Hospice care, Outpatient Private Duty Nursing services or care received in a Skilled Nursing Facility or Inpatient Rehabilitation Facility, the following:
    - services provided for the convenience of the Member or Member's family, such as assistance with bathing, feeding, mobilizing, exercising or homemaking;
    - services as a "sitter" or companion; and
    - general supervision of exercises taught to the Member including, but not limited to, the Association carrying out of a maintenance program.
- Home health care, Hospice care or Outpatient Private Duty Nursing services, the following:
    - administration of oral medication;
    - periodic turning and positioning in bed;
    - food or home-delivered meals;
    - social casework or homemaker services; and
    - transportation services.
- Respite care (Skilled Care or unskilled care to provide relief for a permanent caregiver), unless provided as part of an integrated Hospice care program of services provided by a licensed Hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 6, *Details for Covered Health Services*.
- Rest cures.
- Services of personal care attendants.
- Work hardening programs (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

- Routine eye exams
- Implantable lenses used only to correct a refractive error.
- Contact lens exams; purchase cost and associated fitting charges for eyeglasses or contact lenses. This exclusion does not apply to contact lenses when prescribed to treat a sickness or injury of the cornea.
- Dispensing fees for hearing aids unless
    - You are under 18. This plan provides coverage for the full cost of a medically necessary hearing aid or cochlear implant and related services and supplies for a covered individual who is 18 years of age or younger
- Repairs to a hearing aid, even if the hearing aid purchase was a covered health service under the plan.
- Bone anchored hearing aids except when either of the following applies:

- For members with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- For members with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid, as documented by a physician.

- The plan will not pay for more than one bone anchored hearing aid per member who meets the above coverage criteria during the entire period of time the member is enrolled in this plan. In addition, repairs and/or replacement for a bone anchored hearing aid for members who meet the above coverage are not covered, other than for malfunctions unless otherwise explicitly stated in this agreement.
- Eye exercise or vision therapy, except any of the following therapies when ordered by a physician to treat the specific related condition:
- Occlusion therapy for amblyopia;
- Prism adaptation therapy for esotropia; or,
- Orthoptic or vision therapy for convergence insufficiency.
- Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

The plan allows for replacement of hearing aids every three years.

All Other Exclusions

- Autopsies and other coroner services and transportation services for a corpse
- Charges for:
  - Missed appointments;
  - Room or facility reservations;
  - Completion of claim forms; and
  - Record processing.
- Charges prohibited by federal anti-kickback or self-referral statutes.
- Diagnostic tests that are:
  - Delivered anything than a physician's office or health care facility; or
  - Self-administered home diagnostic tests, including but not limited to, hiv and pregnancy tests.
  - Not medically necessary
- Expenses for health services and supplies:
  - That would otherwise be considered covered health services and are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to members who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone;
  - That are received after the date your coverage under this plan ends, including health services for medical conditions that began before the date your coverage under the plan ends;
  - For which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this plan;
  - That exceed eligible expenses or any specified limitation in this mpd; or
  - For which a non-network provider waives the copay or coinsurance amounts.
- Foreign language and sign language services.
- Storage of blood, umbilical cord or other biological material. Examples include, but are not limited to, cryopreservation of tissue, blood and blood products.
- Health services and supplies that do not meet the definition of a covered health service as shown in section 13, *Glossary*.
- Health services related to a non-covered health service: when a service is not a covered health service, all services related to that non-covered health service are also excluded. This exclusion does apply to services the plan would otherwise determine to be covered health services if they are to treat complications that arise from the non-covered health service even if the treatment of the complication is considered to be medically necessary,

prescribed by a physician or if the member has medical or psychological conditions that could be helped by the surgery, services, supplies, treatments, or procedures.

- For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a cosmetic procedure, that require hospitalization.
- Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:
    - Required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration;
    - Conducted for purposes of medical research. This exclusion does not apply to covered health services provided during a clinical trial for which benefits are provided as described under *clinical trials* in section 6, *details for covered health services*;
    - Related to judicial or administrative proceedings or orders; or required to obtain or maintain a license of any type.

SECTION 8 - CLAIMS PROCEDURES

What this section includes:

- **How Network and Non-Network claims work; and**
- **What you may do if your claim is denied, in whole or in part.**

Note: You may designate an Authorized Representative who has the authority to represent you in all matters concerning your claim or appeal of a claim determination. If you have an Authorized Representative, any references to “you” or “Member” in this Section 8 will refer to the Authorized Representative. See *Authorized Representative* below for details.

Network Benefits

In general, if you receive Covered Health Services from a Network Provider, Decent Inc. will pay the Physician or Facility directly. If a Network Provider bills you for any Covered Health Service other than your Copay or Coinsurance, please contact the Provider or call Decent Inc. at (866) HEARTUS toll free for assistance.

Keep in mind, you are responsible for paying any Copay or Coinsurance owed to a Network Provider at the time of service, or when you receive a bill from the Provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a Non-Network Provider, you (or the Provider if they prefer) must send the bill to Decent Inc. for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and emailed to Decent Inc. at the following address:

Claims@Decent.com

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.decent.com** **or** calling Decent Inc. at (866) HEARTUS toll free or contacting your Benefits Coordinator. If you do not have a claim form, simply attach a brief letter of explanation to the bill and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- Your name and address;
- The member’s name, age and relationship to the subscriber;
- The id number as shown on your Lonestar medical id card;
- The name, address and tax identification number of the provider of the service(s);
- A diagnosis from the physician;
- The date of service;

- An itemized bill from the provider that includes:
- The current procedural terminology (cpt) codes;
- A description of, and the charge for, each service;
- The date the sickness or injury began; and
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other insurer(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

Intentionally false statements of material fact may result in adverse action against you, including, but not limited to, termination of your health coverage and expulsion from the Association.

The above information should be filed with Decent Inc. at the following email address:

Claims@Decent.com

Claim Payment and Assignment

After Decent Inc. has processed your claim, you will receive payment for Benefits that the Plan allows. If you have used a Non-Network Provider, it is your responsibility to pay the Non- Network Provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

Decent Inc. will pay Benefits to you unless:

- The Provider notifies Decent Inc. That you have provided signed Approval to assign Benefits directly to that Provider; or
- You make a written request for the Non-Network Provider to be paid directly at the time you submit your claim.

Decent Inc. will only pay Benefits to you or, with written Approval by you, to your Provider, and not to a third party, even if your Provider has assigned Benefits to that party.

Health Statements

Decent Inc. will provide you with an online Health Statement for your review at www.decent.com. Health Statements make it
easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

You may request that Decent Inc. send you a paper copy of a Health Statement by calling (866) HEARTUS toll free. See Section 13, *Glossary*, for the definition of Health Statement.

Explanation of Benefits (EOB)

Decent Inc. will create an Explanation of Benefits (EOB) after processing each of your medical claims submitted. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. You can locate the EOB at www.decent.com See Section 13, *Glossary*, for the definition of Explanation of Benefits.

You may request that Decent Inc. send you a paper copy of an EOB by calling (866) HEARTUS toll free. See Section 13,
Glossary, for the definition of Health Statement

IMPORTANT - TIMELY FILING OF NON-NETWORK CLAIMS

All claim forms for Non-Network services must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by Decent Inc. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call Decent Inc. at (866) HEARTUS toll free before requesting a formal appeal. If Decent Inc. cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied Pre-Service Request for Benefits, concurrent claim, or Post- Service Claim, or appeal a rescission of coverage - you or your Authorized Representative must submit your appeal as described below in writing within 90 days of receiving the adverse Benefit determination. This communication should include:

- The Member's name and ID number as shown on the Lonestar medical ID card;
- The Provider's name;
- The date of medical service;
- The reason you disagree with the denial; and
- Any documentation or other written information to support your appeal.

You or your Authorized Representative may send a written appeal to: Appeals@Decent.com

You do not need to submit appeals of Urgent Care Requests for Benefits in writing. For Urgent Care Requests for Benefits that have been denied, you or your Provider should call Decent Inc. at (866) HEARTUS toll free to request an appeal.

Types of claims

The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an Urgent Care Request for Benefits, Pre-Service Request for Benefits, concurrent care claim, Post-Service Claim, or rescission of coverage.

First Internal Appeal

Decent Inc. will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional with appropriate expertise who was not consulted during the initial Benefit determination process.

Once the review is complete, if Decent Inc. upholds the denial, you and your Provider will receive a written explanation of the reasons and facts relating to the denial and a description of the additional appeal procedures. If Decent Inc. overturns the denial, you and your Provider will receive notification of its decision and Benefits will be paid, as appropriate.

Notes:

- A denial of Benefits for medical services does not mean that you cannot receive the medical services. A denial of the Benefits simply means that the medical services are not covered under the Plan and no payments will be made to you or any Providers by the Plan if you receive the denied medical services, unless you win a subsequent appeal.
- If your Urgent Care Request for Benefits was denied, you may request an expedited external review at the same time that you request an expedited internal appeal to Decent Inc. Decent Inc. will review the request to determine if the appeal should go directly to the expedited external review instead of through the internal appeal process. If the request for appeal does not meet the expedited external appeal criteria

as determined by Decent Inc., the appeal will be handled as an expedited internal appeal to Decent Inc.

Second Internal Appeal to Decent Inc.

(of an Urgent Care Request for Benefits, a Pre-Service Request for Benefits, or a Concurrent Claim)

If you are not satisfied with the first internal appeal decision regarding an Urgent Care Request for Benefits, a Pre-Service Request for Benefits, or a concurrent claim, you have the right to request a second internal appeal from Decent Inc. You must file a written request for the second internal appeal within 60 days from your receipt of the first internal appeal determination notification.

If your non-urgent Pre-Service Request for Benefits is denied, you may file a second internal appeal to Decent Inc. If the denial is upheld at the second internal appeal level, Decent Inc. will notify you of the reasons for its decision and that your internal appeal options are exhausted. If the appeal involves issues of medical judgment, you may request an external review. If Decent Inc. overturns its decision at the second internal appeal level, Decent Inc. will notify you of its decision and Benefits will be paid, as appropriate.

Note: Upon written request and free of charge, Members may examine documents relevant to their claims and/or appeals and submit opinions and comments. Decent Inc. will review all claims in accordance with the rules established by the U.S. Department of Labor.

Second Internal Appeal to Decent (of a Post-Service Claim or a Rescission of Coverage)

If you are not satisfied with the first internal appeal decision regarding a Post-Service Claim or a rescission of coverage, you have the right to request a second internal appeal from Decent. You must file a written request for the second internal appeal within 60 days from your receipt of the first level appeal determination notification.

If Decent upholds the denial at the second internal appeal level, Decent will notify you of the reasons for its decision and that your internal appeal options are exhausted. If your appeal involves issues of medical judgment or a rescission of coverage, you may request an external review. If Decent overturns the denial, Decent Inc. will notify you and Benefits will be paid, as appropriate.

Decent does not review denials of Pre-Service Requests for Benefits, Urgent Care Requests for Benefits or concurrent claims.

Decent Inc. and Decent will complete reviews within legally applicable time periods; however, Decent Inc. and Decent have the right to an extension under certain circumstances.

Tables below describe the time frames which you and Decent Inc. are required to follow.

TABLE 5	
Urgent Care Request for Benefits[1]	
Action to Be Taken	Timing[2]
If your Request for Benefits is incomplete, Decent Inc. must notify you within:	24 hours or next business day
You must then provide the completed Request for Benefits to Decent Inc. within	48 hours after receiving notice of additional information required
Decent Inc. must notify you and your Provider of the benefit determination within:	72 hours
If Decent Inc. denies your Request for Benefits, you must appeal an adverse Benefit determination no later than:	90 days after receiving the adverse Benefit determination
Decent Inc. must notify you of the first internal appeal decision within:	72 hours after receiving the appeal

Pre-Service Request for Benefits	
Action to Be Taken	Timing[1]
If your Request for Benefits is filed improperly with Decent Inc., it must notify you within:	5 days
If your Request for Benefits is incomplete Decent Inc. must notify you within:	15 days
You must then provide completed Request for Benefits information to Decent Inc. within:	45 days
Decent Inc. must notify you of the Benefit determination:	
If your Request for Benefits is complete, within:	15 days
After receiving the completed Request for Benefits (if your Request for Benefits was incomplete as filed), within:	15 days
You must appeal an adverse Benefit determination no later than:	90 days after receiving the adverse Benefit determination
Decent Inc. must notify you of the first internal appeal decision within:	15 days after receiving the first internal appeal
You must appeal the denial of your first internal appeal (by filing a second internal appeal) no later than	60 days after receiving the first internal appeal decision
Decent Inc. must notify you of the second internal appeal decision within:	15 days after receiving the second internal appeal

[1]From Approval hen the request is made unless otherwise noted below.

[1]You do not need to submit Urgent Care appeals in Approval rating. You should call Decent Inc. as soon as possible to appeal an Urgent Care Request for Benefits.

[2]From Approval hen the request is made unless otherwise noted below.

TABLE 7	
Post-Service Claims	
Action to Be Taken	Timing[1]
If your claim is incomplete, Decent Inc. must notify you within:	30 days
You must then provide completed claim information to Decent Inc. within:	45 days
Decent Inc. must notify you of the Benefit determination:	
● if the claim was complete as filed, within:	30 days
● after receiving the completed claim (if the claim was incomplete as filed), within:	30 days

You must appeal an adverse Benefit determination no later than:	90 days after receiving the adverse Benefit determination
Decent Inc. must notify you of the first internal appeal decision no later than:	30 days after receiving the first internal appeal
You must appeal the denial of your first internal appeal (by filing a second internal appeal with Decent) no later than:	60 days after receiving the first internal appeal decision
Decent Inc. or Decent must notify you of the second internal appeal decision within:	30 days after receiving the second internal appeal

[1]From Approval hen the request is made unless otherwise noted below.

External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by Decent Inc. or if Decent Inc. fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an immediate external review of the determination made by Decent Inc. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of an adverse Benefit determination based upon any of the following:

- Clinical reasons (the determination involves a question of medical judgment);
- Rescission of coverage (coverage that was terminated retroactively); or
- As otherwise required by applicable law.

Note: You may also have the right to pursue external review in the event that Decent Inc. failed to comply with the internal claims and appeals process, except for those failures that are based on deminimis violations that do not cause, and are not likely to cause, prejudice or harm to you.

You or your Authorized Representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your Authorized Representative may request an expedited external review, in urgent situations as detailed below, by calling Decent Inc. at (866) HEARTUS toll free or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you receive Decent Inc.'s determination.

An external review request should include all of the following:

- A specific request for an external review;
- The member's name, address, and insurance id number;
- Your authorized representative's name and address, when applicable;
- The service that was denied, the date of service, the provider's name; and
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). There are two types of external reviews available:

- A standard external review; and
- An expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by Decent Inc. Of the request;
- A referral of the request by Decent Inc. To the IRO;
- The review by the IRO; and
- A decision by the IRO.

Within the applicable time frame after receipt of the request, Decent Inc. will complete a preliminary review to determine whether the Member for whom the request was submitted meets all of the following:

- Was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided;
- Has exhausted the applicable internal appeals process; and
- Has provided all the information and forms required so that Decent Inc. May process the request.

After Decent Inc. completes the preliminary review, Decent Inc. will issue you a notification in writing within five business days of receiving the request for the external review. If the request is eligible for external review, Decent Inc. will assign an IRO to conduct such review.

Decent Inc. will provide the assigned IRO with the documents and information considered in making Decent Inc.'s or Decent'
determination. The documents include:

- all relevant medical records;
- all other documents relied upon by Decent Inc. or Decent;
- all other information or evidence that you or your Provider submitted regarding the claim; and
- all other information or evidence that you or your Provider wish to submit regarding the claim, including, as explained below, any information or evidence you or your Provider wish to submit that was not previously provided.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date you receive notice from the IRO, any additional information that you want the IRO to consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days. In reaching a decision, the IRO will review the claim anew and will not be bound by any decisions or conclusions reached by Decent Inc. or Decent. The IRO will provide written notice of its
determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless the IRO requests additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and Decent Inc., and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision Reversing Decent Inc. determination, Decent Inc. will notify you within 48 hours of receiving the IRO's decision. The Plan will immediately provide coverage or payment of the Benefits at issue in accordance with the terms and conditions of the Plan. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure, and you will have exhausted your appeal rights.

All Final External Review Decisions by an IRO are final and binding on all parties and not subject to further appeal rights.
Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances, you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse Benefit determination of a claim or appeal if the adverse Benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the Member or would jeopardize the Member's ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- A final appeal decision, if the determination involves a medical condition where the time frame for completion of a standard external review would seriously jeopardize the life or health of the Member or would jeopardize the Member's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the Member received Emergency services, but has not been discharged from a Facility.
- Immediately upon receipt of the request, Decent Inc. Will determine whether the Member meets both of the following:

- Was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided; and
- Has provided all the information and forms required so that Decent Inc. May process the request.

After completing the review, Decent Inc. will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, Decent Inc. will assign an IRO in the same manner Decent Inc. utilizes to assign standard external reviews to IROs. Decent Inc. will provide all necessary documents and information considered in making the adverse Benefit determination or final adverse Benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by Decent Inc. The IRO will provide notice of the Final External Review Decision for an expedited external review as expeditiously as the Member's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the
request. If the IRO's notice of the Final External Review Decision is not in writing, within 48 hours of providing such notice, the assigned IRO will provide written confirmation of the decision to you and to Decent Inc.

All Final External Review Decisions by an IRO are final and binding on all parties and not subject to further appeal rights.

You may contact Decent Inc. at (866) HEARTUS toll free for more information regarding external review rights, or if making a verbal request for an expedited external review.

Table 8 below describes the time frames which you, Decent Inc. and the IRO are required to follow.

TABLE 8	
External Review	
Action to Be Taken	Timing[1]
You must submit a request for external review to Decent Inc. within:	Four months after the date you receive the second internal appeal determination
For an expedited external review, the IRO will provide notice of its determination within:	72 hours
For a standard external review, Decent Inc. will complete a preliminary review to ensure the request meets requirements for an external review within:	5 business days
You may submit in writing to the IRO any additional information that you want the IRO to consider within	10 business days
For a standard external review, the IRO will provide written notice of its determination within:	45 days[2] after receiving the request for the external review

[1]From Approval hen the request is made unless otherwise noted below.

[2]This time frame may be extended if the IRO requests additional time and you agree.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Request for Benefits as defined above, your request will be decided

within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. Decent Inc. will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Request for Benefits and decided according to the time frames described above. If an on- going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service time frames, whichever applies.

Authorized Representative

A Member may have one Authorized Representative, and only one Authorized Representative at a time, to assist in submitting a claim or appealing a claim.

An Authorized Representative shall have the authority to represent the Member in all matters concerning the Member's claim or appeal of a claim determination. If the Member has an Authorized Representative, any references to "you" or "Member" in this Section 8 will refer to the Authorized Representative.

One of the following persons may act as a Member's Authorized Representative:

- An individual designated by the Member in writing on a form approved by Decent Inc.;
- A health care Provider if the claim is an Urgent Care claim, or if the Member has designated the Provider in writing in a form approved by Decent Inc. However, a health care Provider may not be an Authorized Representative for the appeal of a claim;
- A person holding the Member's durable power of attorney;
- If the Member is legally incapacitated, a person appointed as guardian to have care and custody of the Member by a court of competent jurisdiction; or
- If the Member is a minor, the Member's parent or legal guardian, unless Decent Inc. Is notified that the Member's claim involves health care services where the consent of the Member's parent or legal guardian is or was not required by law then the Member shall represent himself or herself with respect to the claim.

The authority of an Authorized Representative shall continue for the period specified in the Member's appointment of the Authorized Representative or until the Member is legally competent to represent himself or herself and notifies Decent Inc. in writing that the Authorized Representative is no longer required.

Communication with Authorized Representative –

- If the Authorized Representative represents the Member because the Authorized Representative is the Member's parent or legal guardian or attorney in fact under a durable power of attorney, Decent Inc. shall send all correspondence, notices and benefit determinations in connection with the Member's Claim to the Authorized Representative.
- If the Authorized Representative represents the Member in connection with the submission of a Pre-Service Claim, including a claim involving Urgent Care, Decent Inc. shall send all correspondence, notices and benefit determinations in connection with the Member's claim to the Authorized Representative
- If the Authorized Representative represents the Member in connection with the submission of a Post-Service Claim, Decent Inc. will send all correspondence, notices and benefit determinations in connection with the Member's Claim to the Member, but Decent Inc. will provide copies of such correspondence to the Authorized Representative upon request
- It will take Decent Inc. at least 30 days to notify all of its personnel about the termination of the Member's Authorized Representative. It is possible that Decent Inc. may communicate information about the Member to the Authorized Representative during this 30-day period.

SECTION 9 - COORDINATION OF BENEFITS (COB)

What this section includes:

- **How your Benefits under this Plan coordinate with other medical plans;**
- **How coverage is affected if you become eligible for Medicare; and**
- **Procedures in the event the Plan overpays Benefits.**

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including, but not limited to, any one of the following:

- Another Association-sponsored health benefits plan;
- Another group insurance plan;
- A medical component of a group long-term care plan, such as skilled nursing care;
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an automobile insurance policy;
- Medical payment benefits under any premise's liability or other types of liability coverage; or
- Medicare or other governmental health benefit.

COB does not apply if your other health plan is a health insurance policy that is individually underwritten or issued.

If coverage is provided under two or more plans, COB determines which plan is Primary and which plan is Secondary. The plan considered Primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining Eligible Expenses may be paid under the other plan, which is considered Secondary. The Secondary Plan may determine its benefits based on the benefits paid by the Primary Plan.

DON'T FORGET TO UPDATE YOUR DEPENDENTS' MEDICAL COVERAGE INFORMATION

Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to www.decent.com or call (866) HEARTUS toll-free to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- A plan that covers a Member as a Member pays benefits before a plan that covers the Member as a dependent;
- The plan that has covered the individual claimant for the longest period will pay first; the expenses must be covered in part under at least one of the plans;
- The plan that covers an active Member pays before a plan covering a laid-off or retired Member;
- Your Dependent children will receive Primary coverage from the parent whose birth date occurs first in a Calendar Year. If both parents have the same birth date, the plan that that has been in effect the longest is the Primary Plan. This birthday rule applies only if:
- The parents are married or living together whether or not they have ever been married and not legally separated; or
- A court decree awards joint custody to the parents without specifying that one parent has
- The responsibility to provide health care coverage;
- If two or more plans cover a Dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
    - The parent with custody of the child; then
    - The spouse of the parent with custody of the child; then
    - The parent not having custody of the child; then
    - The spouse of the parent not having custody of the child;
- If you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will be the Primary Plan;
- If you are receiving COBRA continuation coverage under another Association plan, this Plan is the Primary Plan; and
- Finally, if none of the above rules determines which plan is Primary or Secondary, the allowable expenses (as defined below in the textbox titled *What is an allowable expense?*) Shall be shared equally between the plans meeting the definition of an eligible plan for COB purposes.

Under any of the circumstances above, this Plan will not pay more than it would have paid had it been the only plan in effect. The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

DETERMINING PRIMARY AND SECONDARY PLAN – EXAMPLES

Let's say you and your spouse both have family medical coverage through your respective Associations. You are unwell and go to see a Physician. Since you're covered as a Subscriber under this Plan, and as a Dependent under your spouse's plan, this Plan will pay Benefits for the Physician's office visit first. Again, let's say you and your spouse both have family medical coverage through your respective Associations. You take your Dependent child to see a Physician. This Plan will look at your birthday and your spouse's birthday to determine which plan pays first. If you were born on June 11 and your spouse was born on May 30, your spouse's plan will pay first.

TABLE 9

Subscriber is…	**…and has other coverage through:**	**…then Lonestar is:**
an Active Member	the Subscriber's second active employment	either Primary or Secondary depending on which plan is in force the longest
an Active Member	the Subscriber's retirement from another Association	the Primary Plan
a Retiree	the Subscriber's second active employment	the Secondary Plan
a Retiree	the Subscriber's retirement from another Association	either Primary or Secondary depending on which plan is in force the longest
an active Member of a non-Association Association	an Active Member	the Secondary Plan
an active Member of a non-Association Association	a Retiree	the Secondary Plan
a retiree of a non-Association Association	an Active Member	the Primary Plan
a retiree of a non-Association Association	a Retiree	the Secondary Plan

Table 9a summarizes common situations of dual coverage and whether Lonestar would be considered the Primary Plan or the Secondary Plan.

TABLE 9a

Subscriber is…	…and is covered as a dependent under another plan by:	…then Lonestar is:
an Active Member	spouse's Association plan	the Primary Plan
an Active Member	spouse's retiree plan	the Primary Plan
a Retiree	spouse's Association plan	the Primary Plan
a Retiree	spouse's retiree plan	the Primary Plan

When This Plan is Secondary

When this Plan is the Secondary Plan, the Plan determines the amount it will pay for a Covered Health Service according to the following:

- the Plan determines the amount it would have paid based on the allowable expense.
- the Plan pays the difference between the amount paid by the Primary Plan and this Plan's allowable expense.
- the Plan does not pay more than the amount the Plan would have paid had it been the only plan providing coverage.
- the maximum combined payments from all plans cannot exceed 100% of the total allowable expense.

Note: See the textbox below for the definition of allowable expense.

You may be responsible for any Copay, Coinsurance or Deductible payments as part of the COB payment.

Determining the Allowable Expense When This Plan is Secondary

If this Plan is Secondary and the health care services meet the definition of a Covered Health Service under this Plan, the allowable expense is the Primary Plan's network rate for those services. If the Primary Plan bases its reimbursement on reasonable and customary charges, the allowable expense is the Primary Plan's reasonable and customary charge. If both the Primary Plan and this Plan do not have a contracted rate, the allowable expense will be the greater of the two plans' reasonable and customary charges.

When the Provider is a Network Provider for both the Primary Plan and this Plan, the allowable expense is the Primary Plan's network rate. When the Provider is a network Provider for the Primary Plan and a Non-Network Provider for this Plan, the allowable expense is the Primary Plan's network rate. When the Provider is a Non-Network Provider for the Primary Plan and a Network Provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the Primary Plan. When the Provider is a Non-Network Provider for both the Primary Plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges.

WHAT IS AN ALLOWABLE EXPENSE?

For purposes of COB, an allowable expense is a health care expense that meets the definition of a Covered Health Service under this Plan.

When a Member Qualifies for Medicare

To the extent permitted by law, this Plan will pay Benefits as the Secondary Plan to Medicare when you become eligible for Medicare, even if you don't elect to have Medicare.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is Secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the Provider accepts Medicare. If the Provider does not accept Medicare, the Medicare limiting charge (the most a Provider can charge you if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total allowable expense.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount it should have paid.

If the Plan pays you more than it should under this COB section, you should pay the excess back promptly. Otherwise, Decent may recover the overpayment by offsetting the amount owed to Decent from future Benefits or by taking other legal action.

If the Plan overpays a health care Provider, the Plan may recover the excess amount from the Provider pursuant to *Refund of Overpayments*, below.

SECTION 10 - SUBROGATION AND REIMBURSEMENT

What this section includes:

- **How your Benefits are impacted if you suffer a Sickness or Injury caused by a third party.**

The Plan has a right to subrogation and reimbursement, as defined below.

Right of Recovery

The Plan has the right to recover Benefits it has paid on the Member's behalf that were:

- made in error;
- due to a mistake in fact;
- incorrectly paid by the Plan during the time period of meeting the Deductible for the Calendar Year; or
- incorrectly paid by the Plan during the time period of meeting any Out-of-Pocket Maximum for the Calendar Year.

Benefits paid because the Member misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for the Member that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested, or
- reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan incorrectly pays Benefits to you or your Dependent, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits by:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan; and
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

Right to Subrogation

The right to subrogation means the Plan is substituted to and shall succeed to any and all legal claims that the Member may be entitled to pursue against any third party for Benefits that the Plan has paid that are related to the Sickness or Injury for which a third party is or may be considered responsible. Subrogation applies when the Plan has paid to or on behalf of the Member Benefits for a Sickness or Injury for which a third party is or may be considered responsible, e.g. a third party's insurance carrier if the Member is involved in an auto accident with a third party.

To the maximum extent allowed by Texas law, the Plan shall be subrogated to, and shall succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for Benefits the Plan has paid to or on behalf of the Member relating to any Sickness or Injury for which any third party is or may be responsible.

Right to Reimbursement

The right to reimbursement means that if a third party is or may be responsible to pay for the Member's Sickness or Injury for which the Member receives a settlement, judgment, or other recovery from any third party, the Member must use those proceeds to return to the Plan, to the maximum extent allowed by Texas law, Benefits the Member received for that Sickness or Injury.

If a member is not represented by an attorney, the payors' share of a covered individual's recovery is an amount that is equal to the lesser of:
(1) one-half of the covered individual's gross recovery; or
(2) the total cost of benefits paid, provided, or assumed by the payor as a direct result of the tortious conduct of the third party.

If a member is represented by an attorney in obtaining a recovery. A recovery is an amount that is equal to the lesser of:

(1) one-half of the covered individual's gross recovery less attorney's fees and procurement costs as provided
(2) the total cost of benefits paid, provided, or assumed by the payor as a direct result of the tortious conduct of the third party less attorney's fees and procurement costs.

If the payor is represented by an attorney in recovering for a personal injury to a member shall pay to an attorney representing the member a fee as determined per agreement between the attorney and the payor plus a pro rata share of expenses incurred in connection with the recovery.

In the absence of an agreement, the court shall award to the attorney, payable out of the payor's share of the total gross recovery, a reasonable fee for recovery of the payor's share, not to exceed one-third of the payor's recovery.

If an attorney representing the payor's interest actively participates in obtaining a recovery, the court shall award and apportion between the covered individual's and the payor's attorneys a fee payable out of the payor's subrogation recovery. In apportioning the award, the court shall consider the benefit accruing to the payor as a result of each attorney's service.

The total attorney's fees may not exceed one-third of the payor's recovery.

A common law doctrine that requires an injured party to be made whole before a subrogee makes a recovery does not apply to the recovery of a payor under this section.

Third Parties

The following persons and entities are considered third parties:

- A person or entity alleged to have caused the Member to suffer a Sickness, Injury or medical damages, or who is legally responsible to pay for the Sickness, Injury or medical damages;
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or medical damages; or
- Any other persons or entities who are responsible for paying losses caused by the Member's Sickness or Injury when such payments are subject to subrogation under Texas law.

Subrogation and Reimbursement Provisions

As a Member, you agree to the following:

- Up to the maximum amount allowed by Texas law, the Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, to the extent allowed by law, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical Providers, including, but not limited to, Hospitals or Emergency treatment facilities, that assert a right to payment from funds you recover from an allegedly responsible third party.
- Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized and whether or not the third party disclaims liability. Payments include, but are not limited

to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, and no amount of associated costs, including, but not limited to, attorneys' fees and out-of-pocket expenses shall be deducted from the Plan's recovery without the Plan's express written consent, except as required by Texas law. No so-called equitable or common law, "Made-Whole Doctrine," "Fund Doctrine," or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat or limit this right

- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) arbitration, judgment or other monetary award, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule shall limit the Plan's subrogation and reimbursement rights that are allowed under Texas law.
- You will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including, but not limited to:
    - Complying with the terms of this section;
    - Providing any relevant information requested;
    - Signing and/or delivering such documents as the plan or its administering firm reasonably request to secure the subrogation and reimbursement claim;
    - Notifying the plan, in writing, of any potential legal claim(s) you may have against any and all third parties for acts which caused benefits to be paid or become payable;
    - Responding promptly to requests for information about any accident or injuries;
    - Appearing at medical examinations and legal proceedings, such as depositions or hearings; and
    - Obtaining the plan's consent or its administering firm's consent before releasing any party from liability

      Or payment of medical expenses.
- If you receive payment as part of a settlement or judgment from any third party as a result of a Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to it under Texas law, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you to the maximum extent allowed by Texas law.
- You may not accept any settlement that does not fully reimburse the Plan to the maximum extent allowed by Texas law, without its written approval.
- Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties to the extent of Benefits the Plan has paid for a Sickness or Injury allegedly caused by a third party or for which a third party is legally responsible to pay for your Sickness or Injury.
- The Plan's rights to recovery will not be reduced due to your own comparative negligence.
- The Plan may, at its option, take necessary and appropriate action to assert its rights under this section, including, but not limited to, filing suit in your name, which does not obligate it in any way to pay you part of any recovery the Plan might obtain.
- The provisions of this section also apply to the Member's spouse, parents, guardian, or other representative of a Dependent child or Dependent spouse who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- The Member's spouse and the Dependent's spouse are jointly and severally liable for the Plan's subrogation and

  Reimbursement rights herein;
- In case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- Your failure to cooperate with the Plan or its agents is considered a violation of the Plan. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any

Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan.

- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a Member.

- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- Subject to Decent oversight and control, the Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest allowed under Texas law unless the Plan provides written consent to the allocation.

EXAMPLE

Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. If you subsequently bring suit against the insurer of the person who caused the accident and receive a settlement, or receive payment from the insurer without bringing suit, the Plan is entitled to direct payment from you for the Benefits it paid.

Note: The subrogation rights and obligations under the Plan shall be governed by Texas law regardless of where the Member resides or whether the injury occurs in or outside the state of Texas

SECTION 11 - WHEN COVERAGE ENDS

What this section includes:

- **Circumstances that cause coverage to end;**
- **Extended coverage; and**
- **How to continue coverage after it ends.**

Your eligibility for Benefits automatically ends on the date that your coverage ends. When your coverage ends, the Plan will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after your coverage ended, even if the underlying medical condition occurred before your coverage ended, you are hospitalized, or are otherwise receiving medical treatment.

Circumstances that cause coverage to end

- Employer terminates coverage
- a contribution has not been paid as required by the terms of the plan;
- the employer has committed fraud or has intentionally misrepresented a material fact;
- the employer has not complied with the terms of the health benefit plan document;
- the health benefit plan is ceasing to offer any coverage in a geographic area; or
- there has been a failure to meet the terms of an applicable collective bargaining agreement or other agreement requiring or authorizing contributions to the health benefit plan, including a failure to renew the agreement or to employ employees covered by the agreement.
- member or dependent has committed fraud or intentional misrepresentation of a material fact by that person.

This plan may require an employer to meet minimum contribution or participation requirements as a condition of issuance and renewal of coverage in accordance with the terms of this plan document.

The TFA, may not cancel a health benefit plan except for a reason specified for refusal to renew above.
This plan may elect to refuse to renew all health benefit plans delivered or issued for delivery by the arrangement in this state. Decent shall notify:

(1) the commissioner not later than the 180th day before the date coverage under the first health benefit plan terminates; and

(2) each affected employer not later than the 180th day before the date on which coverage terminates for that employer.

(c) This Plan may elect to discontinue a health benefit plan only if the arrangement:

(1) provides notice to each employer of the discontinuation before the 90th day preceding the date of the discontinuation of the plan;

(2) offers to each employer the option to purchase coverage under another health benefit plan offered by the arrangement; and

(3) acts uniformly without regard to the claims experience of the employer or any health status related factor of participating employees or dependents or new employees or dependents who may become eligible for the coverage.

The minimum contribution and participation requirements are stated in the plan document in the section titled ***Eligibility for the Lonestar Plan*** and will be applied uniformly to each employer offered or issued coverage by the Texas Freelancer Association in Texas.

Your coverage under the Plan will end on the later of:

- the last day of the month that Decent Inc. receives written notice to end your coverage,
- the last day of the month of a future date specified in the notice;
- the last day of the month you retire, or

Coverage for your eligible Dependents will end on the earliest of:

- the date your coverage ends;
- the last day of the month your contributions were paid in full if you stop making the required contributions;
- the last day of the month that Decent Inc. receives written notice to end your coverage, or the date specified in the notice;
- the last day of the month your Dependents become ineligible as Dependents under this Plan; or

Extended Coverage

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches 26 years of age, the Plan will continue to cover the child, as long as the child is mentally or physically incapacitated to such an extent that he or she is dependent upon you for care or support. You must apply with Decent to continue benefits before the first day of the month following the child's 26th birthday. If an extension of coverage is temporarily approved, you must reapply with Decent for an additional
extension of coverage for the child before the prior temporary extension approval's expiration date.

If you have a disabled Dependent who was not covered at the time, they turned age 26, or if your Dependent becomes disabled after they turned age 26, you may apply for coverage for them during your next annual enrollment period or within the first 30 days from the date of your Dependent child's first medical treatment related to his or her disability. As a new Member, you may apply for coverage for a disabled Dependent age 26 and over during your initial enrollment period as a new Member. **Coverage for a Dependent child past age 26 is not guaranteed** and is subject to approval by Decent.

COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as defined in Section 13, *Glossary*. Much of the language in this section comes from the federal law that governs continuation coverage under COBRA. You should call Decent if you have questions about your right to continue coverage under COBRA.

In order to be eligible for continuation coverage under COBRA, you must meet the definition of a "Qualified Beneficiary." A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

- a Subscriber;
- a Subscriber's covered Dependent; or
- a Subscriber's covered spouse upon divorce.

Qualifying Events for Continuation Coverage under COBRA

Table 10 describes situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are qualifying events, for purposes of continuation of coverage under COBRA

TABLE 10

If Coverage Ends Because of the Following Qualifying Events:	You May Elect: COBRA for the following maximum periods:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your work hours are reduced[1]	18 months	18 months	18 months

Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your Dependent becomes eligible for Social Security disability benefits at any time within the first 60 days of losing coverage[2]	Up to 29 months	Up to 29 months	Up to 29 months
You die	N/A	36 months	36 months
You divorce	N/A	36 months	36 months [3]
Your child is no longer an eligible Dependent (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See Table 11	See Table 11

[2]Subject to the following conditions: (i) the Qualified Beneficiary must give Decent notice of the disability not later than the end of the first 18 months;
(ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members Approval ho are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided to Decent Approval within 30 days of such determination.
Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

[3]This period applies to children Approval ho lose coverage due to the divorce. If the former spouse's children Approval were covered under the Plan, they Approval will lose coverage and may elect coverage under COBRA. The COBRA election does not apply to the Subscriber's children Approval ho continue to be eligible for coverage as the Subscriber's Dependents.

TABLE 11

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage for Up To:
You become eligible for Medicare and don't experience any additional qualifying events	36 months
You become eligible for Medicare, after which you experience a second qualifying event1 before the initial 18-month period expires	36 months
You experience a qualifying event[1], after which you become eligible for Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare eligibility would have resulted in loss of Dependent coverage under the Plan	36 months

Note: While some Qualifying Life Events as described in Section 2, *Introduction*, are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed in that section.

How Your Medicare Eligibility Affects Dependent COBRA Coverage Table 11 below describes how your Dependents' COBRA coverage is impacted if you become eligible for Medicare.

[1]For example, your employment is terminated for reasons other than gross misconduct.

A group health plan may terminate coverage earlier than the end of the maximum period for any of the following reasons:

- Premiums are not paid in full on a timely basis;
- The employer ceases to maintain any group health plan;
- A qualified beneficiary begins coverage under another group health plan after electing continuation coverage;
- A qualified beneficiary becomes entitled to Medicare benefits after electing continuation coverage; or
- A qualified beneficiary engages in conduct that would justify the plan in terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage (such as fraud).

If continuation coverage is terminated early, the plan must provide the qualified beneficiary with an early termination notice. The notice must be given as soon as practicable after the decision is made, and it must describe the date coverage will terminate, the reason for termination, and any rights the qualified beneficiary may have under the plan or applicable law to elect alternative group or individual coverage.

If you decide to terminate your COBRA coverage early, you generally won't be able to get a Marketplace plan outside of the open enrollment period.

Getting Started

Decent will notify you by mail if you become eligible for COBRA coverage. The notification will give you instructions for electing COBRA coverage and advise you of the monthly cost. Your monthly cost is the full cost, including both Subscriber and Dependent costs, if applicable, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 105 days from the date you receive notification or from the date your coverage ends, whichever is later, to elect and pay the cost of your COBRA coverage. The payment must include the monthly cost for all months retroactive to the date your Plan coverage ended.

During the 105-day election period, the Plan will, only if you request, inform the Provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a Member in the Plan under COBRA, you have the right to change your coverage election:

- during Annual Enrollment; and
- following a Qualifying Life Event, as described under *Changing Your Coverage* in Section 2*, Introduction*.

Notification Requirements

If your covered Dependents lose coverage due to divorce or loss of Dependent status, you or your Dependents must notify the Decent or your Benefit Coordinator within 60 days of the latest of:

- the date of the divorce or an enrolled Dependent's loss of eligibility as an enrolled Dependent;
- the date your enrolled Dependent would lose coverage under the Plan; or
- the date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Dependents must also notify Decent when a secondary qualifying event occurs that will extend continuation coverage under COBRA.

If you or your Dependents fail to notify Decent of these events within the 60-day period, the Plan is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under COBRA, you must also notify Decent within 31 days of any Qualifying Life Event.

Once you have notified Decent, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide Decent with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to Decent at the address stated in Section 14, *Important Administrative Information*. The contents of the notice must be such that Decent is able to determine the covered Member and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Subscribers who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Subscribers are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after his/her group health plan coverage ended.

If a Subscriber qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact Decent for additional information. The Subscriber must contact Decent promptly after qualifying for assistance under the Trade Act of 1974 or the Subscriber will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost but begins on the first day of the special second election period.

When COBRA Ends

COBRA coverage will end, before the maximum continuation period, on the earliest of the following dates:

- the date, after electing continuation coverage, that coverage is first obtained under any other group health plan;
- the date, after electing continuation coverage, that you or your covered Dependent first becomes entitled to Medicare;
- the date coverage ends for failure to make the required premium payment; or
- the date coverage would otherwise terminate under the Plan as described in the beginning of this section.
- The Association ceases to maintain any group health plan,
- A qualified beneficiary begins coverage under another group health plan after electing continuation coverage,
- A qualified beneficiary becomes entitled to Medicare benefits after electing continuation coverage, or
- A qualified beneficiary engages in fraud or other conduct that would justify terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier

Uniformed Services Employment and Reemployment Rights Act

A Subscriber who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Subscriber and the Subscriber's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Subscribers may elect to continue coverage under the Plan by notifying their Association in advance and providing payment of any required contribution for the health coverage. This may include the amount the Association normally pays on a Subscriber's behalf. If a Subscriber's Military Service is for a period of time less than 31 days, the Subscriber may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

A Subscriber may continue Plan coverage under USERRA for up to the lesser of:

- the 24-month period beginning on the date of the Subscriber's absence from work; or
- the day after the date on which the Subscriber fails to apply for, or return to, a position of employment.

Regardless of whether a Subscriber continues health coverage, if the Subscriber returns to a position that is eligible for participation in the Association, the Subscriber's health coverage and that of the Subscriber's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on a Subscriber or the Subscriber's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call your Decent, Inc. If you have questions about your rights to continue health coverage under USERRA.

SECTION 12 - OTHER IMPORTANT INFORMATION

What this section includes:

- **Qualified Medical Child Support Orders;**
- **Your relationship with Decent Inc. and the Texas Freelancers Association**
- **Relationships between Providers, Decent Inc. and TFA**
- **Interpretation of the Plan;**
- **Records; and**
- **How to access the Member Plan Document.**

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If it is determined that it does, and your child meets the definition of an eligible Dependent, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as provided under the Plan.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with Decent Inc. and the Texas Freelancers Association

In order to make choices about your health care coverage and treatment, it is important for you to understand how Decent Inc. interacts with the Plan and how it may affect you. The TFA Board of Trustees has contracted with Decent Inc. as an administrator of the Plan to assist in the administration of the Plan. **Neither TFA nor Decent Inc. provides medical services or makes treatment decisions.**

Decent Inc. processes claims for Benefits and communicates with you regarding decisions about whether the Plan will cover the health care that you may receive. The Plan pays for Covered Health Services, which are more fully described in this MPD.

Relationships Between Network Providers, Decent Inc. and TFA

The relationships between Decent Inc. and Network Providers are solely contractual relationships between independent contractors. Network Providers are not agents or employees of Decent, Lonestar or Decent Inc. Decent and its employees are not agents or employees of Network Providers, nor are Decent Inc. and its employees' agents or employees of Network Providers.

Decent Inc. arranges for health care Providers to participate in the Lonestar Network and administers the Lonestar Plan, on behalf of TFA subject to Decent oversight. Network Providers are independent practitioners who run their own offices and Facilities.

Decent and Decent Inc. do not have any other relationship with Network Providers. Decent and Decent Inc. are not liable for any act or omission of any Provider in caring for any Member receiving health care services covered under the Plan.

Your Relationship with Providers

The relationship between you and any Provider is that of Provider and patient. Your Provider is solely responsible for the quality of the health care goods and services provided to you. You are responsible for:

- Choosing your own Provider;
- Paying, directly to your Provider, any amount identified as a Member's responsibility, including Copayments, Coinsurance, any other amount a Non-Network Provider charges that exceeds Eligible Expenses;
- Paying, directly to your Provider, the cost of any health care service not covered by the Plan;
- Deciding if each Provider treating you is right for you (this includes Network and Non-Network Providers you choose as well as Providers to whom you have been referred); and
- Deciding with your Provider what care you should receive, even if it is not covered under the Plan.

Interpretation of the Plan

Decent has discretion to interpret Plan provisions including this MPD and any Amendment or Addendum.

TFA has delegated to Decent Inc. the discretion to determine whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan, according to guidelines established by the Plan and/or Decent Inc.

In certain circumstances, for purposes of overall cost savings or efficiency, Decent, in its discretion, may approve Benefits for services that would otherwise not be Covered Health Services. The fact that Decent does so in any particular case shall not in any way be deemed to require Decent to do so in other similar cases.

Records

All Member records that are in the custody of Decent Inc. subject to the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

For complete listings of your medical records, Decent Inc. recommends that you contact your health care Provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms. If you request medical forms or records from Decent Inc., it also may charge you reasonable fees to cover costs for completing the forms or providing the records

How to Access the Member Plan Document

A copy of this Member Plan Document and other Plan information may be downloaded from **www.decent.com** You may also request a copy of this Member Plan Document by making a written request to Decent. The copy will be provided for a reasonable charge within 30 days of its receipt of the request.

SECTION 13 - GLOSSARY

Definitions of terms used throughout this Member Plan Document (MPD).

Many of the terms used throughout this MPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this MPD, but it does not describe the Benefits provided by the Plan.

Actively at Work, Actively Working, Active Work, Active Service or Active Duty – the expenditure of time and energy in the service of their independent business and as a member of the Texas Freelancers Association.

Addendum – an attached written description of additional or revised provisions to the Plan. The Benefits and exclusions of this Member Plan Document and any Amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and Member Plan Document and/or Amendments to the Member Plan Document, the Addendum shall be controlling. ***Changes to*** The Plan ***may only be made at*** renewal.

Affordable Care Act (ACA) – federal law that includes the Patient Protection and Affordable Care Act (Public Law 111-148; March 23, 2010; 124 Stat. 119) and the Health Care and
Education Reconciliation Act of 2010 (Public Law 111-152; March 30, 2010; 124 Stat. 1029). This is also referred to as the federal health care reform statute.

Allowable Amount – see Eligible Expenses.

Alternate Facility – a health care Facility that is not a Hospital and that provides one or more of the following services on an Outpatient basis, as permitted by law:

- Surgical services;
- Emergency health services; or
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance Use Disorder Services on an Outpatient basis or Inpatient basis (for example a Residential Treatment Facility).

Amendment – any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the Amendment specifically changes.

Association – the Texas Freelancers Association and its current members

Enrollment – the period of time during which eligible Subscribers may enroll themselves and their Dependents in the Plan. Decent determines the Enrollment period.

Applied Behavior Analysis – Intensive Behavioral Therapy, given or supervised by a Board-Certified Behavior Analyst (BCBA), which consists of a series of behavioral and/or habilitative interventions for the treatment of Autism Spectrum Disorders.

Austin Plan Service Area – The select Zip Codes in and around the city of Austin Texas where a member would be well serviced by the Network Providers. Current List of Zip Codes available at www.decent.com.

Authorized Representative – a person authorized to act on behalf of a Member. This does not include a Provider or other entity acting as an assignee of a Member's claim. See Authorized Representative in Section 8, *Claims Procedures*, for information on how to properly designate an Authorized Representative. An Authorized Representative must be properly designated in order to protect against improper disclosure of information about a Member including protected health or other confidential information.

Autism Spectrum Disorders – a neurodevelopmental disorder marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits – Plan payments for Covered Health Services, the terms and conditions of the Plan and any Addendums and/or Amendments

Body Mass Index (BMI) – a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

Calendar Year – the annual period of time from January 1 to December 31, inclusive, as distinguished from Plan Year, which is from September 1 through August 31, inclusive.

CHD – see Congenital Heart Disease (CHD).

Chiropractic Treatment – the therapeutic application of chiropractic treatment and/or manipulative treatment with or without ancillary physical therapy and/or rehabilitative methods rendered to restore or improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Clinical Trial – a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the Member is not allowed to choose which treatment he or she will receive.

COBRA – see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance – the percentage of Eligible Expenses you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*. The percentage of Eligible Expenses paid by the Plan for Covered Health Services is shown in Section 5, *Schedule of Benefits and Coverage*.

Complications of Pregnancy – complications (when Pregnancy is not terminated) for which diagnoses are distinct from Pregnancy but adversely affected or caused by Pregnancy, such as nephritis, cardiac decompensation and miscarriage. It does not include false labor, occasional spotting, physician prescribed rest during Pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, eclampsia, and similar conditions associated with Pregnancy not constituting a nosologically distinct complication of Pregnancy. Covered Health Services for Complications of Pregnancy do not include services and supplies provided at termination of Pregnancy.

Congenital Anomaly – a physical developmental defect that is present at birth and is identified within the first twelve months after birth.

Congenital Heart Disease (CHD) – any structural heart condition or abnormality that has been present since birth. Congenital heart disease may:

- be passed from a parent to a child (inherited);
- develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy; or
- have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – a federal law that requires Associations to offer continued health insurance coverage at the insured's expense to certain Members and their Dependents whose group health insurance has been terminated.

Convenience Care Clinic (formerly known as Retail Health Clinic) – health care clinic located in a retail setting, such as a supermarket or pharmacy, that provides treatment of common illnesses and routine preventive health care services that can be rendered by appropriately licensed Providers located in the clinic.

Copayment (or Copay) – the set dollar amount you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Cosmetic Procedures – procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Plan. Reshaping a nose with a prominent bump is a good example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in a function, e.g., breathing.

Cost-Effective – the least expensive item or service that performs the necessary function. This term applies to Durable Medical Equipment, prosthetic devices and certain other Covered Health Services.

Covered Drug – ***Note:*** this term applies to Outpatient prescription medications covered under the Lonestar Prescription Drug Program through Costco. Any legend drug (a drug that, by law, can be obtained only by prescription) or injectable insulin, including disposable syringes and needles needed for self-administration that meets the following requirements:

- That is Medically Necessary and is ordered by a Prescriber naming a Member as the recipient;
- For which a written or verbal Prescription Order or Refill is prepared by a Prescriber;
- For which a separate charge is customarily made;
- That is used for the purpose for which U.S. Food and Drug Administration (FDA) approval has been given, or used consistent with the applicable program criteria approved by the Prescription Drug List (PDL) Management Committee;
- That is dispensed by a Pharmacy and is received by the Member while covered under this Program, except when received in a Physician's or Other Provider's office, or during confinement while a patient in a Hospital or other acute care institution or Facility; and
- That is not identified in Section 7, *Exclusions*: *What the Prescription Drug Program Will Not Cover*, as not covered.

Covered Health Services – those health services, supplies and Pharmaceutical Products, which the Plan determines to be:

- Medically necessary;
- Included in sections 5 and 6, *schedule of benefits* and *details for covered health services*, described as a covered health service;
- Provided to a member who meets the plan's eligibility requirements, as described under *eligibility* in section 2, *Introduction*; and
- Not identified in section 7, *exclusions*: *what the medical plan will not cover*, as not covered.

Custodial Care – services that do not require special skills or training and that:

- Provide assistance in activities of daily living (including, but not limited to, feeding or cooking, dressing, going to the toilet, preventive and pain-relieving skin care, bathing, ostomy care, incontinence care, checking of routine vital signs and ambulating or exercising functions);
- Are provided for the primary purpose of meeting the personal needs of the member or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence; or
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Decent or Decent, Inc.– The Company employed by your Association to provide assistance for Members with various benefit programs, including the Plan.

Declaration of Informal Marriage – a document that memorializes that a man and a woman desire to consider themselves married for all legal purposes. The completed document requires the notarized signatures of both parties and must be filed with the District Clerk of the county of the couple's residence.

Dependent – an individual who, because of a statutorily defined relationship with a Subscriber, meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*, and is enrolled as a Member in the Plan. A Dependent does not include anyone who is enrolled in the Plan as a Subscriber. No one can be enrolled as a Dependent of more than one Subscriber.

Designated Network Provider – a provider or facility that has entered into an agreement with Decent Inc., or with an organization contracting on Decent Inc.'s behalf, to deliver certain Covered Health Services via interactive audio and video modalities.

DME – see Durable Medical Equipment (DME).

Domiciliary Care – a supervised living arrangement in a home-like environment, providing assistance with activities of daily living, for Members who are unable to live independently because of age-related impairments or physical, mental or visual disabilities.

Durable Medical Equipment (DME) – any medical equipment appropriate for use in the home to aid in a better quality of living for Members with a Sickness, Injury or disability, and that meets the requirements specified under *Durable Medical Equipment (DME)* in Section 6, *Details for Covered Health Services*.

Educational – services, supplies, and related expenses provided to address a Member's developmental delays, or otherwise provide training, skills, practice and exercises designed to enhance academic performance, to teach positive behaviors and/or discourage inappropriate, destructive or otherwise negative conduct. It includes, but is not limited to, special education or conventional learning techniques, operant conditioning or other forms of training.

Eligible Expenses – (sometimes known as the Allowable Amount). For Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by Decent Inc. as stated below and as detailed in Section 3, *How the Plan Works*.

Eligible Expense determinations are subject to Decent Inc.'s reimbursement policy guidelines. Decent Inc. develops the reimbursement policy guidelines, in Decent Inc.'s discretion, following evaluation and validation of all Provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS);
- As reported by generally recognized professionals or publications;
- As used for Medicare; or
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that Decent Inc. Accepts.

Emergency – a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness, or substance-related and addictive disorder which:

- Arises suddenly; and
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.
- The plan determines if a medical condition is an emergency based on factors that include, but are not limited to,
  Medical information supplied by the member's provider.

Emergency Health Services – health care services and supplies necessary for the treatment of an Emergency.

Member – Texas Freelance Association Members and their eligible dependents enrolled in the Lonestar Plan.

End-Stage Renal Disease (ESRD) – permanent kidney failure, where the kidneys stop working well enough for a Member to live without dialysis or a kidney transplant.

EOB – see Explanation of Benefits (EOB).

Experimental or Investigational Services – medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorder or other health care services, technologies, supplies, treatments, procedures, drug or other therapies, medications or devices that, at the time the Plan makes a determination regarding coverage in a particular case, the Plan determines to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- Subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational); or

- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Routine patient care costs for Clinical Trials for which Benefits are available as described under *Clinical Trials* in Section 6, *Details for Covered Health Services*.
- If you have a significantly life-threatening Sickness, Injury or other medical condition, Decent Inc. As its designee, may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness, Injury or other medical condition. Prior to such a consideration, the Plan must first establish, based on good faith medical judgment supported by sufficient scientific evidence, that although Experimental or Investigational, the service has significant potential as an effective life-sustaining treatment for that Sickness, Injury or other medical condition.

In making its determination, Decent Inc. as its designee, will refer to a certification the Member's Physician must provide stating that he or she, based on good- faith medical judgment, believes:

- The Sickness, Injury or other medical condition is significantly life threatening and imminently fatal if the treatment is limited to Covered Health Services; and
- Although designated as Experimental or Investigational, the service has significant potential as an effective life-sustaining treatment for the Sickness, Illness or condition.

In addition to clinical studies regarding the Experimental or Investigational Service, the Plan may consider scientifically grounded standards based on Physician specialty society recommendations and professional standards of care. The Plan reserves the right to obtain expert opinion(s) in determining whether an otherwise Experimental or Investigational Service shall be considered as a Covered Health Service for a particular Sickness, Injury or other medical condition. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Plan's sole discretion.

Appeals from a Decent Inc. pre-service decision not to consider the Experimental or Investigational Service to be a Covered Health Service will be handled as an appeal of an Urgent Care Request for Benefits under Section 8, *Claims Procedures* of this MPD.

Explanation of Benefits (EOB) – a statement provided by Decent Inc. to you, your Physician, or another health care professional regarding a specific claim for health services or supplies that explains:

- The Benefits provided (if any);
- The allowable reimbursement amounts;
- Deductibles;
- Coinsurance and Copays;
- Any other reductions;
- The net amount paid by the Plan;
- The amount you may owe your Provider; and
- The reason(s) why the service or supply was not covered by the Plan.

Facility – a Hospital, Alternate Facility, Inpatient Rehabilitation Facility, Skilled Nursing Facility, Residential Treatment Facility or Urgent Care Center (all as defined in this Glossary) or other institution that is licensed to provide services and supplies covered by the Plan and that is approved by Decent Inc. Other Facilities include, but are not limited to:

- Substance-related and addictive disorder treatment facilities;
- Birthing centers;
- Hospices;
- Imaging centers;
- Independent laboratories;
- Psychiatric day treatment facilities;
- Radiation therapy centers; and
- Renal dialysis centers.

In states where there is a licensure requirement, other Facilities must be licensed by the appropriate state administrative agency.

Genetic Testing – examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Group Benefits Program (Association or the Program) – the Texas Freelancers Association Benefits Trust Lonestar Plan

Health Statement(s) – a single, integrated statement that summarizes EOB information by providing detailed content regarding account balances and claim activity.

Home Health Agency – a program or organization authorized by law to provide health care services in the home and certified by Medicare as a supplier of Home Health Care.

Hospice – a Facility or agency primarily engaged in providing Hospice care as described in Section 6, *Details for Covered Health Services*, licensed under state law, and certified by Medicare as a supplier of Hospice care.

Hospital – an institution, operated as required by law, that is: primarily engaged in providing health care services, on an Inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, and substance-related and addictive disorder, diagnostic and surgical Facilities, by or under the supervision of a staff of Physicians; and has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care, Domiciliary Care or care of the aged and it is not a Skilled Nursing Facility, convalescent home or similar institution.

In-Area Benefits – Network and Non-Network Benefits that the Plan pays for Covered Health Services received by Subscribers and their Dependents for Subscribers whose eligibility is in the Plan Service Area.

Injury – bodily damage other than Sickness or disability, including all related conditions and recurrent symptoms.

Inpatient – a Member who has been admitted to a Hospital, Nursing Facility or Inpatient Rehabilitation Facility or an Inpatient Facility for Mental Health Services, Serious Mental Illness Services or Substance Use Disorder Services.

Inpatient Rehabilitation Facility – a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an Inpatient basis, as authorized by law.

Inpatient Stay – an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility or an Inpatient Care Facility for Mental Health Services, Serious Mental Illness Services or Substance Use Disorder Services.

Intensive Behavioral Therapy – an umbrella term for a variety of outpatient behavioral interventions that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorder. The most common Intensive Behavioral Therapy is Applied Behavior Analysis (ABA).

Intensive Outpatient Treatment – a structured Outpatient mental health or substance-related and addictive disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Skilled Nursing Care – skilled nursing care that is provided either for:

- Fewer than seven days each week; or
- Fewer than eight hours each day for a period of 21 days or less

The Plan may make exceptions for special circumstances when the need for additional skilled nursing care is finite and predictable.

Kidney Resource Services (KRS) – a program administered and made available to you by Decent Inc. or its affiliates. The KRS program provides:

- Specialized consulting services to Members with ESRD or chronic kidney disease;

- Access to dialysis centers with expertise in treating kidney disease; and
- Guidance for the Member on the prescribed plan of care.

Marriage and Family Therapy/Counseling – the provision of professional therapy services to individuals, families, or married couples, singly or in groups, involving the professional application of family systems theories and techniques in the delivery of therapy services to those persons.

The term includes, but is not limited to, the evaluation and remediation of cognitive, affective, behavioral, or relational dysfunction within the context of marriage or family systems.

Medicaid – a federal program administered and operated individually by participating state and territorial governments and providing health care coverage to eligible low-income people.

Medical Social Services – those social services relating to the treatment of a Member's medical condition. Such services
include, but are not limited to:

- Assessment of the social and emotional factors related to the Member's medical condition, need for care, response
  To treatment and adjustment to care; and
- Assessment of the relationship of the Member's medical and nursing requirements to the home situation, financial
  Resources, and available community resources

Medical Supplies - expendable items required for care related to a Sickness or Injury. Not all Medical Supplies are Covered Health Services under the Plan. See *Medical Supplies* in Section 6, *Details for Covered Health Services* and *Medical Supplies and Equipment* in Section 7, *Exclusions*, for a description.

Medically Necessary, Medical Necessity – health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance- related and addictive disorder, Serious Mental Illness, or disease (and symptoms), that are all of the following as determined by the Plan. The health care services must be:

- Performed in accordance with Generally Accepted Standards of Medical Practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorder, Serious Mental Illness, or disease (and symptoms);
- Not primarily performed for your comfort or convenience or that of your health care Provider; and
- Not costlier than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as alternatives with respect to the diagnosis or treatment of your Sickness, Injury, Mental Illness, substance-related and addictive disorder, Serious Mental Illness, or disease (and symptoms).

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled Clinical Trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the health care services and positive health outcomes.

If no credible scientific evidence is available, then standards based on Physician specialty Approval society recommendations or professional standards of care may be considered. The Plan reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Plan's sole discretion.

Decent Inc. develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific health services. These clinical policies (as developed by Decent Inc. and revised from time to time), are available to Members at **www.decent.com** or by calling (866)-Heart-US toll-free, and to Physicians and other health care professionals on Decent Inc. Online.

Medicare – Parts A, B, C and D of the insurance program for Americans 65 years of age and over as well as younger Americans with certain disabilities, established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Provider - a Provider who is licensed to provide services and/or supplies for treatment of Mental Illness and acts within the scope of that license. Mental Health Providers include, but are not limited to:

- Doctor of Psychology (Syd. or Ph.D.) (certified as a health service Provider);
- psychiatrist (M.D.);
- addictionologist (M.D.);
- nurse-practitioner;
- Licensed Clinical Social Worker (LCSW) or Licensed Masters Social Worker – Advanced Practice (LMSW-AP);
- Licensed Marriage and Family Therapist (LMFT);
- licensed professional counselor;
- licensed dependency counselor; and
- licensed psychological associate.

If the Mental Health Provider provides services outside of the Plan Service Area, Mental Health Providers must be licensed by the appropriate state administrative agency where the services are provided.

Mental Health Provider also includes an Applied Behavior Analysis (ABA) provider – a Mental Health Provider who has advanced training in developmental disorders and ABA at the Masters or higher level and is certified as a Board-Certified Behavior Analyst (BCBA) by the Behavior Analyst Certification board, or an appropriately trained and qualified paraprofessional directly supervised by the above. If the state where services are provided licenses ABA professionals, the state licensure is required in addition to the above.

Mental Health Services – Covered Health Services performed for the diagnosis and treatment of Mental Illnesses, as described in Section 6, *Details for Covered Health Services*. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Illness – mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, or any other diagnostic coding system as used by the Plan, whether or not the cause of the disease, disorder or condition is physical, chemical, or mental, in nature or origin, unless the service or diagnostic category is listed in Section 7, *Exclusions: What the Medical Plan Will Not Cover*.

Network – (sometimes referred to as Lonestar Network) a system of Providers in the Plan Service Area developed by Decent Inc. or its affiliate to provide Covered Health Services to Members in the Plan. Each Network Provider has a participation agreement in effect (either directly or indirectly) with Decent Inc. or with its affiliate to participate in the Network.
Decent Inc.'s affiliates are those entities affiliated with Decent Inc. through common ownership or control with Decent Inc. or with Decent Inc.'s ultimate corporate parent, including direct and indirect subsidiaries.

A Provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network Provider for only certain products. In this case, the Provider will be a Network Provider for the Covered Health Services and products included in the participation agreement, and a Non-Network Provider for other Covered Health Services and products. The participation status of Providers may change from time to time. You may find out the services for which a Provider is a Network Provider by calling Decent Inc. at (866) 336- 9371 toll-free.

Network Benefits - Benefits that the Plan pays for Covered Health Services provided by Network Providers. Refer to Section 5,
Schedule of Benefits and Coverage, for details about how Network Benefits apply.

Non-Network – when used to describe a Provider of health care services, this means a Provider outside of the Network as established and maintained by Decent Inc.

Non-Network Benefits - description of how Benefits are paid for Covered Health Services provided by Non-Network Providers. Refer to Section 5, *Schedule of Benefits and Coverage*, for details about how Non-Network Benefits apply.

Out-of-Area – describes the part of the Lonestar Plan that is available to Members whose eligibility county is outside the Plan Service Area or who are Retirees 65 years of age or over and their Dependents.

Out-of-Pocket Coinsurance Maximum – the most you are required to pay each Calendar Year for Coinsurance. Refer to Section 5, *Schedule of Benefits and Coverage*, for the Out-of-Pocket Coinsurance Maximum amount. Refer to Section 3, *How the Plan Works*, for a description of how the Out-of-Pocket Coinsurance Maximum works.

Outpatient – a Member who has been treated at a Hospital or Facility for other than Inpatient treatment.

Outpatient Clinic Facility – a health care Facility that is not a Hospital or an Alternate Facility and that provides Physician's
office services for Sickness or Injury on an Outpatient basis, as permitted by law.

Oral Chemotherapy (Orally administered anticancer medication) – Anticancer medication that a member is able to take via their mouth.

Partial Hospitalization/Day Treatment – a structured ambulatory program that may be free- standing or Hospital-based and that provides services for at least 20 hours per week.

Member – a Member or other persons eligible for coverage and enrolled under the Plan. References to "you" and "your" throughout this Member Plan Document are references to a Member.

PCP – see Primary Care Physician.

Pharmaceutical Products – U.S. Food and Drug Administration (FDA)-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care Provider within the scope of the Provider's license, and not otherwise excluded under the Plan. Pharmaceutical Products do not include medications that are typically available by prescription order or refill at a pharmacy under the Lonestar Prescription Drug Program administered by Costco.

Physician – any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Please note: The fact that a Provider is described as a Physician does not mean that Benefits for services from that Provider are available to you under the Plan.

Plan – the Lonestar.

Plan Administrator –Decent, Inc. or its designee.

Plan Service Area – the geographical area or areas designated by the Board of Trustees as the area in which In-Area Benefits are available.

Post-Service Claim - a claim for Benefits that is not a Pre-Service Request for Benefits or Urgent Care Request for Benefits. Post-Service Claims include claims that involve only the payment or reimbursement of Eligible Expenses for Covered Health Services that have already been provided.

Prior Approval or Predetermination – See Prior Approval.

Pregnancy – includes, but is not limited to, prenatal care, postnatal care and childbirth. Complications of Pregnancy are considered separately as defined in this section.

Prescriber – any health care professional who is properly licensed and qualified by law to prescribe Prescription Drugs to humans. The fact that a Prescriber has prescribed a medication or product, or the fact that it may be the only available treatment for a Sickness, Injury, mental illness, substance-related and addictive disorder, disease or its symptoms does not make the product a Covered Drug under the Program.

Pre-Service Request for Benefits – a claim for Benefits where the Plan conditions receipt of the Benefit, in whole or in part, on approval of the Benefit in advance of obtaining medical care. This includes Covered Health Services which the Plan must approve or for which you must obtain Prior Approval from Decent Inc. before non-Urgent Care is provided.

Primary or Primary Plan - when you are covered by more than one health benefits plan, the Primary Plan is the plan that pays benefits first under coordination of benefits (COB) guidelines. Remaining Eligible Expenses may be paid under the other plan, which is called the Secondary Plan. Refer to, *Coordination of Benefits (COB)*, for details on COB guidelines.

Primary Care Physician (PCP) – The physician responsible for ensuring members of the Lonestar plan are getting the care they need. A PCP is generally a Physician who practices in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. A *PCP* provides and coordinates medical treatment. Refer to, *How the Plan Works*, for a detail on selecting a PCP.

Prior Approval – (sometimes known as Prior Approval or predetermination) the review process that the Plan uses to determine whether certain services are Covered Health Services under the Plan. See, *Prior Approval*, for the list of services requiring Prior Approval and for details on the Prior Approval process.

Private Duty Nursing – shift or continuous nursing care that encompasses nursing services for Members who require more individual and continuous care than is available from a visiting nurse through a Home Health Agency. Private Duty Nursing services are provided where longer durations of Skilled Care are required and may include shift care or continuous care 24 hours a day, 7 days a week in certain settings. Private Duty Nursing care is not care provided primarily for the comfort or convenience of the Member.

Program – See Group Benefits Program (Association).

Provider – a Facility, Hospital, Physician or Mental Health Provider or other Provider that is licensed to provide health care services and supplies and acts within the scope of that license and that is approved by Decent Inc. In states where there is a licensure requirement, other Providers must be licensed by the appropriate state administrative agency.

Qualifying Life Event (QLE) – a life experiences whose occurrence allows a Member to change health care coverage during a Plan Year, provided that the change in coverage is consistent with the life event. See *Changing Your Coverage* in Section 2, *Introduction*, for a list of Qualifying Life Events and how to change your coverage.

Reconstructive Procedure – a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function.

Reconstructive Procedures include, but are not limited to, surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary intended result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the condition does not classify surgery or any other procedure done to relieve the condition as a Reconstructive Procedure.

Referral – Approval for Members to receive Network Benefits for Covered Health Services provided by a Specialist Physician when medical care is required by a Provider other than the Member's PCP. A Referral from the Member's PCP must be obtained and authorized through Decent Inc. before the Member receives services from a Provider other than his or her PCP, except for those services provided by Specialist Physicians that do not require a Referral, as described in, *How the Plan Works*.

Residential Treatment Facility – a Facility that provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs;
- It provides a program of treatment under the association participation and direction of a physician and approved by decent, inc;

- It has or maintains a written, specific and detailed treatment program requiring full -time residence and full-time participation by the patient; and
- It provides at least the following basic services in a 24-hour per day, structured milieu:
    - Room and board;
    - Evaluation and diagnosis;
    - Counseling; and
    - Referral and orientation to specialized community resources

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

Secondary or Secondary Plan - when you are covered by more than one health benefits plan, the Secondary Plan is the plan that pays benefits second, following the Primary Plan, under coordination of benefits (COB) guidelines. The Secondary Plan may or may not pay all remaining Eligible Expenses after the Primary Plan has paid, depending on how COB is determined. Refer to Section 9, *Coordination of Benefits (COB)*, for details on COB guidelines.

Semi-private Room - a room with two or more beds.

Serious Mental Illness - the following psychiatric illnesses as defined in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*:

- Schizophrenia;
- Paranoid and other psychotic disorders;
- Bipolar disorders (hypomanic, manic, depressive, and mixed);
- Major depressive disorders (single episode or recurrent);
- Schizo-affective disorders (bipolar or depressive);
- Pervasive developmental disorders;
- Obsessive-compulsive disorders; and
- Depression in childhood and adolescence.

Sickness – physical illness, disease or Pregnancy. The term Sickness as used in this MPD includes Mental Illness and substance-related and addictive disorder, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care – skilled nursing, skilled teaching, and skilled rehabilitation services when:

- They are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the Member;
- A Physician orders them;
- They are not delivered for the purpose of assisting with activities of daily living, including, but not limited to, dressing, feeding, bathing or transferring from a bed to a chair;
- They require clinical training in order to be delivered safely and effectively; and
- They are not Custodial Care, as defined in this section.

Skilled Nursing Facility – a nursing Facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Specialist Physician - (sometimes known as specialty care Physician) a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, family practice or general medicine.

Texas Freelancers Association (TFA) – An Association whose members work for themselves as sole-proprietors, small business owners, etc. TFA is invested in improving the lives of people who have the courage to strike out on their own and start their own business.

Texas Freelancers Association Benefits Trust (TFABT) – The benefits trust established by the Texas Freelancers Association to offer their members health benefits.

Lonestar Plan or Lonestar – a self-funded health benefit plan offered through the Group Benefits Program administered by Decent Inc. It includes a Prescription Drug Program.

Subscriber – the Member who is the person enrolled in the Plan as provided for under the Association, and who is not a Dependent.

Substance Use Disorder (Chemical Dependency) Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorder that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded by the Plan. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Health Service.

Telehealth service - means a health service, other than a telemedicine medical service, delivered by a health professional licensed, certified, or otherwise entitled to practice in this state and acting within the scope of the health professional's license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.

Telemedicine medical service - means a health care service delivered by a physician licensed in this state, or a health professional acting under the delegation and supervision of a physician licensed in this state, and acting within the scope of the physician's or health professional's license to a patient at a different physical location than the physician or health professional using telecommunications or information technology.

Tertiary or Tertiary Plan - when you are covered by more than one health benefits plan, the Tertiary Plan is the plan that pays benefits third, following both the Primary and Secondary Plans, under coordination of benefits (COB) guidelines. The Tertiary Plan may or may not pay all remaining Eligible Expenses after the Primary and Secondary Plans have paid, depending on how COB is determined. Refer to, *Coordination of Benefits (COB)*, for details on COB guidelines.

Total Network Out-of-Pocket Maximum – the most you are required to pay each Calendar Year for Network Coinsurance and Copays, as detailed in, *Schedule of Benefits and Coverage*. Refer to, *How the Plan Works*, for a description of how the Total Network Out-of-Pocket Maximum works.

Transitional Care – Mental Health Services/Substance Use Disorder Services that are provided through transitional living Facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing and alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may
- Be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the member with recovery; or
- Supervised living arrangements that are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment does not offer the intensity and structure needed to assist the member with recovery.

Unproven Services – health services, including medications, that have not been determined to be effective for treatment of the Sickness, Injury or other medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer- reviewed medical literature:

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

Decent Inc. has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, Decent Inc. issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **Www.decent.com**.

Please note: If you have a significantly life-threatening Sickness, Injury or other medical condition, Decent Inc. as its designee may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness, Injury or other medical condition. Prior to such a consideration, the Plan must first establish, based on good faith medical judgment supported by sufficient scientific evidence that albeit unproven, the service has significant potential as an effective treatment for that Sickness, Injury or other medical condition.

In making its determination, Decent, or Decent Inc. as its designee, will refer to a certification the Member's Physician must provide stating that he or she, based on good-faith medical judgment, believes: the Sickness, Injury or other medical condition is significantly life threatening and imminently fatal if the treatment is limited to Covered Health Services; and although designated as Experimental or Investigational, the service has significant potential as an effective life-sustaining treatment for the Sickness, Illness or condition.

In addition to clinical studies regarding the Unproven Service, the Plan may consider scientifically grounded standards based on Physician specialty society recommendations and professional standards of care. The Plan reserves the right to obtain expert opinion(s) in determining whether an otherwise Unproven Service shall be considered as a Covered Health Service for a particular Sickness, Injury or other medical condition. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Plan's sole discretion.

Appeals from a Decent Inc. decision not to consider the Experimental or Investigational Service to be a Covered Health Service will be handled as an appeal of an Urgent Care Request for Benefits under Section 8, *Claims Procedures* of this Member Plan Document.

Urgent Care – treatment of an unexpected Sickness or Injury that is not life-threatening but requires Outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.

Urgent Care Center – a Facility that provides Urgent Care services, as previously defined in this section. In general, Urgent Care Centers:

- Do not require an appointment;
- Are open outside of normal business hours, so you can get medical attention for a minor sickness or injury that occurs at night or on weekends; and
- Provide an alternative to an emergency room if you need immediate medical attention, but your physician cannot see you right away.

Urgent Care Request for Benefits – a claim for medical care or treatment with respect to which application of the time periods for making non-urgent determinations (a) could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, or (b) in the opinion of the Member's Physician, would subject the Member to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

Primary Care Physician (VPCP) – The physician responsible for ensuring members of the Lonestar plan are getting the care they need. A PCP is generally a Physician who practices in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. The services are offered ly rather than in person. They are able to prescribe medications as well as order labs. A VPCP provides and coordinates medical treatment. Refer to, How the Plan Works, for a detail.

Additional Disclosure regarding Guaranty Fund nonparticipation - The Texas Freelance Association offers an Association Health Plan. The plan is subject to limitations and exclusions and requires continuous residence in the service area.

Texas law establishes a system to protect Texas policyholders if their life or health insurance company fails. The Texas Life and Health Insurance Guaranty Association administers this protection system. The Texas Freelancers Association does not qualify for protections offered because of exclusions Texas Insurance Code.

The policy referenced herein is not protected by the Texas Life and Health Insurance Guaranty Association because of statutory limitations.

Decent is required to disclose to you conspicuously that the policy or contract is not covered by the Texas Life and Health Insurance Guaranty Association.

SECTION 14 - PHARMACY PLAN

The Pharmacy plan offered to Texas Freelance Association members is administered by Costco.

www.costcohealthsolutions.com

P.O. Box 4366 Seattle, WA 98124

Customer Service: 1-877-908-6024

Prescription Drug Formulary Disclosure –

This plan covers prescription drugs. Drugs that are covered under this plan are identified in the Lonestar Plan formulary which is available on the www.decent.com web-site and can be sent to you upon request. A formulary is a comprehensive list of FDA approved prescription and nonprescription drugs for which this health benefit plan provides coverage and for which a health benefit plan issuer approves payment.

Costco Health Solutions Formulary Advisory Committee (FAC), a sub-committee of the Pharmacy and Therapeutics (P&T) Committee, conducts an initial review on all new medications within 90 days of FDA approval. Each medication is placed into the following categories: Standard Review, Expedited Review (breakthrough in treatment) and Line Extension (if active ingredients have been previously reviewed at P&T).

The P&T Committee makes formulary recommendations for inclusion on the formulary based on clinical evidence, including the safety and efficacy of a product. The Committee uses drug monographs and related information developed by a comprehensive review of the available clinical literature, current treatment guidelines, and any other related data when available.

We consider products for formulary inclusion only if the drug has a positive therapeutic index (e.g., the clinical efficacy is greater than any toxicity). Medications may be denied inclusion on any of our formularies if the potential for toxicity outweighs the medication's therapeutic advantages.

If we determine a drug to be both safe and effective, we then determine whether the drug is unique or clinically superior to others in that therapeutic class or has a unique approved indication. Our clinical staff critically analyzes medical literature and stratifies this literature based upon its quality. We perform this review to make reasonable predictions of effect or outcomes for a particular drug in our member population. We scrutinize data in order to separate that which is clinically meaningful from that which may only be statistically significant. The strongest evidence we obtain is that which systematically compiles and compares randomized, double blind, placebo-controlled trials (RCTs). The best composite studies enable us to make sound decisions using such statistical principles as NNT (number needed to treat) and NNH (number needed to harm).

Costco Health Solutions formulary is reviewed semi-annually.

Members may contact the Costco or Decent determine whether a specific drug is included in a particular drug formulary. Costco and/or Decent will respond to your request no later than the third business day after the date of the request, whether a specific drug is included in a particular drug formulary; and we will notify our members and any other individual who requests information under this section that the inclusion of a drug.

A drug being part of the formulary does not guarantee that an enrollee's health care provider will prescribe that drug for a particular medical condition or mental illness.

MODIFICATION OF DRUG COVERAGE UNDER PLAN

Modifications of drug coverage provided under a health benefit plan will only be modified at the time of coverage renewal or at any time if the modification is effective uniformly among all group health benefit plan with 60 days advance written notice of the modification. Modifications affecting drug coverage that require notice include:

(1) Removing a drug from a formulary;

(2) Adding a requirement that an enrollee receive prior authorization for a drug;
(3) Imposing or altering a quantity limit for a drug;
(4) Imposing a step-therapy restriction for a drug; and
(5) Moving a drug to a higher cost-sharing tier unless a generic drug alternative to the drug is available.
(c) These changes may, with members permission, be sent via email notification.

CONTINUATION OF COVERAGE REQUIRED; OTHER DRUGS NOT PRECLUDED

This plan offers members, at the contracted benefit level and until the enrollee's plan renewal date, any prescription drug that was approved or covered under the plan for a medical condition or mental illness, regardless of whether the drug has been removed from the health benefit plan's drug formulary before the plan renewal date. This does not prohibit a physician or other health professional from prescribing an alternative to a drug for which continuation of coverage is required - if the alternative drug is covered under the health benefit plan; and medically appropriate for the enrollee.

CERTAIN PAYMENTS AND REFILLS

This plan does not require an enrollee to make a payment for a prescription drug at the point of sale in an amount greater than the lesser of:

(1) The applicable copayment;
(2) The allowable claim amount for the prescription drug; or
(3) The amount an individual would pay for the drug if the individual purchased the drug without using a health benefit plan or any other source of drug benefits or discounts.

EYE DROPS

This plan covers prescription eye drops to treat a chronic eye disease or other conditions and allows members to refill prescription eye drops if the member pays at the point of sale and: the original prescription states that additional quantities of the eye drops are needed; the refill does not exceed the total quantity of dosage units authorized by the prescribing provider on the original prescription, including refills; and
the refill is dispensed on or before the last day of the prescribed dosage period and:

(A) Not earlier than the 21st day after the date a prescription for a 30-day supply of eye drops is dispensed;
(B) Not earlier than the 42nd day after the date a prescription for a 60-day supply of eye drops is dispensed; or
(C) Not earlier than the 63rd day after the date a prescription for a 90-day supply of eye drops is dispensed.

PRESCRIPTION DRUG SYNCHRONIZATION

This plan will provide coverage for a medication dispensed in accordance with the dates established in the medication synchronization plan.
The plan will establish a process that allows a pharmacist or pharmacy to override the health benefit plan's denial of coverage for a medication
The plan will allow a pharmacist or pharmacy to override the plan's denial of coverage, and this plan shall provide coverage for the medication if:

(1) the prescription for the medication is being refilled in accordance with the medication synchronization plan and
(2) the reason for the denial is that the prescription is being refilled before the date established by the plan's general prescription refill guidelines.

PRORATION OF COST-SHARING AMOUNT REQUIRED.

This plan will prorate (based on the number of days' supply of the drug actually dispensed) any cost-sharing amount charged for a partial supply of a prescription drug if:

(1) The pharmacy or your prescribing physician or health care provider notifies the health benefit plan that:
(A) The quantity dispensed is to synchronize the dates that the pharmacy dispenses your prescription drugs; and
(B) The synchronization of the dates is in your best interest; and
(2) You agree to the synchronization.

Proration does not apply to the fee paid to the pharmacy for dispensing the drug for which the cost-sharing amount was prorated.

Step therapy

Step therapy is administered to help increase appropriate utilization of certain drugs and influence the process of managing costs. Step therapy drugs are designated on the formulary with a “ST” indicator on the plan’s formulary. While step therapy can successfully control costs, in some instances, delaying the right treatment could result in increased disease activity, loss of function and possible irreversible progression of disease.

In working with your provider, you can request an exception to Step Therapy. Here is how:

1. Ask provider or help provider initiate a request for a step therapy extension using the Step Therapy form or by calling 1-877-908-6024
2. This is sent to Costco Health Solutions and reviewed by the prior authorization department
3. If the plan does not deny the exception request within 72 hours of the request, the request is considered granted.
4. When the provider believes death or serious harm is probable, the request is considered granted if the health plan does not deny the request before 24 hours.
5. Denial of an exception is considered an adverse determination subject to an expedited review.

ADDENDUM - LIST OF COVERED PREVENTIVE CARE SERVICES

Preventive services that are currently rated as A or B according to the United States Preventive Services Task Force (USPSTF) are listed below. This list is subject to change according to the guidelines and recommendation provided by USPSTF. Coverage is subject to guidelines based on age, risk factors, dosage, and frequency.

Under the Affordable Care Act, certain preventive health services are paid at 100% (i.e., at no cost to the Member) conditioned upon physician billing and diagnosis. In some cases, you may be responsible for payment on certain related services that are not guaranteed payment at 100% by the Affordable Care Act.

List of Covered Preventive Care Services	
Children	**Adults**

Newborns	General Health Screenings	Men
• Screening for hearing loss, hypothyroidism, sickle cell disease, and phenylketonuria (PKU) • Gonorrhea preventive medication for eyes	• Blood pressure screening • Type 2 diabetes screening • HIV, HPV and STI screenings • Hepatitis B screening • Hepatitis C screening • Obesity screening and counseling • Early detection of cardiovascular disease who is: (A) a male older than 45 years of age and younger than 76 years of age; or (B) a female older than 55 years of age and younger than 76 years of age; and who is diabetic; or has a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm, that is intermediate or higher Computed tomography (CT) scanning measuring coronary artery calcification; or ultrasonography measuring carotid intima-media thickness and plaque are noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five years, performed by a laboratory that is certified by a national organization.	• Abdominal aortic aneurysm one-time screening

Immunizations	Cancer Screenings	Women's Health
• Varicella (chicken pox) • Diphtheria, Tetanus, Pertussis • Haemophilus influenzae B • Hepatitis A and B • Human Papillomavirus (HPV) • Influenza (Flu) • Measles, Mumps, Rubella • Meningococcal • Pneumococcal (pneumonia) • Inactivated Poliovirus • Rotavirus • Varicella (chicken pox)	• Breast cancer mammography • Breast cancer chemoprevention counseling • Cervical cancer pap test for women* • Colorectal cancer screenings including fecal occult blood testing, sigmoidoscopy, or colonoscopy, including specialist consultation prior to visit • Prostate cancer (PSA) screening for men • Lung Cancer Screening	• Osteoporosis screening • Chlamydia infection screening • Gonorrhea and syphilis screening • BRCA Genetic Testing and counseling • Breast cancer preventive medications • Contraceptive methods and counseling

*The Lonestar Plan does not impose the age limitations outlined in the current USPSTF guidelines.

List of Covered Preventive Care Services		
Children	**Adults**	
● General Health Screenings ● Medical history for all children throughout development ● Height, weight, and Body Mass Index (BMI) measurements ● Developmental screening ● Autism screening* ● Behavioral assessment ● Visual acuity screening ● Oral health risk assessment ● Dental caries prevention ● Hematocrit or hemoglobin screening ● Obesity screening and weight management counseling ● Lead screening ● Dyslipidemia screening ● Tuberculin testing ● Depression screening ● Alcohol and drug use assessment ● Counseling to prevent sexually transmitted infections (STIs) ● Cervical dysplasia screening ● HIV screening ● Blood Pressure screening ● Tobacco use interventions	Health Counseling Doctors are encouraged to counsel patients about these health issues and refer them to appropriate resources as needed: ● Healthy diet ● Weight loss ● Tobacco use ● Alcohol misuse ● Depression ● Prevention of STIs ● Use of aspirin to prevent cardiovascular disease ● Falls prevention ● Intimate partner violence screening ● Skin cancer behavioral health counseling ● Immunizations ● Haemophilus influenzae type B ● Hepatitis A and B ● Herpes Zoster ● Human Papillomavirus (HPV) ● Influenza (Flu) ● Measles, Mumps, Rubella ● Meningococcal ● Pneumococcal (pneumonia) ● Tetanus, Diphtheria, Pertussis ● Varicella (chicken pox)	Pregnant Women ● Anemia screening for iron deficiency ● Tobacco cessation counseling ● Syphilis screening ● Hepatitis B screening ● Rh incompatibility blood type testing ● Bacteriuria urinary tract infection screening ● Breastfeeding support, supplies, and counseling ● Gestational diabetes screening

*The Lonestar Plan does not impose the age limitations outlined in the current USPSTF guidelines

Costco Step Therapy Exception Form

COSTCO WHOLESALE | Health Solutions

Exception to Coverage Request
Complete Legibly to Expedite Processing

COMPLETE REQUIRED CRITERIA AND FAX TO: 855-668-8551 (toll free) or 920-735-5350 (local)			
Date:		Prescriber Name:	
Patient Name:		Prescriber NPI:	
Unique ID:		Prescriber Phone:	
Date of Birth:		Prescriber Fax:	

REQUEST TYPE:	☐ Quantity Limit Increase[1]	☐ Gender-Specific[2]	☐ High Dose[3]
	☐ New Drug[4]	☐ Not Covered[5]	

[1] **Quantity Limit Increase:** Dose prescribed exceeds allowed quantity limits. Indicate diagnosis/clinical rationale why the covered quantity and/or dosing are insufficient. See formularies at navitus.com for specific quantity limit restrictions.

[2] **Gender-Specific Medications:** Indicate diagnosis / clinical rationale for use.

[3] **High Dose Alert:** Dose prescribed is flagged as >2.5 times the recommended maximum daily dose. Please provide monitoring criteria and/or clinical rationale for use of high dose.

[4] **New Drugs:** Drug prescribed has not yet been reviewed by the P&T Committee. For coverage consideration, all covered alternatives must be tried and failed or contraindicated. Complete the formulary alternatives table.

[5] **Not Covered Drugs:** All formulary alternatives must be tried and failed or contraindicated. Complete the formulary alternatives table.

REQUESTED DRUG INFORMATION	INDICATION / REASON FOR USE / CLINICAL RATIONALE
DRUG*	
STRENGTH	
FREQUENCY	
QUANTITY	

* If the drug requested is **BRAND** with an **A-RATED GENERIC,** an FDA MedWatch Form **must** be submitted. Access the form at http://www.fda.gov/medwatch/getforms.htm and attach a completed copy to request.

Formulary Alternative(s)	Max Dose Used	Dosing Frequency	Use Start-End Dates	Describe Specific and Significant Side Effects and/or Ineffectiveness

** If complex medical management exists, supply supporting documentation with this request.

If Approved, Coverage is Granted for One Year

Prescriber Signature: _____ **Date:** _____