



Health & Welfare Benefit Plans

Summary Plan Description (SPD)



Updated as of January 1, 2019

Within these documents, the terms “Baylor Scott & White Health”, “BSWH” and “Company” refer to Baylor Scott & White Health and its affiliates. A complete list of employers participating in the health and welfare plans may be obtained by a participant or beneficiary upon written request to the Plan Administrator, and is available for examination by a participant or beneficiary.

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Introduction: A Guide to Your Benefits

This booklet contains Summary Plan Descriptions (SPDs) that describe how the Baylor Scott & White Health employee benefit plans (the plans) work. Each section has important details about specific plans. This section provides important information on eligibility, enrollment and paying for coverage.

HIGHLIGHTS

- Baylor Scott & White Health benefit plans help protect you and your family, day to day and over the long term. Along with your pay, your benefits are an important and valuable part of your total compensation.
- The Company pays all of the cost for certain benefits and asks you to pay all or part of the cost for others. Your portion of the cost is small compared to what you would pay to purchase this coverage elsewhere.

This SPD is your benefits resource. You should be able to find everything you need here. But if you can't find what you need, help is just a phone call away. Call PeoplePlace at 1-844-417-5223, Monday through Friday, 7:30 a.m. to 5 p.m. CT, except on holidays, and a Human Resources Representative will assist you. You can also visit the Baylor Scott & White Health benefits site at bswhbenefits.com.

See the [Administrative & General Information](#) section for additional information.

ELIGIBILITY

Your eligibility to participate in the plans is based on your employment status.

Your health and welfare benefits include Medical, Dental, Vision, Life Insurance, Accidental Death & Dismemberment (AD&D) Insurance, Disability Income, the Employee Assistance Program (EAP), Flexible Spending Accounts (FSAs), Business Travel & Accident Benefits, and Legal Services.

Baylor Scott & White Health offers health and welfare benefits to:

- Full-time employees regularly scheduled to work 30+ hours per week who are not classified in a PRN position
- Part-time employees regularly scheduled to work 20 – 29 hours per week

When you are hired or become benefits-eligible, you are automatically enrolled in Basic Life Insurance, Basic AD&D Insurance, the EAP, and Basic Long-Term Disability. In addition, if you are eligible for Business Travel & Accident benefits, you are automatically enrolled in that coverage when your eligibility begins.

On the date you meet the above eligibility requirements (your hire date or another date), you are immediately eligible to enroll in the following options:

- Medical Benefits
- Dental Benefits
- Vision Insurance
- Voluntary Life Insurance
- Spouse/Child(ren) Life Insurance
- Voluntary Dependent AD&D Insurance
- Voluntary Short-Term Disability Insurance
- Voluntary Long-Term Disability Insurance
- Healthcare FSA (General Purpose and Limited Purpose)
- Dependent Care FSA
- Health Savings Account (HSA)
- Legal Services Plan

Additional Eligibility Rules

- If both you and your spouse work for Baylor Scott & White Health, you may each enroll in the health and welfare plans as employees or one of you may enroll as an employee and the other as a dependent.
- No one can be covered for health and welfare benefits both as an employee and as a dependent, or as a dependent of more than one employee.
- As an active employee, you cannot cover dependents under a health and welfare plan unless you also are covered under the same plan.
- If you fit one of the following descriptions, you are not eligible to participate in the health and welfare plans:
 - Non-active employee
 - Temporary worker
 - Employee classified as a “call-in employee”, including a PRN employee
 - Leased employee
 - Individual classified by the Company as an independent contractor
 - Individual who has agreed in writing or whose offer of employment states that he or she is ineligible for benefits
 - Employees who are nonresident aliens who receive no earned income from sources within the U.S.

YOUR DEPENDENTS' ELIGIBILITY

If you are eligible for the health and welfare plans and you enroll, you may also enroll your eligible dependents. In general, your eligible dependents are:

- Your spouse or common-law spouse (if the common-law marriage is recognized under applicable state law), and
- Your children.

Dependent eligibility varies among the Baylor Scott & White Health benefit offerings from different providers.

The term "spouse", as used in this document and unless otherwise defined by the applicable insurer, means the person to whom you are legally married, but does not include a domestic partner or person with whom you have entered into a civil union.

The chart below shows the definitions and eligibility for dependent children under our Medical, Dental, Vision, Life and Accidental Death & Dismemberment (AD&D) insurance offerings.

	Medical, Dental, Vision	Life	AD&D
Age	Up to 26	Up to 26	Up to 26
Marital Status	Does not affect eligibility	Does not affect eligibility	Does not affect eligibility
Family Relationship	Natural	Natural	Natural
	Step	Step	Step
	Legally adopted	Legally adopted	Legally adopted
	Placed for adoption	Foster	Foster
	Foster		
	Child covered by Qualified Medical Child Support Order (QMCSO)*		
	Any child living with employee on a full-time basis, whom the employee claims as a dependent on his/her federal income tax return, and for whom the employee has legal custody (or had legal custody immediately prior to the child attaining age 18)		
Other Conditions	N/A	N/A	N/A
Disabled Children Age 26 and Older	Unmarried, physically and mentally incapacitated and unable to earn his/her own living; dependent on employee for at least 50% of financial support; claimed by employee as a dependent on federal income tax return; and disabled and covered under plan before age 26**	Primarily dependent on employee for financial support and maintenance; and became disabled before age 26 and at such time was the employee's dependent	Primarily dependent on employee for financial support and maintenance; and became disabled before age 26 and at such time was the employee's dependent

* A copy of Baylor Scott & White Health's Qualified Medical Child Support Order (QMCSO) procedures may be obtained by contacting PeoplePlace.

** If you are a new hire, or newly benefits eligible employee you may enroll a dependent over age 26 if the dependent:

- Is physically or mentally handicapped, and
- Meets the criteria shown above, and
- Has been enrolled for coverage as your dependent continually since the disability

You may be required to provide evidence of your dependent's eligibility. If Baylor Scott & White Health is unable to verify an individual's status as a dependent, coverage will not be provided to such individual.

Health and Welfare Enrollment

WHEN YOU ARE FIRST ELIGIBLE

When you are hired or become benefits-eligible, you must enroll within 30 days of hire or eligibility. You can enroll in two ways: on-line through the HR system found on www.myPeoplePlace.com.

If you do not enroll by the deadline, you must wait until the next annual enrollment period to enroll in the plan(s) unless you experience a qualifying event (see [page 6](#)). You must submit your qualifying event within 30 days of the qualifying event in order to start, change or stop certain benefit coverages. You may submit the event on-line through the HR system found on www.myPeoplePlace.com. If you are not at work because of an approved leave of absence on the day your coverage would normally become effective, coverage for you and your dependents starts as soon as you have been at work for one full day (excludes medical, dental, and vision). Once you enroll, coverage begins immediately.

ANNUAL ENROLLMENT

Each year during annual enrollment, you can start, change or waive coverage for the next calendar year by accessing www.myPeoplePlace.com. You may also add dependents or drop dependents you are covering. Your election is effective the January 1 following the annual enrollment period; it remains in effect for the entire year. You cannot make changes to your elections during the year unless you experience a qualifying event (see [page 6](#)). You must notify PeoplePlace within 30 days of the qualifying event in order to start, change or stop certain benefit coverages. If you do not file a new election during the annual enrollment period, your current elections, including FSA elections, will remain unchanged.

IF YOU DON'T ENROLL

If you don't enroll by the deadline date when you are first eligible, you will receive default coverage as follows:

Plan	Default Coverage
Medical	None
Dental	None
Vision	None
FSA's	No contributions
Life Insurance	Basic employee coverage only; no voluntary or spouse/child(ren) coverage
AD&D Insurance	Basic employee coverage only; no voluntary or spouse/child(ren) coverage
Disability	Basic long-term coverage and voluntary short-term coverage; no voluntary long-term
Legal Services	None
Employee Assistance Program	Covered
Business Travel & Accident	Covered if eligible

Don't Miss Your Enrollment Deadline

If you do not contact PeoplePlace or make a change on-line to enroll a newly eligible dependent (including a spouse, newborn child or newly adopted child) within 30 days of the day he or she becomes eligible, you must wait until the next annual enrollment period to enroll the new dependent. You must notify PeoplePlace of the new dependent even if you are enrolled in family coverage.

QUALIFYING EVENTS

The charts on the next few pages give an overview of how some life and work events affect your benefits. Federal law governs what changes you can make to some plans during the year if certain life and work events occur. As the charts indicate, any change you make to your benefit elections during

the year must be consistent with the change in status. You must take action within 30 days of the qualifying event or wait until the next annual enrollment. During annual enrollment, you can make any changes you wish to your benefit elections.

Event	Medical, Dental, Vision	Voluntary Life Insurance for Employee	Spouse Life Insurance	AD&D for Employee & Dependents
Birth or Adoption	If not enrolled, elect any option and tier; If enrolled, add new dependent to current coverage	Maintain, start or increase coverage by one level	Maintain, start or increase coverage	Maintain, start or increase coverage*
Death of a Dependent Child	If enrolled, cancel dependent child coverage if this is your only dependent child; otherwise, no change	No change	Maintain, decrease or cancel coverage	Coverage ends if this is your only dependent; otherwise, no change
Death of a Spouse	If not enrolled, elect any option and tier to add coverage for employee and dependent(s) who lost coverage under spouse's employer's plan because of spouse's death If enrolled, cancel coverage for spouse or add coverage for dependent(s) who were covered by spouse's employer's plan	Maintain, decrease or cancel coverage or start coverage if previously covered by deceased spouse's employer's plan	Coverage ends	Maintain or start coverage if child(ren) were covered by spouse's employer's plan
Divorce/ Annulment	If not enrolled, elect any option and tier to add coverage for employee and dependent(s) who were covered by ex-spouse's employer's plan if coverage is lost If enrolled, cancel coverage for spouse only or cancel coverage for spouse and dependent(s) if dependent(s) become covered by ex-spouse's employer's plan. Add dependent(s) who were covered by ex-spouse's employer's plan if coverage is lost	Maintain, decrease or cancel coverage or start coverage if previously covered by ex-spouse's employer's plan	Cancel coverage	Maintain or start coverage if previously provided by ex-spouse's employer's plan and that coverage is lost

*Requests to increase coverage will only apply to those who are actively at work. Child life is not subject to this rule.

Event	Medical, Dental, Vision	Voluntary Life Insurance for Employee	Spouse Life Insurance	AD&D for Employee & Dependents
Marriage	If not enrolled, elect any option and tier. If enrolled, add coverage for new dependent(s) or decrease or cancel if employee and dependent(s) become covered by new spouse's employer's plan.	Maintain, start or increase coverage; or decrease or cancel coverage if become covered by new spouse's employer's plan	Start coverage	Maintain or start coverage for new dependent child(ren)
Loss of Dependent Eligibility (e.g. child turns 26)	Cancel dependent child coverage if this is your only dependent; otherwise, no change	No change	No change	Cancel coverage if this is your only dependent
Beginning Unpaid Leave of Absence	Maintain or cancel coverage	Maintain or cancel coverage	Maintain or cancel coverage	Maintain or cancel coverage
Return from Unpaid Leave of Absence	Reinstate previous option and tier	Reinstate previous option and tier	Reinstate previous option and tier	Reinstate previous option
Paid Leave of Absence	No change	No change	No change	No change
Change from Part-Time Benefits Eligible to Full-Time Benefits Eligible Employment	Maintain, start or increase coverage (medical plan only). Dependents can be added. No change allowed for dental and vision.	Maintain, start or increase coverage	No change	No change
Change from Full-Time Benefits Eligible to Part-Time Benefits Eligible Employment	Decrease coverage or cancel. Dependents can be dropped. No change allowed for dental and vision.	Maintain, decrease or cancel coverage	No change	No change
Spouse/ Dependent Starts Employment	Maintain, decrease or cancel coverage for employee, spouse and/or dependent(s) if coverage provided by new employer's plan	Maintain, decrease or cancel coverage if coverage provided by new employer's plan (no change permitted based on dependent's employment)	Maintain, decrease or cancel coverage if coverage provided by new employer's plan	Maintain, decrease or cancel coverage if coverage provided by new employer's plan

*Requests to increase coverage will only apply to those who are actively at work. Child life is not subject to this rule.

Event	Medical, Dental, Vision	Voluntary Life Insurance for Employee	Spouse Life Insurance	AD&D for Employee & Dependents
Spouse/ Dependent Loses Employment	Maintain, start or increase coverage of employee, spouse and/ or dependent(s) who lose coverage under spouse's former employer's plan	Maintain, start or increase coverage if previously covered by spouse's former employer's plan (no change permitted based on dependent's employment)	No change	No change
Spouse Changes Between Part-Time and Full-Time Employment	No change	No change	No change	No change
Loss of Other Coverage	Maintain, start or increase tier to cover employee, spouse and/or dependent	No change	No change	No change
Qualified Medical Child Support Order (QMCSO)	Maintain, start or increase tier to cover dependent(s) if QMCSO requires employee to provide coverage; decrease tier to cancel coverage for dependent(s) if QMCSO requires another individual to provide coverage and the other individual in fact provides coverage	No change	No change	No change
Medicaid/ Medicare	Medical: Maintain, decrease or cancel coverage if individual becomes eligible for Medicaid or Medicare; maintain, start or increase tier if individual loses eligibility for Medicaid or Medicare Dental/Vision: no change	No change	No change	No change
Marketplace Eligibility	Medical: Maintain, decrease or cancel coverage if individual becomes eligible for coverage in the Marketplace. Dental/Vision: no change	No change	No change	No change

Event	Voluntary AD&D Insurance	Voluntary Short or Long-Term Disability	Health Care FSA	Dependent Care FSA
Birth or Adoption	Maintain, start or increase coverage	Maintain or start coverage	Maintain, start or increase contribution	Maintain, start or increase contribution
Death of Dependent Child	Maintain or cancel family coverage if this is your only dependent	Maintain or cancel coverage	Maintain, decrease or stop contribution	Maintain, decrease or stop contribution
Death of Spouse	Maintain or cancel family coverage if spouse is your only dependent; start or increase coverage for employee and dependents if previously covered by spouse's employer's plan	Maintain or start coverage	Maintain, start or increase contribution if employee and/or dependents previously participated in spouse's employer's plan; decrease or stop contribution	Maintain, start, increase, decrease or stop contribution
Divorce/ Annulment	Maintain or cancel family coverage if spouse is your only dependent; start or increase coverage for employee and family if previously covered by ex-spouse's employer's plan	Maintain or start coverage	Maintain, start or increase contribution if employee and/or dependents previously participated in ex-spouse's employer's plan; decrease or stop contribution for spouse and dependents who become participants in ex-spouse's employer's plan	Decrease or stop contribution only if custody of child is with ex-spouse; otherwise, maintain contribution
Marriage	Maintain, start or increase family coverage; decrease or cancel coverage for employee and/or family if coverage provided by new spouse's employer's plan	Maintain or start coverage	Maintain, start or increase contribution; decrease or stop contribution if employee and/or dependent(s) participate in new spouse's employer's plan	Maintain, start, increase or stop contribution
Loss of Dependent Eligibility	Cancel family coverage if this is your only dependent; maintain self coverage	No change	Maintain, decrease or stop contribution	Maintain, decrease or stop contribution for dependent who loses eligibility
Beginning Unpaid Leave of Absence	Maintain or cancel coverage	Maintain or cancel coverage	Maintain, decrease or stop contribution	Maintain, decrease or stop contribution

Event	Voluntary AD&D Insurance	Voluntary Short or Long-Term Disability	Health Care FSA	Dependent Care FSA
Return from Unpaid Leave of Absence	Reinstate previous option and tier	Reinstate previous option	Reinstate previous contribution	Reinstate previous contribution
Paid Leave of Absence	No change	No change	No change	No change
Change from Part-Time Benefits Eligible to Full-Time Benefits Eligible Employment	No change	No change	No change	Increase or add coverage
Change from Full-Time Benefits Eligible to Part-Time Benefits Eligible Employment	No change	No change	No change	Decrease or reduce coverage
Spouse/ Dependent Starts Employment	Maintain, decrease or cancel coverage for employee and family if coverage provided by new employer's plan	Maintain, decrease or cancel coverage if coverage provided by new employer's plan	Maintain, decrease or stop contribution if employee and/ or dependents participate in new employer's plan	Maintain, decrease or stop contribution (for spouse event only)
Spouse/ Dependent Loses Employment	Maintain, start or increase tier for coverage of employee and/ or family who lose coverage under spouse's former employer's plan	Maintain or start coverage if coverage provided by former employer's plan	Maintain, start or increase contribution	Maintain, decrease or stop contribution (for spouse event only)
Spouse Changes Between Part-Time and Full-Time Employment	No change	No change	No change	No change
Loss of Other coverage	No change	Maintain or start coverage	Maintain, start or increase contribution	No change

Event	Voluntary AD&D Insurance	Voluntary Short or Long-Term Disability	Health Care FSA	Dependent Care FSA
Qualified Medical Child Support Order (QMCSO)	No change	No change	Maintain, start or increase contribution if QMCSO requires employee to elect option; decrease or stop contribution if QMCSO requires another individual to elect option and other individual in fact elects option	No change
Medicaid/Medicare	No change	No change	No change	No change
Marketplace Eligibility	No change	No change	No change	No change

In addition to the qualifying events described above, you may be able to change your elections (other than the Healthcare FSA) during the year if there are certain significant cost or coverage changes in your benefits. These rules are summarized below:

- If there is an insignificant increase or decrease in the cost of a benefit option, Baylor Scott & White Health may automatically change your premium election to cover the change in cost.
- If there is a significant increase in the cost of a benefit option, you may, on a prospective basis, revoke your election and elect coverage under another benefit option providing similar coverage, or drop coverage if no other benefit option provides similar coverage. If there is a significant decrease in the cost of a benefit option, you may revoke your election and commence participating in the benefit option with the decrease in cost. You may change your Dependent Care FSA election if your daycare provider changes the cost of daycare, unless the provider is a relative or family member.
- If your coverage is significantly curtailed without a loss of coverage (for example, a significant increase in the deductible, co-pay, or out-of-pocket limit), you may revoke your election under the option that is being curtailed, but only if you elect similar coverage under an alternate benefit option.
- If your coverage is significantly curtailed with a loss of coverage (for example, elimination of a benefit option), you may revoke coverage under the plan being curtailed and make a new election for similar coverage under a new benefit option, or drop coverage if no other similar benefit option is available.

- If during a period of coverage, a new benefit option is added or an existing benefit option is significantly improved, you may be allowed to elect the new option or improved benefit option prospectively on a pre-tax basis and change your election with respect to the other benefit option providing similar coverage.
- You may change your election if you experience a change in coverage under another employer-sponsored plan so long as the other plan permits a change in election or has a non-calendar plan year.
- You may change your election to add coverage for yourself or a dependent if you or your dependent loses group health coverage sponsored by a governmental or educational institution, such as SCHIP.

PAYING FOR COVERAGE

Your cost for coverage depends on the options you choose. Your share of the cost for coverage and your contributions to the FSAs will be deducted from your paycheck beginning with the first available paycheck after you enroll as a new hire or newly eligible employee.

For annual enrollment elections you make each fall, coverage costs and contribution deductions generally begin with the first paycheck of the new calendar year. Health and welfare deductions are normally taken from all 26 paychecks during the year.

By enrolling in the health and welfare plans, you give the Company permission to take pre-tax paycheck deductions as described below. In the event that premiums are missed from a pay period, we reserve the right to collect from future paychecks.

Pre-Tax vs. After-Tax Dollars

A few tax-related issues affect some of your benefits. While these issues probably won't affect your benefit decisions, you should be aware of them.

When you pay for your benefits with pre-tax dollars, deductions are taken before federal and (in some cases) state income taxes are calculated. So you actually lower your taxable income, which means you pay less in taxes overall.

You use pre-tax dollars to pay for coverage in these areas:

- Medical
- Dental
- Vision
- General Purpose and Limited Purpose FSA contributions
- Voluntary Short-Term Disability
- HSA Contributions

By paying for certain benefits with after-tax dollars, you do not have to pay income tax on the value of the benefit if received. You use after-tax dollars to pay the premium for coverage in these areas:

- Voluntary Life Insurance
- Spouse/Child(ren) Life Insurance
- Voluntary and Family AD&D
- Voluntary Long-Term Disability
- Legal Services Plan

Any benefit you receive from the Basic Long-Term Disability plan is considered taxable income. Any benefit you receive from Basic Life Insurance, Voluntary Life Insurance, Spouse/Child Life Insurance, Basic and Voluntary AD&D Insurance, Voluntary Long-Term Disability, Business Travel & Accident or the Legal Services Plan is not considered taxable income.

Effect on Other Benefits

Pre-tax dollars reduce your income for tax purposes only. Each plan's coverages and benefits are based on your annualized base pay before pre-tax deductions are taken.

Effect on Social Security

Pre-tax payments reduce your taxable income. And, they lower your Social Security taxes. Because you may be paying lower Social Security taxes, you should be aware that any future Social Security benefits you may receive might be slightly reduced.

However, your current tax savings more than offset future Social Security benefit reductions. If you need more information, contact your local Social Security Administration office.

WHEN HEALTH AND WELFARE COVERAGE ENDS

Your benefit coverage ends when any of the following occurs:

- You choose not to elect coverage during annual enrollment or after experiencing a qualifying event
- You stop paying your share of the cost for the coverage
- You terminate employment
- You no longer meet the eligibility requirements
- Your employer stops participating in a plan
- A plan is terminated or amended to terminate coverage for a group or class of employees that includes you

Your spouse's benefit coverage ends when any of the following occur:

- Your coverage ends
- You choose not to enroll your spouse for coverage during annual enrollment or after experiencing a qualifying event
- You stop paying for spouse coverage
- You and your spouse divorce
- A plan is terminated or amended to terminate coverage for dependents
- Your spouse dies

Your other dependents' benefit coverage ends when any of the following occur:

- Your coverage ends
- You choose not to enroll your dependents for coverage during annual enrollment or after experiencing a qualifying event
- You stop paying for dependent coverage
- Your dependent no longer meets the eligibility requirements for dependent coverage
- A plan is terminated or amended to terminate coverage for dependents
- Your dependent dies

Special Rules for PRN Employees

If your employment status changes to PRN, you will no longer be eligible to participate in the health and welfare plans and your coverage will cease in the same manner as if you had terminated employment on the date of your employment status change. See the *If You Leave the Company* section on the next page for additional information as to the termination of your health and welfare benefits.

If You Leave the Company

If you leave the Company, your Medical, Dental, Vision, Life Insurance, AD&D Insurance, Long-Term Disability, and Legal Services coverage ends on the last day (12:00 midnight) of the month in which your employment terminates. Premium payments for continuation of this coverage occur on each paycheck that you receive. Each paycheck that covers any calendar days in the month in which you terminate will have a premium payment deducted.

Voluntary Short-Term Disability, Business Travel Accident, and Employee Assistance Plan coverage end on your last day of

employment. FSA contributions end with your last paycheck. For the FSAs, you generally have 90 days after the end of the plan year in which you terminate employment to file claims for benefits incurred while you were covered under the FSA.

You may convert your Basic Life Insurance coverage to an individual policy. You may be able to elect portability of your additional life insurance and AD&D insurance coverage to an individual policy at the carrier group rate within 62 days of your termination. Contact PeoplePlace to obtain information.

Plan	Coverage Ends	Contribution Ends
Medical	Last day of the month in which your employment terminates	With your last paycheck
Dental	Last day of the month in which your employment terminates	With your last paycheck
Vision	Last day of the month in which your employment terminates	With your last paycheck
Basic Life	Last day of the month in which your employment terminates	With your last paycheck
Voluntary Life	Last day of the month in which your employment terminates	With your last paycheck
Spouse Life	Last day of the month in which your employment terminates	With your last paycheck
Child(ren) Life	Last day of the month in which your employment terminates	With your last paycheck
Basic AD&D	Last day of the month in which your employment terminates	With your last paycheck
Voluntary AD&D	Last day of the month in which your employment terminates	With your last paycheck
Basic Long-Term Disability	Last day of the month in which your employment terminates	With your last paycheck
Voluntary Long-Term Disability	Last day of the month in which your employment terminates	With your last paycheck
Healthcare FSA	You have until your last day of employment to incur eligible expenses	With your last paycheck
Dependent Day Care FSA	You have until your last day of employment to incur eligible expenses	With your last paycheck
Voluntary Short-Term Disability	Last day of employment	With your last paycheck
Legal Services	Last day of the month in which your employment terminates	With your last paycheck
Business Travel & Accident	Last day of employment	N/a
Employee Assistance Program	Last day of employment	N/a

CONTINUATION OF COVERAGE THROUGH COBRA

COBRA continuation coverage is a temporary extension of coverage under the medical, dental, vision and Healthcare FSA plans. The right to COBRA continuation coverage was created by a federal law. COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage.

It can also become available to other members of your family who are covered under the plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the plans and under federal law, you should review this Summary Plan Description or contact PeoplePlace.

How COBRA Works

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse and your dependent children could become qualified beneficiaries if your medical, dental or vision coverage or Healthcare FSA participation ends because of the qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your group health coverage or Healthcare FSA participation because either one of the following qualifying events happens:

- Your hours of employment are reduced
- Your employment ends for any reason other than your gross misconduct

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your group health coverage because any of the following qualifying events happens:

- Your spouse dies
- Your spouse’s hours of employment are reduced
- Your spouse’s employment ends for any reason other than his or her gross misconduct
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both)
- You become divorced or legally separated from your spouse

Your dependent children will become qualified beneficiaries if they lose group health coverage because any of the following qualifying events happens:

- The parent-employee dies
- The parent-employee’s hours of employment are reduced
- The parent-employee’s employment ends for any reason

other than his or her gross misconduct

- The parent-employee becomes entitled to Medicare benefits (under Part A, Part B or both)
- The parents become divorced or legally separated
- The child stops being eligible for coverage as a “dependent child”

When COBRA Coverage Is Available

COBRA continuation coverage is offered to qualified beneficiaries only after the COBRA Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer or the employee’s becoming entitled to Medicare benefits (under Part A, Part B or both), Baylor Scott & White Health must notify the COBRA Administrator of the qualifying event.

For other qualifying events (divorce, legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the COBRA Administrator in writing within 60 days after the qualifying event occurs. Documentation of the qualifying event is required.

How COBRA Coverage Is Provided

Once the COBRA Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation on behalf of their spouse, and parents may elect COBRA continuation coverage on behalf of their dependent children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee’s becoming entitled to Medicare benefits (under Part A, Part B or both), divorce or legal separation, or a dependent child’s loss of eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee’s hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight (8) months before the date on which his employment terminates, COBRA continuation coverage for his spouse and dependent children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months–8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee’s hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in

which this 18-month period of COBRA continuation coverage can be extended:

- **Disability extension of 18-month period of continuation coverage.** If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled and you notify Baylor Scott & White Health in writing in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. This notice must be in writing and sent to the COBRA Administrator. In all cases, this notice must be sent within 60 days after the Social Security determination of disability is issued.
- **Second qualifying event extension of 18-month period of continuation coverage.** If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given in writing to the COBRA Administrator within 60 days of the second qualifying event. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred.

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or COBRA Administrator.

You can obtain further information about COBRA continuation coverage from PeoplePlace.

Continuation Coverage for a Healthcare FSA

If your employment terminates for any reason other than your gross misconduct while you were contributing to a Healthcare FSA, you or a qualified beneficiary may continue contributions, on an after-tax basis, until the end of the calendar year in which your employment terminated. You may submit claims until April 30 of the year following the calendar year in which your employment terminated, for eligible healthcare expenses incurred through March 15 of that year. See the [Flexible Spending Accounts](#) section for additional information.

Electing COBRA Continuation Coverage

When a qualifying event occurs, you or your dependent(s) who are qualified beneficiaries must request continued coverage. Baylor Scott & White Health's COBRA Administrator will give you and your dependent(s) all of the details about continued coverage, including the cost, and will provide you or your dependent(s) with an election form. To continue coverage, the completed election form must be sent to the address shown on the form within 60 days after the latest of the date:

- You or your dependent were provided the election form, or
- Plan coverage ends.

Each of your eligible dependents has an independent election right for COBRA coverage. If you or your dependents elect to continue coverage, either you or they must pay 102% (or in the case of an extension of continuation coverage due to a disability, 150% during the disability extension period) of the cost of the coverage elected (including the portion previously paid by Baylor Scott & White Health). Coverage costs may change from year to year.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You may have the right to request special enrollment in the Health Insurance Marketplace, Medicaid, or in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Early Termination of COBRA Continuation Coverage

COBRA continuation coverage will stop before the end of the maximum period under any of the following circumstances:

- The required contributions are not made on a timely basis
- Recovery from disability, if the individual is eligible for extended continuation coverage due to disability, but not before 18 months of continuation coverage
- The group health plans provided by Baylor Scott & White Health are terminated
- After electing COBRA continuation coverage, a qualified beneficiary becomes entitled to Medicare (under Part A, Part B or both) or another group plan that does not have a pre-existing conditions clause

COBRA continuation coverage may also be terminated for any reason if the group health plans would terminate coverage of a participant who is not receiving continuation coverage (such as fraud).

If you have already received 18 months of COBRA continuation coverage, you are receiving extended COBRA continuation coverage due to your or a family member's disability, and the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you are required to

notify the COBRA Administrator of that fact within 30 days after the Social Security Administration's determination.

If you provide notice to the COBRA Administrator as described in this Summary Plan Description and you are determined to be ineligible for COBRA continuation coverage or for a disability or second qualifying event extension, you will be notified in writing.

Continuation during a Leave of Absence

If you are on an authorized medical, personal, and/or family leave, you may continue your insurance coverage at the same cost as active employees for the first six months of leave. If you are on a military leave, benefits may continue up to 24 months. If you are on an authorized leave and receiving Long-Term Disability (LTD) benefits, you may continue your coverage at the same cost as active employees for up to a maximum of 12 months.

Paid Leave

If you are on a paid leave, insurance coverage deductions will be payroll deducted for up to six months.

Unpaid Leave

If you are on an unpaid leave, you will be billed for your benefit premiums. It is your responsibility to make payments as directed or your medical insurance coverage automatically ends after 60 days of non-payment.

Military Leave

If you are on a military leave, your medical insurance coverage may continue for up to 24 months. The first six months will be treated as described above in Unpaid Leave. After six months, your cost for medical coverage will be the COBRA rate.

If You Retire

Retiree benefits (including the cost of coverage) can be changed, amended or terminated at any time.

Retiree Medical/Dental Plan

The Scott & White Retiree Medical Program is available to legacy Scott & White Healthcare employees who meet the

eligibility requirements described below.

1. If you met the eligibility requirements for access to pre-65 Retiree Medical coverage (without a subsidy) as of December 31, 2013, you will continue to be eligible when you retire from Baylor Scott & White Health.
2. If you met the eligibility requirements for subsidized access to pre-65 Retiree Medical coverage as of December 31, 2013, you will continue to be eligible when you retire from Baylor Scott & White Health.
3. If you did not meet either requirement as outlined in 1 and 2 as of December 31, 2013, you will not be eligible for pre-65 Retiree Medical coverage in the future.
4. The program is closed to new hires, and to employees who become a part of Baylor Scott & White as the result of a merger or acquisition in the future. Hillcrest employees are not eligible for this plan.

You are eligible for benefits under the Retiree Medical Program until age 65 if you met the following age and service requirements as of December 31, 2013.

If the retiree waives retiree medical or dental coverage at retirement, during annual enrollment, due to a qualifying event or for any other reason, the retiree cannot enroll or re-enroll in the retiree medical plan or the dental plan.

If the retiree is not eligible for subsidized medical coverage as noted above, the retiree's spouse and/or children are also not eligible. Coverage for dependents on this plan ends when the retiree turns 65 and is no longer eligible for coverage.

If the retiree should die, the retiree's spouse and any of the retiree's dependent children covered at the time of the retiree's death lose coverage under the retiree medical plan and the dental plan. However, they will be eligible to elect COBRA coverage.

Employees who retire after the age of 65 with at least 5 years of service may be eligible for a discount on Medicare Advantage plans offered through Scott & White Health Plan.

Age at Retirement	Years of Service	Premium Paid by BSWH	Premium Paid by Retiree
Access Only – No Subsidy			
50-54	20	0	100%
55-61	5 to 24	0	100%
62-65	5 to 9	0	100%
Access & Subsidy			
55-61	25 or more	50%	50%
62 – 65	10 to 24	50%	50%
62-65	25 or more	Same as active staff	Same as active staff

Life Insurance for Retirees

Retiree life insurance applies to those who retired on or before December 31, 2015, and whose names are on file with Cigna Group Insurance. Retiree life insurance is not offered to any employee who retires after December 31, 2015.

Retirees pay 100% of the cost of this coverage based on their coverage amount. Retiree life insurance is administered by AmWINS Group Benefits Inc., an administrator for Cigna. For questions related to retiree life insurance contact AmWINS Group Benefits Inc., at 1-800-423-1282.

Administrative & General Information

This section describes administrative, general and legal information regarding your health and welfare benefit plans. Your benefit plans are governed by federal law, official plan documents, insurance carrier contracts and the Baylor Scott & White Employee Benefits Administrative Committee.

IMPORTANT NOTE

This information is designed to explain, in simple language, all important features of the plans. Every effort has been made to provide clear, complete and understandable information. However, the legal plan documents and insurance contracts, where applicable, have the final word about the rights of participants and their dependents.

PLAN DETAILS

Plan Option	Official Plan Name	Type of Plan	Plan Funding	Paid Through Welfare Trust	Plan ID Number	COBRA Administrator	Employer ID Number
Medical Plan	Baylor Scott & White Health Medical and Welfare Benefits Plan	Health & Welfare Benefit Plan	Self-Insured	Yes	508	508	46-3130985
Dental Plan	Baylor Scott & White Health Medical and Welfare Benefits Plan	Health & Welfare Benefit Plan	Fully Insured	Yes	508	508	46-3130985
Vision Plan	Baylor Scott & White Health Medical and Welfare Benefits Plan	Health & Welfare Benefit Plan	Fully Insured	Yes	508	508	46-3130985
Healthcare Flexible Spending Account	Baylor Scott & White Health Medical and Welfare Benefits Plan	Health & Welfare Benefit Plan	Participating Employees' Pre-Tax Contributions	Yes	508	508	46-3130985
Dependent Day Care Flexible Spending Account	Baylor Scott & White Health Medical and Welfare Benefits Plan	Health & Welfare Benefit Plan	Participating Employees' Pre-Tax Contributions	Yes	508	N/A	46-3130985

Plan Option	Official Plan Name	Type of Plan	Plan Funding	Paid Through Welfare Trust	Plan ID Number	COBRA Administrator	Employer ID Number
Business Travel & Accident	Baylor Scott & White Health Medical and Welfare Benefits Plan	Health & Welfare Benefit Plan	Fully Insured	No	508	N/A	46-3130985
Short-Term Disability Plan	Baylor Scott & White Health Medical and Welfare Benefits Plan	Health & Welfare Benefit Plan	Self-Insured	No	508	N/A	46-3130985
Long-Term Disability Plan	Baylor Scott & White Health Medical and Welfare Benefits Plan	Health & Welfare Benefit Plan	Fully Insured	Yes	508	N/A	46-3130985
Life Insurance Plan	Baylor Scott & White Health Medical and Welfare Benefits Plan	Health & Welfare Benefit Plan	Fully Insured	Yes	508	N/A	46-3130985
AD&D Plan	Baylor Scott & White Health Medical and Welfare Benefits Plan	Health & Welfare Benefit Plan	Fully Insured	Yes	508	N/A	46-3130985
Employee Assistance Program	Baylor Scott & White Health Medical and Welfare Benefits Plan	Health & Welfare Benefit Plan	Fully Insured	Yes	508	N/A	46-3130985
Legal Services Plan	Baylor Scott & White Health Medical and Welfare Benefits Plan	Health & Welfare Benefit Plan	Fully Insured	Yes	508	N/A	46-3130985

ADMINISTRATORS

Plan Administrator

Baylor Scott & White Holdings is Plan Administrator for all plans described in this book. The Plan Administrator has ultimate responsibility for administering all plans. These responsibilities are sometimes delegated to the various vendors described in this section. The Plan Administrator's address is:

Baylor Scott & White Holdings

Attn: Benefits Department
440 Lyndon B. Johnson Frwy
Plaza II, Suite 225
Irving, TX 75063

Agent for Service of Legal Process

File legal papers on the plans at:

Baylor Scott & White Holdings

Attn: Benefits Department
440 Lyndon B. Johnson Frwy
Plaza II, Suite 225
Irving, TX 75063

Legal papers may also be served on the Plan Trustee.

Claims Administrators

Each claims administrator has the discretionary authority to determine the benefit amount payable, to interpret the plans' terms for eligibility and coverage issues, to resolve uncertainties and to make decisions about the facts and circumstances of plan claims.

For information regarding eligibility, refer to the Eligibility portion of the Guide to Your Benefits section. Coverage issues include:

- Covered claims for benefits
- Determinations regarding disabilities
- Documentation required by the claims administrator
- Validity of beneficiary designations
- Portability rights
- Other questions concerning plan coverage

The following is a list of claims administrators:

Medical Options

Scott & White Health Plan

1206 West Campus Drive
Temple, TX 76502
1-844-843-3229

Prescription Drug Benefit

Scott & White Health Plan

1206 West Campus Drive
Temple, TX 76502
800-728-7947

Dental Options

MetLife

P.O. Box 981282
El Paso, TX 79998-1282
1-800-942-0854

Vision Option

First American Administrators, Inc.

EyeMed Vision Care
P.O. Box 8504
Mason, OH 45040-7111

Life Insurance

Cigna

1640 Dallas Parkway
Plano, TX 75093

Short-Term Disability

Absence Center

844-511-5762

Long-Term Disability

Cigna

1601 Chestnut Street
Philadelphia, PA 19192-2235

Flexible Spending Accounts

Optum

P.O. Box 30516
Salt Lake City, UT 84130-0516

Employee Assistance Program

Cigna

11095 Viking Drive
Eden Prairie, MN 55344

Accidental Death & Dismemberment Insurance

Cigna

1640 Dallas Parkway
Plano, TX 75093

Business Travel & Accident

Chubb Group of Insurance Companies

600 Independence Parkway
P.O. Box 4700
Chesapeake, VA 23327-4700
1-800-252-4670

Legal Services Plan

Hyatt Legal Plans

1111 Superior Ave.
Cleveland, OH 44114-2407
1-800-821-6400
www.legalplans.com

EMPLOYEE BENEFITS ADMINISTRATIVE COMMITTEE

For the Baylor Scott & White Health plans, the Baylor Scott & White Employee Benefits Administrative Committee consists of employees and officers of Baylor Scott & White Health. The Baylor Scott & White Employee Benefits Administrative Committee has specific authority and duties in plan administration as outlined in its Rules of Operation. The Baylor Scott & White Employee Benefits Administrative Committee has the discretionary authority to interpret the terms of the plans, resolve all questions of fact and other uncertainties relating to the plans.

The Baylor Scott & White Employee Benefits Administrative Committee is responsible for advising on overall plan design and day-to-day administrative matters.

The Committee can be contacted at:

Baylor Scott & White Holdings

Attn: Employee Benefits Administrative Committee,
Benefits Department
440 Lyndon B. Johnson Frwy
Plaza II, Suite 225
Irving, TX 75063

PEOPLEPLACE

Baylor Scott & White Health has established PeoplePlace to aid you with your benefit plans. Human Resources Representatives are available weekdays to help you from 7:30 a.m.–5 p.m. CT, except on nationally recognized holidays. Call 1-844-417-5223.

The PeoplePlace website is available 24 hours a day, seven days a week. It provides detailed information regarding your plans and answers to frequently asked questions. Visit the website at www.myPeoplePlace.com.

ASSIGNING YOUR BENEFITS

Your benefits belong to you. You may not assign, sell, transfer or pledge any benefits or claim for benefits under this Plan to any third party, including, but not limited to any provider of services. Any assignment by you will be void. Assignment means the transfer to another person or to an organization of your right to the services provided under the Plan or your right to receive payment from the Plan for those services. However, you may request that the Plan make payment for services directly to a provider instead of payment to you. You also may designate beneficiaries to receive your life insurance and AD&D benefits in the event of your death.

The Plan Administrator reserves the right to pay plan benefits to someone acting on your behalf if you are not competent to receive plan benefits, or to your estate if you die while plan benefits are still owed to you. If the Plan Administrator pays benefits to a third party in good faith, benefits will not be paid again.

Court Orders

If you become divorced, certain court orders could require you to provide healthcare coverage to your dependent child(ren). A court order of this type is known as a Qualified Medical Child Support Order (QMCSO). If the QMCSO satisfies legal requirements and you are eligible to participate, you may enroll yourself and your eligible children covered by the QMCSO in the medical, dental and vision plans and the Healthcare Flexible Spending Account. Enrollment procedures are as follows:

- If you are currently enrolled in required coverages, you may add the designated child(ren) to your current option selections. This may result in an increase in premiums if your coverage tier changes. Coverage is effective on the date specified in the court order.
- If you are not currently participating in required coverages, you will be given the opportunity to elect options offered by Baylor Scott & White Health. The coverage levels you elect must be consistent with Baylor Scott & White Health offerings.
- If you do not respond to the court order within the designated period, Baylor Scott & White Health is required by law to comply by automatically enrolling the designated child(ren) as the QMCSO instructs. If the QMCSO does not otherwise dictate coverage, the designated child(ren) will be enrolled in the following coverages. This may result in an increase in premiums if your coverage tier changes.
 - Medical: BSWH PPO
 - Dental: MetLife PPO Standard
 - Vision: Vision Option
- If you satisfy the court order by covering the designated child(ren) under a plan outside of Baylor Scott & White Health, you must provide confirmation of that coverage to PeoplePlace within the designated period. If you do not, enrollment will be automatic.

As soon as you are aware of any court proceedings that may affect your benefits, contact PeoplePlace. You will need to provide them with a copy of the QMCSO. You may obtain a copy of the plan's QMCSO procedures from PeoplePlace at 1-844-417-5223.

CLAIMS AND APPEALS PROCEDURES FOR THE MEDICAL PLAN

To receive benefits through the medical plan, you or your healthcare provider must file a claim. This section includes claims instructions, as well as some important rules for receiving benefits.

In-network providers are responsible for filing claims for services provided. If you get services from out-of-network providers, they may choose not to file the claim with your insurance. You have 12 months after the date on which the medical service is provided to submit a claim for benefits. However, as discussed below, the claims procedure and your right to a review of a denied claim will differ depending on the nature of the claim.

Your claim should include the following items, if applicable:

- Complete claim form required by your Claim Administrator
- Employee name, Social Security number, address and patient name
- Date, type and five-digit procedure code for the medical service received or requested
- Diagnosis code for the illness or injury
- Itemized charge and proof of payment (e.g. credit card receipt or voided check)
- Name and address of the doctor or hospital, along with the federal Tax Identification number
- If appropriate, other insurance explanation of benefits (EOB)
- If the claim is for a benefit requiring advance approval before medical treatment is received, indicate whether the claim is an urgent/emergent request as described on page 34

All claims must be submitted to the appropriate Claim Administrator. The Claim Administrator for each medical option under the plan is listed in the *Administrative & General Information* section.

Claims Relating to Eligibility and Enrollment

If your claim is for a determination as to your eligibility or the eligibility of your dependents to participate in the plan or your enrollment under the plan and is not accompanied by a claim for plan benefits, you must obtain a claim initiation form from PeoplePlace, then submit your claim, in a timely manner, in writing to the designated recipient. Your claim will be determined by the Plan Administrator. The decision of the Plan Administrator will be final and will not be subject to the appeals process. All determinations as to eligibility for participation in the plan made in connection with a claim for benefits under the plan will be made in accordance with the applicable claims procedure described below. To substantiate claims relating to eligibility or enrollment, you are encouraged to provide supporting documents such as a copy of personal enrollment confirmation or documentation regarding your employment status.

Review of Benefit Determination

The Claim Administrator has procedures for applying for benefits and for requesting a review of a benefit determination. If you have followed the Claim Administrator's procedures for benefit review and believe the result is incorrect, you may file a written appeal as outlined in this section.

Your "authorized representative" is a person you authorize, in writing, to act on your behalf or a person given authority by court order to submit claims on your behalf. In the case of a claim involving urgent care, a healthcare professional with knowledge of your condition may always act as your authorized representative. Any appeal actions described in this section that may be done by you may also be done by your authorized representative on your behalf.

If Your Claim Is Denied

Disagreements about benefit eligibility or payment amounts can occasionally arise. In most cases, they are resolved quickly by the appropriate Claim Administrator. If you can't resolve the disagreement, formal appeal procedures are in place for your use. Unless otherwise noted, you must file a written appeal with the appropriate Claim Administrator within 180 days of receiving the notice that your claim has been denied.

Notice of Initial Determination

If your claim is wholly or partially denied, you will be furnished with notice of the decision. The notice will include the following information:

- Information sufficient to identify the claim involved, including the date of service, healthcare provider, claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- The specific reason for the denial, including the denial code and its corresponding meaning, as well as a description of the plan's standard, if any, that was used in denying the claim;
- A reference to the pertinent plan provisions upon which the denial is based;
- A description of any additional material or information you might be required to provide and an explanation of why such material or information is necessary;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review;
- If the denial is based on an internal rule, guideline, protocol or other similar criterion, a copy of the criterion or a statement that a copy will be provided free of charge upon request;
- If the denial is based on lack of medical necessity or an exclusion of experimental treatment, an explanation of the scientific or clinical judgment that was applied to your medical circumstances, or a statement that an explanation will be provided free of charge upon request;
- In the case of an urgent care claim, a description of the expedited review process applicable to such claims; and
- Contact information for the Office of Health Insurance Consumer Assistance or Ombudsman to assist participants with the internal claims and appeals and external review process.

Filing an Appeal

You have the right to file an appeal following a denial of your initial claim for benefits or a rescission of coverage. The following procedures apply to appeals, which are reviewed by the Claim Administrator.

Appeals can be filed in writing to the Claim Administrator at the address shown on the notice of the Claim Administrator's initial determination or at the following address:

Scott & White Health Plan

ATTN: Customer Advocacy
1206 West Campus Drive, Bldg. A-4
Temple, TX 76502

For an urgent/emergent request, you may request expedited review. For an expedited review, all information will be communicated between you and the Claim Administrator by telephone, fax or similar method. Your appeal will not be considered to be timely filed until such appeal is received by the Customer Advocacy department at the address shown above or by the Claims Administrator at the address shown on the initial notice of adverse determination.

Appeals must be submitted within 180 calendar days from the date that you receive the original decision. After that, the original decision will be final.

You may supply additional information that you would like the Claim Administrator to consider. In addition, you may request copies of documents relevant to your claim (free of charge) by contacting the Claim Administrator at the number on your member identification card.

You will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Claims Administrator in connection with the claim and you will be given a reasonable opportunity to respond before a decision is made on your appeal.

If an appeal decision is based on new or additional rationale, you will be provided, free of charge, with the rationale and you will be given a reasonable opportunity to respond. If necessary to provide you with a reasonable opportunity to respond, the time period for providing notice of the appeal decision will be tolled.

Review of your appeal will not provide deference to the earlier decision and will be performed by a person different from the person who decided the initial request, and who is not the prior decision-maker's subordinate. If your request was denied based on a medical judgment, the Claim Administrator will consult with a health professional with appropriate training and experience, who was not the health professional consulted during the earlier decision or a subordinate of that person. The Claim Administrator will provide the name of any such expert consulted upon request.

All appeals will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual, including a claim or appeal decision maker, will not be made based on the likelihood that the individual will support the denial of benefits.

Review of an Appeal

The Claim Administrator will review the appeal and notify you of the decision within the following timeframes, which differ depending on the type of the claim:

Type of Health Claim	Response Time
Urgent Claim	Within 72 hours after appeal is received
Pre-Service Claim	No later than 30 days after receipt of appeal
Post-Service Claim	No later than 60 days after receipt of appeal

Notice of Determination on Appeal

If your appeal is wholly or partially denied, you will be furnished with notice of the decision. The notice will include the following information:

- Information sufficient to identify the claim involved, including the date of service, healthcare provider, claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- The specific reason for the denial, including the denial code and its corresponding meaning, as well as a description of the plan's standard, if any, that was used in denying the claim, and a discussion of the decision;
- A reference to the pertinent plan provisions upon which the denial is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- A statement describing any voluntary appeal, including external review, and your right to receive information about the process;
- A statement of your right to bring a civil action under Section 502(a) of ERISA;
- If the denial is based on an internal rule, guideline, protocol or other similar criterion, a copy of the criterion or a statement that a copy will be provided free of charge upon request;
- If the denial is based on lack of medical necessity or an exclusion of experimental treatment, an explanation of the scientific or clinical judgment that was applied to your medical circumstances, or a statement that an explanation will be provided free of charge upon request;

- The following statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”; and
- Contact information for the Office of Health Insurance Consumer Assistance or Ombudsman to assist participants with the internal claims and appeals and external review process.

Rights after the Appeal

The Claim Administrator’s decision stated in the appeal decision letter will be final. If you do not agree with the appeal decision, you have the right to bring a civil action under Section 502(a) of ERISA within 12 months following the date of the appeal decision.

Alternatively, if your claim involves medical judgment, you may request an external review, which will be reviewed by an External Review Organization.

Appeal for External Review of Healthcare Claims

The Claim Administrator may deny a healthcare claim because it determines that the care is not medically necessary, or a service or treatment is experimental or investigational in nature. In either of these situations, you may request an external review if you or your provider disagrees with the Claim Administrator’s decision. An external review is a review by an independent physician, selected by an External Review Organization, who has expertise in the problem or question involved.

To request an external review, the following requirements must be met:

- You have received notice of the denial of a claim by the Claim Administrator;
- Your claim involved medical judgment (including medical necessity or a determination that the treatment was experimental or investigational) or a rescission of coverage;
- The cost of the service or treatment in question for which you are responsible exceeds \$500; and
- You have exhausted the applicable internal appeal processes.

The appeal denial letter you receive from the Claim Administrator will describe the process to follow if you wish to pursue an external review, including a copy of the Request for External Review Form.

You must submit the Request for External Review Form to the Claim Administrator within four (4) months of the date you received the appeal denial letter. You also must include a copy of the appeal denial letter and all other pertinent information that supports your request. The Claim Administrator will determine within five (5) business days after receiving your request whether the requirements for external review have been met. Within one (1) business day after completing this review, the Claim

Administrator will notify you in writing if your request is or is not eligible for external review, or if it is incomplete. If your request is incomplete, the written notice will describe the information necessary for completion and allow you to complete your request within the remainder of the four-month filing period or the 48-hour period after receiving the notice, whichever is later.

The Claim Administrator will contact the External Review Organization that will conduct the review of your claim. The External Review Organization will select an independent physician with appropriate expertise to perform the review. The External Review Organization will notify you in writing of your request’s eligibility and acceptance for external review and will provide an opportunity for you to submit in writing within 10 business days following the date of receipt any additional information for the External Review Organization to consider when conducting the external review.

In making a decision, the external reviewer may consider any appropriate credible information that you send along with the Request for External Review Form or within 10 business days of notification, and will follow the Claim Administrator’s contractual documents and plan criteria governing the benefits. You will be notified of the decision of the External Review Organization usually within 45 calendar days of the Claim Administrator’s receipt of your request form and all necessary information.

A quicker review is possible if your physician certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would endanger your health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited external appeal. After referral to an External Review Organization, the External Review Organization will render a decision on an expedited review as expeditiously as necessary but in no event more than 72 hours after receiving the request for review. If the decision is not in writing, the External Review Organization will provide written confirmation of the decision within 48 hours after the date of notification of the decision.

The Claim Administrator, Baylor Scott & White Health and the plan will abide by the decision of the External Review Organization, except where the Claim Administrator can show conflict of interest, bias or fraud.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the External Review Organization to the Claim Administrator. The Claim Administrator is responsible for the cost of sending this information to the External Review Organization and for the cost of the external review.

For more information about the Claim Administrator’s External Review process, call the toll-free customer service telephone number shown on your ID card.

Consistency of Treatment

The Employee Benefits Administrative Committee will take action from time to time as necessary to ensure all claims for

benefits under the plans are determined in accordance with the applicable plan documents. Also, the Committee will ensure the provisions of the applicable plan documents are applied consistently to similarly situated plan participants and their dependents.

Changes to Appeal Procedures

Any of these appeal procedures may be changed by governmental law or by the Plan Administrator. You will be notified of any significant change in a timely manner. If you have further questions or problems, contact PeoplePlace or the Claim Administrator for the plan. Before submitting an appeal, it is your responsibility to contact the appropriate vendor directly to verify the deadline for filing an appeal and the information you need to submit.

CLAIMS AND APPEALS PROCESS FOR OTHER PLANS

The following claims and appeals process applies to all health and welfare plans other than the medical plan.

Claims Relating to Eligibility and Enrollment

If your claim is for a determination as to your eligibility or the eligibility of your dependents to participate in the plan or your enrollment under the plan and is not accompanied by a claim for plan benefits, you must obtain a claim initiation form from PeoplePlace, then submit your claim, in a timely manner, in writing to the designated recipient. Your claim will be determined by the Plan Administrator. The decision of the Plan Administrator will be final and will not be subject to the appeals process. All determinations as to eligibility for participation in the plan made in connection with a claim for benefits under the plan will be made in accordance with the applicable claims procedure described below. To substantiate claims relating to eligibility or enrollment, you are encouraged to provide supporting documents such as a copy of personal enrollment confirmation or documentation regarding your employment status.

Review of Benefit Determination

Each of the claims administrators has procedures for applying for benefits and for requesting a review of a benefit determination. If you have followed the claims administrator's procedures for benefit review and believe the result is incorrect, you may file a written appeal as outlined in this section.

Your "authorized representative" is a person you authorize, in writing, to act on your behalf or a person given authority by court order to submit claims on your behalf. Any appeal actions described in this section that may be done by you may also be done by your authorized representative on your behalf.

Dental Claims

See the [dental plan section](#) of this SPD for procedures for filing initial claims for benefits. The claims administrator will make a decision on the claim no later than 24 days after receiving your

claim. In special circumstances, the time period may be extended by an additional 15 days. If an extension is necessary, you will receive written notice prior to the expiration of the initial 24-day period, advising you of the special circumstances requiring an extension and the date by which the claims administrator expects to make a decision.

Vision Claims

See the [vision plan section](#) of this SPD for procedures for filing initial claims for benefits. The claims administrator will make a decision on the claim no later than 30 days after receiving your claim. In special circumstances, the time period may be extended by an additional 15 days. If an extension is necessary, you will receive written notice prior to the expiration of the initial 30-day period, advising you of the special circumstances requiring an extension and the date by which the claims administrator expects to make a decision.

Disability Claims

A disability claim is a claim for benefits that requires the claims administrator to determine if you are disabled within the meaning of the plan. Claims under the long-term and short-term disability plans that do not involve a determination of disability (for example, a claim regarding the amount of disability benefits) are covered under All Other Claims.

The claims administrator will make a decision on a disability claim no later than 45 days after the claims administrator receives the claim. This review period may be extended twice for up to 30 days each time. If an extension is necessary, you will receive written notice prior to the expiration of the initial 45-day period (or first 30-day extension), advising you of the special circumstances requiring an extension, the date by which the claims administrator expects to make a decision and if any additional information is needed to resolve the claim.

You will have at least 45 days to supply any missing information. The extension period will be put on hold until you supply the missing information. If you do not supply the missing information, your appeal may be decided without that information. For additional extensions, the plan needs your consent.

All Other Claims

All other claims include the following:

- [Claims for Life and AD&D Insurance](#)
- [Long-Term and Short-Term Disability claims that are not determinations of disability](#)
- [Claims relating to the Healthcare and Dependent Care Flexible Spending Accounts](#)
- [Claims relating to the Legal Services Plan](#)
- [Claims relating to Business Travel & Accident benefits](#)

The claims administrator will make a decision no later than 90 days after receiving your claim. In special circumstances, the time period may be extended by an additional 90 days. If an extension is necessary, you will receive written notice prior to

the expiration of the initial 90-day period, advising you of the special circumstances requiring an extension and the date by which the claims administrator expects to make a decision.

If Your Claim Is Denied

Disagreements about benefit eligibility or payment amounts can occasionally arise. In most cases, they are resolved quickly by the appropriate claims administrator. If you can't resolve the disagreement, formal appeal procedures are in place for your use. You must file a written appeal with the appropriate claims administrator within 60 days (180 days for a dental, vision or disability claim) of receiving the notice that your claim has been denied.

Notice of Initial Determination

If your claim for benefits is wholly or partially denied, you (or your beneficiary for life insurance) will be furnished with notice of the decision. The notice will include the following:

- The specific reason for the denial
- A reference to the pertinent plan provisions upon which the denial is based
- A description of any additional information you might be required to provide and an explanation of why it is needed
- An explanation of the plan's claim review procedures, including your rights to:
 - Submit a written appeal,
 - Review documents, records, and other information relevant to your claim for benefits,
 - Submit issues and comments in writing, and
 - Bring a civil action following an adverse determination on appeal

Special Rules for Dental, Vision or Disability Claims

If denial of your claim was based on an internal rule, guideline, protocol or other similar criterion, the notice of denial will either include a copy of the criterion or state that a copy will be provided free of charge upon request (or in the case of disability claims filed on or after April 1, 2018, that such rules, guidelines, protocols or other similar criterion do not exist).

If a denial is based on lack of medical necessity or an exclusion of experimental treatment, the notice of denial will either include an explanation of the scientific or clinical judgment that was applied to your medical circumstances, or it will state that an explanation will be provided free of charge upon request.

Beginning with disability claims filed on or after April 1, 2018, any notice of denial will also include: (i) a discussion of the decision, including an explanation of the basis for disagreeing with medical or vocational experts; and (ii) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Filing an Appeal

You have the right to file a written appeal, as described in this section. Appeals must be submitted within 60 calendar days (180 calendar days for a dental, vision or disability claim) from the date that you receive the original decision. After that, the claims administrators will consider the original decision to be final.

You may supply additional information that you would like the claims administrator to consider. In addition, you may request copies of documents relevant to your claim (free of charge) by contacting the claims administrator at the number provided in this Summary Plan Description.

Special Rules for Dental, Vision or Disability Claims

Review of your appeal will not provide deference to the earlier decision and will be performed by a person different from the person who decided the initial claim and who is not the prior decision-maker's subordinate. If your claim was denied based on a medical judgment, the claims administrator will consult with a health professional with appropriate training and experience, who was not the health professional consulted during the earlier decision or a subordinate of that person. The claims administrator will provide the name of any such expert consulted upon request.

All appeals will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual, including a claim or appeal decision maker, will not be made based on the likelihood that the individual will support the denial of benefits.

Review of an Appeal

Dental and Vision Appeals

The claims administrator will make a decision no later than 30 days after receiving your appeal. In special circumstances, the time period may be extended by an additional 30 days. If an extension is necessary, you will receive written notice prior to the expiration of the initial 30-day period, advising you of the special circumstances requiring an extension and the date by which the claims administrator expects to make a decision.

Disability Appeals

The claims administrator will make a decision no later than 45 days after receiving your appeal. In special circumstances, the time period may be extended by an additional 45 days. If an extension is necessary, you will receive written notice prior to the expiration of the initial 45-day period, advising you of the special circumstances requiring an extension and the date by which the claims administrator expects to make a decision.

All Other Appeals

The claims administrator will make a decision no later than 60 days after receiving your appeal. In special circumstances, the time period may be extended by an additional 60 days. If an extension is necessary, you will receive written notice prior to

the expiration of the initial 60-day period, advising you of the special circumstances requiring an extension and the date by which the claims administrator expects to make a decision.

Notice of Determination on Appeal

If your appeal is wholly or partially denied, you will be furnished with notice of the decision. The notice will include the following information:

- The specific reason for the denial;
- A reference to the pertinent plan provisions upon which the denial is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- A statement of your right to bring a civil action under Section 502(a) of ERISA; and
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

The decision stated in the appeal decision letter will be final.

Special Rules for Dental, Vision or Disability Claims

If denial of your claim was based on an internal rule, guideline, protocol or other similar criterion, the notice of denial will either include a copy of the criterion or state that a copy will be provided free of charge upon request (or in the case of disability claims filed on or after April 1, 2018, that such rules, guidelines, protocols or other similar criterion do not exist).

If a denial is based on lack of medical necessity or an exclusion of experimental treatment, the notice of denial will either include an explanation of the scientific or clinical judgment that was applied to your medical circumstances, or it will state that an explanation will be provided free of charge upon request.

If the denial is based on new or additional evidence or a new or additional rationale, you will be provided, free of charge, with the new or additional evidence relied upon, or generated by the claims administrator in connection with the claim, as well as any new or additional rationale for a denial, and a reasonable opportunity to respond to such new evidence or rationale.

For disability claims filed on or after April 1, 2018, the notice of denial on appeal will include: (i) a discussion of the decision, including an explanation of the basis for disagreeing with medical or vocational experts; and (ii) a description of any contractual limitations on your right to bring a civil action under ERISA, including the calendar date on which such right expires.

Rights after the Appeal

If you do not agree with the appeal decision, you have the right to bring a civil action under Section 502(a) of ERISA within 12 months following the date of the appeal decision.

Consistency of Treatment

The Baylor Scott & White Employee Benefits Administrative Committee will take action from time to time as necessary to ensure all claims for benefits under the plans are determined in accordance with the applicable plan documents. Also, the Committee will ensure the provisions of the applicable plan documents are applied consistently to similarly situated plan participants and their dependents.

Changes to Appeal Procedures

Any of these appeal procedures may be changed by governmental law or by the Plan Administrator. You will be notified of any significant change in a timely manner. If you have further questions or problems, contact PeoplePlace or the claims administrator for the plan. Before submitting an appeal, it is your responsibility to contact the appropriate vendor directly to verify the deadline for filing an appeal and the information you need to submit.

COORDINATION OF BENEFITS

You or your dependents may be covered by other group healthcare plans. If the other plan (or plans) is also sponsored by an employer, benefits from that plan and Baylor Scott & White Health's healthcare plan are coordinated to avoid double payment. A common set of guidelines is used to determine which plan pays first. These guidelines apply to the medical, dental and vision plans.

Under coordination of benefits (COB) rules, one plan is considered primary, and the other plan is considered secondary. When a claim is made, the plan considered primary pays benefits first, without regard to the other plan. The secondary plan may pay additional benefits, depending on its COB provisions. When the Baylor Scott & White Health plan is secondary, your reimbursement is adjusted so the total benefits paid by both plans will not exceed 100% of the eligible charges.

In general, the plan covering the patient as an employee will be the primary plan, which means it will pay first. For a dependent child, if both parents have group healthcare plans, the parent whose birth date comes first during the calendar year (excluding the year of birth) will have the primary plan. For instance, if the father was born on May 15 and the mother was born on July 20 (regardless of the parents' birth years), the father's plan is primary.

There are additional guidelines concerning dependents. In a divorce or separation, the plan of the parent with custody of a dependent child usually pays benefits for the child first. If the person with custody remarries, the stepparent's plan pays second, and the plan of the parent without custody pays third. If a court decree places financial responsibility for the child's healthcare coverage on one parent, that parent's plan always pays first. If the court does not assign financial responsibility for the child's healthcare coverage and the parents have joint custody, the birthday rule will apply.

If none of these situations applies, the plan covering the person for the longest time pays first. If the other plan has no guidelines for coordinating benefits, that plan will pay benefits before Baylor Scott & White Health's healthcare plan.

Subrogation and Right of Recovery

The following subrogation and right of recovery provisions apply to all health and welfare plans other than the medical plan. Please see the [medical plan section](#) of this SPD for the subrogation and right of recovery provisions that apply to the medical plan.

As used throughout this provision, the term Responsible Party means any party actually, possibly or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness or condition. The term Responsible Party includes the liability insurer of such party, or any insurance coverage.

For purposes of this provision, the term Insurance Coverage refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage or any first-party insurance coverage.

For purposes of this provision, a Covered Person includes anyone on whose behalf the plan pays or provides any benefit including, but not limited to, the minor child or dependent of any plan participant or person entitled to receive any benefits from the plan.

Subrogation

Immediately upon paying or providing any benefit under this plan, the plan shall be subrogated to (stand in the place of) all rights of recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to a Covered Person due to a Covered Person's injury, illness or condition to the full extent of benefits provided or to be provided by the plan.

Reimbursement

In addition, if a Covered Person receives any payment from any Responsible Party or Insurance Coverage as a result of an injury, illness or condition, the plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts this plan has paid and will pay as a result of that injury, illness or condition from such payment, up to and including the full amount the Covered Person receives from any Responsible Party.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person agrees that if he or she receives any payment from any Responsible Party as a result of an injury, illness or condition,

he or she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the plan.

Lien Rights

Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury or condition for which the Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment or otherwise, including from any insurance coverage related to treatment for any illness, injury or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, the Covered Person; the Covered Person's representative or agent; Responsible Party; Responsible Party's insurer, representative or agent; and/or any other source possessing funds representing the amount of benefits paid by the plan.

First-Priority Claim

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person acknowledges that this plan's recovery rights are a first-priority claim against all Responsible Parties and are to be paid to the plan before any other claim for the Covered Person's damages. This plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party's payments, even if such payment to the plan will result in a recovery to the Covered Person that is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply, and the plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only.

Cooperation

The Covered Person shall fully cooperate with the plan's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to

injury, illness or condition sustained by the Covered Person. The Covered Person and his or her agents shall provide all information requested by the plan, the claims administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request. Failure to provide this information may result in the termination of health benefits for the Covered Person or the institution of court proceedings against the Covered Person.

The Covered Person shall do nothing to prejudice the plan's subrogation or recovery interest or to prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan.

The Covered Person acknowledges that the plan has the right to conduct an investigation regarding the injury, illness or condition to identify any Responsible Party. The plan reserves the right to notify the Responsible Party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the claims administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile.

OTHER IMPORTANT PLAN INFORMATION

Discounts and Refunds

Under some of the medical, dental and vision plan coverage options, some providers may agree to charge participants negotiated rates that are lower than their regular rates. In these cases, the amount you pay will be based on the reduced rate the provider has agreed to charge plan participants.

In addition, some of the contracts between the plans and providers, insurers or other organizations provide for other kinds of discounts, refunds and incentive rebates that belong solely to the plans. These discounts, refunds and rebates are designed to reduce the cost of benefits to the applicable plan as

a whole, but do not reduce your cost of coverage, deductibles or copays. The plans have no obligation to pass on any of these discounts, refunds or rebates to participants.

Mistake of Fact

Any misstatement or other mistake of fact in this information will be corrected when discovered.

No Right of Employment

Nothing contained in this information or in the provisions of the plans creates or should be inferred to create an employment contract.

Omission or Misrepresentation of Information

If you don't provide the claims administrator required information regarding your claim, your benefits may be delayed or denied until you do so.

When you file a claim for benefits, you certify the statements you make on the claim are complete and accurate to the best of your knowledge. If you misrepresent information or send in a fraudulent claim, you will be responsible for repaying any benefits based on that claim. Also, you may be subject to disciplinary action up to and including termination of employment.

Liability for Payment

Neither Baylor Scott & White Health nor any company participating in the plans has any obligation to make a benefit payment to you or your dependents under a plan that is fully insured. The insurer is solely responsible to make such benefit payments, and Baylor Scott & White Health has no liability to you or your dependents if the insurer fails to make any payments required under any insured plan.

The following plans are fully insured:

- [Vision benefits](#)
- [Life Insurance benefits](#)
- [AD&D benefits](#)
- [Business Travel & Accident benefits](#)
- [Long-Term Disability benefits](#)
- [Legal Services benefits](#)

Overpayment of Benefits

The amount of your plan benefits will be adjusted for any of the following reasons:

- You have misstated any information in your application for plan coverage (including any information on the Statement of Good Health Form) or in your application for benefits
- You do not report required information while receiving Baylor Scott & White Health-provided benefits
- Any error is made in calculating your benefits

If a benefit is overpaid or benefits are duplicated, you are expected to repay the plan(s) within 60 days of the overpayment.

If you do not, the Plan Administrator may request that you enter into a written payroll withholding agreement providing for repayment of the amount due.

No interest will be charged on the amount of any overpayment or duplication of benefits, and unless required by law, no interest will be paid on any underpayment of benefits or on any benefit payments that have been delayed for any reason.

Plan Amendment or Termination

Although Baylor Scott & White Holdings expects to continue the benefits described in this document, Baylor Scott & White Holdings has the right to amend or end the plans, in whole or in part, at any time and without prior notice to participants. Also, benefits may be discontinued at any time for any groups of employees or inactive participants, including retirees. Your cost for coverage is also subject to change at any time.

Certain amendments to the plans may be made by designated executive officers of Baylor Scott & White Health without approval by the Board of Trustees of Baylor Scott & White Holdings.

The right to amend or terminate includes the right to reduce or eliminate coverage for any treatment, procedure or service. This right is applicable regardless of whether any participant is receiving such treatment, procedure or service for any injury, illness or disease, including those occurring before the effective date of the amendment.

You will be notified in writing if you are affected by any change to the plan.

Plan Funding

Plan funding arrangements are listed in the Plan Details chart on [page 18-19](#). Plans described as “self-insured” pay benefits from separate trust funds set up for the exclusive benefit of participants.

Plan Year

The Plan Year for all plans described, unless stated otherwise, is Jan. 1 through Dec. 31.

Severability of Plan Provisions

Each plan provision is independent and does not affect the validity of any other plan provisions. If any provision is found to be invalid or unenforceable, the remaining plan provisions remain fully effective.

HIPAA Privacy

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires health plans to protect the confidentiality of your private health information. More detailed information is given in the notices of HIPAA privacy rights from Scott & White Health Plan, MetLife and EyeMed, as applicable. You may request a copy of the privacy notices by contacting PeoplePlace at 1-844-417-5223.

YOUR BENEFIT RIGHTS

ERISA

The following plans are governed by the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

- Health benefits
 - Medical benefits
 - Dental benefits
 - Vision benefits
 - Healthcare Flexible Spending Account
 - Employee Assistance Program (EAP)
- Welfare benefits
 - Life Insurance benefits
 - Accidental Injury
 - Accidental Death & Dismemberment (AD&D) Insurance benefits
 - Critical Illness
 - Long-Term and Short-Term Disability benefits
 - Business Travel & Accident benefits
 - Legal Services

Other employee programs (including the Dependent Care Flexible Spending Account) may be explained in this summary but are not governed by the rules discussed in this section.

As a participant in the plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA), as amended. ERISA provides that plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator’s office, all documents governing the plans, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the plans with the U.S. Department of Labor.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plans, including insurance contracts and copies of the latest annual report (Form 5500 Series) and the updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of each plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue healthcare coverage for yourself, spouse or dependents if there is a loss of coverage under a healthcare plan as result of a qualifying event as provided under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). You or your dependents may have to pay for such coverage. See Continuation of Coverage through COBRA and the applicable plan documents on the rules governing your COBRA continuation rights.

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the plans. The people who operate the plans, called “fiduciaries” of the plans, have a duty to do so prudently and in the interest of participants and beneficiaries.

No one may end your employment or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim..

Under ERISA, there are steps you may take to enforce the previously discussed rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If plan fiduciaries misuse a plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these court costs and fees. If you lose, the court may order you to pay the court costs and fees (for example, if it finds your claim frivolous).

If you have any questions about the plans, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or:

Division of Technical Assistance and Inquiries

Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

USERRA Rights

As required by federal law, Baylor Scott & White Health provides benefits during or following a period of qualified military service. You must continue to pay your share of your coverage cost during your military leave of absence. If Baylor Scott & White Health pays a portion of the premium payment on your behalf to continue your coverage while you are on military leave, you may be required to reimburse Baylor Scott & White Health for your portion of the premium payment whether or not you return to work.

If you do not continue your coverage during your military leave, your coverage will be reinstated when you return on a timely basis from military leave.

GLOSSARY

Actively at work — Means you are physically present at your customary place of employment with the intent and ability to work your scheduled hours and do the normal duties of your job.

Appeal — A request or reference to some person or authority for a decision, corroboration or judgment.

Creditable Coverage — Any individual or group policy, contract or program.

Fiduciaries — Any person or people who operate the plans.

Lien — The legal claim of one person upon the property of another person to secure the payment of a debt or the satisfaction of an obligation.

Subrogation — To stand in the place of.

Trustee — A person who holds the title to property for the benefit of another.

Medical

The medical plan makes quality healthcare affordable for you and your family. The plan provides coverage for a wide range of medical expenses, including prescription drugs and preventive care.

PLAN HIGHLIGHTS

- You can select from three medical plan options, which differ in the amount you pay for coverage, the way you access care and the amount you pay when you need medical care.
- The plan covers well-child care and immunizations for your children, mammograms, adult annual physicals and other preventive services at no out-of-pocket cost to you when you use in-network providers.
- All medical plans include prescription drug coverage at Baylor Scott & White Health (BSWH) pharmacies and through BSWH pharmacy mail-order.
- All medical plans also include prescription drug coverage through Scott & White Health Plan, which has a network of retail pharmacies.

YOUR MEDICAL CHOICES

Your medical choices include a Select Exclusive Quality Alliance (SEQA) / Exclusive Quality Alliance (EQA), Preferred Provider Organization (PPO) and one Consumer Drive Health Plan (CDHP) with a Health Savings Account (HSA). These plans will be referenced in this document as follows:

- SEQA/EQA
- PPO
- HSA

The SEQA/EQA plan is a single-network and exclusively includes providers in the Baylor Scott & White Quality Alliance (BSWQA) network. The PPO and HSA plans offer an extended network and you'll have lower office visit copays, coinsurance and out-of-pocket costs using the Tier 1 BSWQA network.

HEALTH REIMBURSEMENT ACCOUNT (HRA)

If you were previously covered by the BSWH HRA medical plan and had funds remaining in your HRA the maximum rollover from 2018 to 2019 was two times your 2018 Tier 1 deductible if you selected the SEQA/EQA or PPO plan. The HRA plan is being discontinued and any remaining employer funds after Dec. 31, 2020, will be forfeited.

These funds can be used to cover your medical out-of-pocket costs incurred from a Tier 1 BSWQA network provider, including non-Tier 1 BSWQA urgent and emergency care. HRA rollover funds cannot be used for pharmacy member out-of-pocket costs.

YOUR COVERAGE TIERS

Your coverage tiers include Employee (referred to in this document as EE), Employee + Spouse (referred to in this document as ES), Employee + Children (referred to in this document as EC) and Employee + Family (referred to in this document as EF).

See *Benefits at a Glance* on pages [35](#), [38](#), [41](#) and [43](#) for specific details about plan benefits.

TIER 1 BSWQA FACILITIES

When you need hospital care, you'll pay less if you use a Tier 1 BSWQA facility. Tier 1 includes all BSWQA facilities, as well as the network of physicians, hospitals and other care providers in the BSWQA network.

For a full list of Tier 1 BSWQA facilities, visit bswh.swhp.org and use the Find a Provider search tool based on the plan in which you are enrolled.

OUT-OF-AREA COVERAGE (OOA)

Employees and dependents enrolled in the PPO and HSA plans who live 40 or more miles from the nearest Tier 1 acute care hospital may visit Tier 2 providers and receive a higher benefit (80% vs. 50%, after deductible) for inpatient and outpatient services. You can determine your proximity to Tier 1 acute care network hospitals by using the Scott and White Health Plan Find a Provider search tool located on the member portal. If you or one of your dependents lives 40 or more miles from a Tier 1 acute care hospital, notify the Customer Advocacy Center at 1-844-843-3229. To ensure your claims process correctly, please notify them prior to accessing services. Or, if you or your dependent had the OOA coverage activated but no longer live 40 or more miles from a Tier 1 acute care hospital, contact Customer Advocacy Center to deactivate this coverage. **This coverage is not available to SEQA/EQA members.**

SEEING A HOSPITAL-BASED PHYSICIAN

Hospital-Based Physicians (Radiologists, Anesthesiologists, Pathologists, Emergency Providers, Neonatologists and Hospitalists) will not be part of your provider directory searchable options because they may be independent contractors. If you receive care from any of these physicians at any Tier 1 BSWQA facility, they will be paid at the Tier 1 benefit level. However, a hospital-based physician in Tier 3 may bill the participant the difference between the physician's out-of-network rate and the deductible and coinsurance amount. If this situation applies to you, prior to paying amounts above allowed charges, contact Scott and White Health Plan at the number listed on the back of your medical ID card for assistance.

PROVISION FOR PPO AND HSA PLANS: Claims for Tier 2 hospital-based physicians can be reprocessed (if requested by member) at the Tier 1 benefit.

PRE-AUTHORIZATION/ PRE-NOTIFICATION

Certain services, such as inpatient stays, certain tests and imaging, procedures and outpatient surgery require pre-authorization. Pre-authorization is a process that helps you and your physician determine whether the services being recommended are covered expenses under the plan. It also allows Scott & White Health Plan (“SWHP”) to help your provider coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning) and to register you for specialized programs or case management when appropriate.

You do not need to get pre-authorization for services provided by an in-network provider. These providers are responsible for obtaining necessary pre-authorization for you. Failure to get pre-authorization for services will result in denial of services and payment. Please contact Customer Service to verify benefits, eligibility and pre-authorization requirements.

When you go to an out-of-network provider, it is your responsibility to ensure your provider obtains prior authorization for any services or supplies on the pre-authorization list. Failure to get pre-authorization for services will result in denial of services and payment.

The Pre-Authorization Process

Prior to being hospitalized or receiving certain medical services or supplies, certain pre-authorization procedures must be followed.

You or a member of your family, a hospital staff member or the attending physician must notify SWHP to pre-approve any of the out-of-network admissions or medical services and expenses on the pre-authorization list, prior to receiving any of the services or supplies, within the time frames specified below. To obtain pre-authorization, call SWHP at the telephone number listed on your ID card. This call must be made in the circumstances shown in the table below.

SWHP will provide a written notification to you and your physician of the pre-authorization decision. If your pre-authorized expenses are approved, the approval is good for the dates of service on the Coverage Determination letter as long as you remain enrolled in the plan.

When you have an inpatient admission to a facility, SWHP will notify you, your physician and the facility about your pre-authorized length of stay. If your physician recommends that your stay be extended, additional days will need to be certified. Your physician or the facility will need to call SWHP at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. SWHP will review and process the request for an extended stay. You and your physician will receive a notification of an approval or denial.

If pre-authorization determines that the stay or services and supplies are not covered expenses, the notification will explain why and how SWHP’s decision can be appealed, including where to send your appeal. You or your provider may request a review of the pre-authorization decision according to the Appeals Process in the Administrative & General Information section.

Type of Admission or Service	Time Period for Pre-authorization
Non-Emergency Admission	You, your physician or the facility must call and request pre-authorization at least 15 days before the date you are scheduled to be admitted.
Emergency Outpatient Medical Services	You or your physician must call prior to the outpatient care, treatment or procedure, if possible, or as soon as reasonably possible.
Emergency Admission	You, your physician or the facility must call within 24-48 hours or as soon as reasonably possible after you have been admitted.
Urgent Admission	You, your physician or the facility must call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness, the diagnosis of an illness or an injury.
Outpatient Non-Emergency Medical Services Requiring Pre-Authorization	You or your physician must call at least 15 days before the outpatient care is provided or the treatment or procedure is scheduled.

Pre-Authorization and Concurrent Reviews

Pre-authorization/Pre-service request

A Pre-authorization/Pre-service request is a request for coverage of medical care, drugs or services that SWHP must approve in advance, in whole or in part consistent with the benefit plan language.

The appropriate Utilization Management (UM) Clinician will notify you of his or her determination with respect to a pre-authorization/pre-service request, whether adverse or not, no later than 15 calendar days after the receipt of the request. This 15-day period may be extended for an additional 15 days if the UM Clinician determines the extension is necessary due to matters beyond the control of the plan and notifies you of the extension before the end of the initial 15-day period. If the UM Clinician has not received all the necessary information to make a determination, he or she will notify your Provider via notification that will outline the information needed. Your Provider will be given a reasonable period of time, but not less than 45 calendar days, in which to supply the missing information. If a pre-authorization/pre-service request is denied by the UM Clinician, you have 180 days from the notice of official denial to file an appeal of the denial.

Urgent/emergent request

Urgent/emergent request is a request for medical care, drugs or services where application of the time frame for making routine or non-life threatening care determinations could seriously jeopardize the life, health or safety of yourself or others, due to your medical or psychological state, or in the opinion of a provider with knowledge of your medical or behavioral condition, would subject you to adverse health consequences without the care or treatment that is the subject of the request.

The UM Clinician will notify you with respect to an urgent/emergent request, whether adverse or not, no later than 72 hours after the receipt of the request. If the UM Clinician has not received all the necessary information to make a determination, he or she will notify your Provider within 24 hours of receiving the request via notification that will outline the information needed. Your Provider will be given a reasonable period of time, but not less than 48 hours, in which to supply the missing information.

If an urgent/emergent request is denied by the UM Clinician, you have 180 days from the notice of official denial to file an appeal of the denial.

Concurrent request

Concurrent request is a request for coverage of inpatient medical care or services made while you are in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care. The UM Clinician will notify you of his or her decision within 72 hours of receiving your request, provided the request was received at least 72 hours before the course of treatment was scheduled to terminate.

Services That Require Pre-Authorization

The list of services that require pre-authorization may change from time to time. You can find out if your service requires pre-authorization by calling 1-844-843-3229 or by visiting bswh.swhp.org. From the Menu bar on upper-left corner, go to the Tools and Resources tab to review the Pre-authorization list.

How Failure to Pre-Authorize Affects Your Benefits

If your in-network provider fails to obtain a required pre-authorization prior to incurring any expenses that require pre-authorization, there will be no coverage for the service and the provider cannot bill you for the unpaid balance of the bills. Unless, you sign a financial responsibility waiver at the time of service.

You are responsible for obtaining the necessary pre-authorization from SWHP prior to receiving services from an out-of-network provider. Your provider may request authorization of your treatment for you; however, you should verify with SWHP prior to the procedure that the provider has obtained pre-authorization. If pre-authorization is not obtained by you or your provider, your expenses will not be covered.

Any additional out-of-pocket expenses incurred because your pre-authorization requirement was not met will not count toward your deductible, coinsurance or out-of-pocket maximum.

HOW THE SEQA PLAN WORKS

The Select Exclusive Quality Alliance (SEQA) plan is available to employees making \$25.00 or less per hour. This plan has no deductible and exclusively includes providers in the Tier 1 BSWQA Network, except in cases of urgent/emergency care or rare situations when an in-network provider is not available and authorization is provided.

Plan highlights:

- There is no deductible
- Preventive care is covered at 100% (when billed as preventive care)
- Copays apply for non-preventive visits
 - \$10 copay for a PCP visit
 - \$40 copay for specialist visit
 - \$50 copay for urgent care
 - \$150 copay per day for inpatient hospitalization (up to a max of five days)
 - \$150 copay for outpatient care
 - \$150 copay for MRI, MRA
 - \$100 copay for advanced imaging (CT, CAT, and PET scans)
 - \$250 copay for emergency visit (waived if admitted, then inpatient copay applies)
 - 10% coinsurance for durable medical equipment, private duty nursing, hearing aids, skilled nursing, home health and hospice care

How You Pay for Care

You pay for care from your pocket. You can also set aside pre-tax dollars through a flexible spending account (FSA) to help cover certain expenses. Still have 2018 HRA dollars? You can use remaining HRA funds to pay for care in 2019 if you received care from a Tier 1 BSWQA network provider and non-BSWQA urgent/emergency care. You cannot use HRA dollars to pay for your pharmacy copays.

Deductible

This plan does not have a deductible.

Copays

You pay copays from your pocket. You can also set aside pre-tax dollars through an FSA to help cover certain expenses. Preventive visits are covered at 100%. This plan also offers very low copays for non-preventive office visits (for example, a primary care visit is \$10). Urgent care visits, inpatient and outpatient services also have copays making it easy to understand your out-of-pocket responsibility.

Prescriptions

You pay copays for prescriptions (as low as \$3-\$5) from your pocket or from your FSA. There's no cost for diabetic medicine and supplies with this plan.

Network

This plan only includes providers in our Tier 1 BSWQA Network. Be sure to check bswh.swhp.org to verify your provider is available with this plan. No out-of-network coverage is available, except in cases of urgent/emergency care or rare situations when an in-network provider is not available and authorization is provided.

Out-of-Pocket Maximum

The out-of-pocket maximum is the most that you will pay for eligible healthcare expenses, including your copays, and coinsurance, in a plan year. Once you reach the out-of-pocket maximum, the plan pays 100% for covered services throughout the remainder of the plan year.

This plan has embedded out of pocket maximums which means no one person in your family has to pay more than the individual maximum, even if together you haven't met the family out-of-pocket maximum. The individual out-of-pocket maximum equates to the employee out-of-pocket maximum.

IMPORTANT! Amounts you pay toward the cost of certain medical services will not count toward your annual out-of-pocket maximum. These include any cost you pay for:

- Any service not considered to be an eligible covered service
- Expenses in excess of annual maximums and limits
- Charges over the recognized charge
- Any out-of-network expenses
- Non-covered expenses

- Expenses for non-emergency use of the emergency room
- Expenses that are not paid due to a required prior authorization for the service(s) or supply was not obtained
- Preventive care expenses
- Premiums

Preventive Care

Preventive care*, such as physicals, screenings, immunizations and more are provided at no cost. Preventive eye exams are not included as part of our medical plans. If you or a covered dependent need routine eye care, our vision plan can help make glasses and contacts more affordable.

**Services will be covered at 100% when billed with a preventive diagnosis code.*

SEQA PLAN AT A GLANCE

Medical Plan	SEQA
Network	Tier 1 Only
Employer Funded Dollars	(Use HRA rollover funds)
Annual Deductible	
Employee Only	\$0
Family	\$0
Out-of-Pocket Maximum	
Employee Only	\$3,000
Family	\$6,000
Per Service	
Inpatient	\$150/day (max of 5)
Outpatient	\$150/visit
Office Visits	
Primary Care Visit	\$10
Specialist Office Visit	\$40
Urgent Care Office Visit	\$50
Labs in any setting	20%
Radiology - X-rays	\$75
Radiology - MRI	\$150
Radiology - PET, CAT	\$100
Emergency Room*	\$250

*ER copay is waived if admitted.

Medical Plan	SEQA
Network	Tier 1 Only
Pharmacy Benefit	BSWH Pharmacy (30-day supply)
Preferred Generic	\$3
Preferred Brand	\$25
Non-Preferred Brand	Less of \$50 or 50%
Specialty	\$100
Chronic and Preventive	\$10 \$0 Diabetes Treatment
Employer Funded Dollars	HRA funds are not usable toward the pharmacy benefit

NOTE: Review the pharmacy section for details about mail-order and non-BSW pharmacy copays.

HOW THE EQA PLAN WORKS

The Exclusive Quality Alliance (EQA) plan is available to employees making \$25.01 or more per hour. This plan has a lower deductible than the PPO or HSA plan and exclusively includes providers in the Tier 1 BSWQA Network, except in cases of urgent/emergency care or rare situations when an in-network provider is not available and authorization is provided.

Plan highlights:

- Preventive care is covered at 100% (when billed as preventive care)
- Copays apply for non-preventive visits
 - \$30 copay for a PCP visit
 - \$50 copay for specialist visit
 - \$75 copay for urgent care
 - \$150 copay per day for inpatient hospitalization (up to a max of five days)
 - \$150 copay for outpatient care
 - \$150 copay for MRI, MRA
 - \$100 copay for advanced imaging (CT, CAT, and PET scans)
 - \$250 copay for emergency visit (waived if admitted, then inpatient copay applies)
 - Once deductible is met, 10% coinsurance for durable medical equipment, private duty nursing, hearing aids, skilled nursing, home health and hospice care

How You Pay for Care

You pay for care from your pocket. You can also set aside pre-tax dollars through a flexible spending account (FSA) to help cover certain expenses. Still have 2018 HRA dollars? You can use remaining HRA funds to pay for care in 2019 if you received care from a Tier 1 BSWQA network provider and non-BSWQA urgent/emergency care. You cannot use HRA dollars to pay for your pharmacy copays.

Deductible

This plan offers a lower deductible than the PPO and the HSA plans. You meet your deductible with durable medical equipment expenses, private duty nursing, hearing aids, skilled nursing, home health and hospice care. After the deductible, you have a 10% coinsurance for these services.

Copays

You pay copays from your pocket. You can also set aside pre-tax dollars through an FSA to help cover certain expenses. Preventive visits are covered at 100%. This plan also offers low copays for non-preventive office visits (for example, a primary care visit is \$30). Things like urgent care visits, inpatient and outpatient services also have copays, making it easy to understand your out-of-pocket responsibility.

Prescriptions

You pay copays for prescriptions (as low as \$3-\$5) from your pocket or from your FSA.

Network

This plan only includes providers in our Tier 1 BSWQA Network. Be sure to check bswh.swhp.org to verify your provider is available with this plan. No out-of-network coverage is available, except in cases of urgent/emergency care or rare situations when an in-network provider is not available and authorization is provided.

Out-of-Pocket Maximum

The out-of-pocket maximum is the most that you will pay for eligible healthcare expenses, including your copays, deductibles and coinsurance in a plan year. Once you reach the out-of-pocket maximum, the plan pays 100% for covered services throughout the remainder of the plan year.

This plan has embedded out of pocket maximums which means no one person in your family has to pay more than the individual maximum, even if together you haven't met the family out-of-pocket maximum. The individual out-of-pocket maximum equates to the employee out-of-pocket maximum.

IMPORTANT! Amounts you pay toward the cost of certain medical services will not count toward your annual out-of-pocket maximum. These include any cost you pay for:

- Any service not considered to be an eligible covered service
- Expenses in excess of annual maximums and limits
- Charges over the recognized charge
- Any out-of-network expenses
- Non-covered expenses
- Expenses for non-emergency use of the emergency room
- Expenses that are not paid due to a required prior authorization for the service(s) or supply was not obtained
- Preventive care expenses
- Premiums

Preventive Care

Preventive care*, such as physicals, screenings, immunizations and more are provided at no cost. Preventive eye exams are not included as part of our medical plans. If you or a covered dependent need routine eye care, our vision plan can help make glasses and contacts more affordable.

*Services will be covered at 100% when billed with a preventive diagnosis code.

EQA PLAN AT A GLANCE

Medical Plan	EQA
Network	Tier 1 Only
Employer Funded Dollars	(Use HRA rollover funds)
Annual Deductible	
Employee Only	\$500
Family	\$1,000
Out-of-Pocket Maximum	
Employee Only	\$4,000
Family	\$8,000
Per Service	
Inpatient	\$150/day (max of 5)
Outpatient	\$150/visit

Medical Plan

EQA

Network

Tier 1 Only

Office Visits

Physician Care Visit	\$30
Specialist Office Visit	\$50
Urgent Care Office Visit	\$75
Labs in any setting	30%
Radiology - X-rays	\$75
Radiology - MRI	\$150
Radiology - PET, CAT	\$100
Emergency Room*	\$250

Pharmacy Benefit

BSWH Pharmacy (30-day supply)

Preferred Generic	\$3
Preferred Brand	\$35
Non-Preferred Brand	Less of \$50 or 50%
Specialty	20% (\$200 max)
Chronic and Preventive	\$10
Employer Funded Dollars	HRA funds are not usable toward the pharmacy benefit

*ER copay is waived if admitted.

NOTE: Review the pharmacy section for details about mail-order and non-BSW pharmacy copays.

HOW THE HSA PLAN WORKS

With the Health Savings Account (HSA) plan, you may set up an HSA that can help you pay medical expenses. You pay expenses (either out of pocket or from your HSA) until you reach your deductible. After the deductible amount is paid, you and the plan share the costs until you reach your annual out-of-pocket maximum. Then, the plan pays 100% of any further Tier 1 and Tier 2 covered expenses for the plan year.

To qualify for an HSA, you must meet the following requirements:

- You must be covered under BSWH's high deductible health plan (HDHP) on the first day of the month.
- You have no other health coverage except what is permitted by the IRS, as described in the "Other Health Coverage" section of IRS Publication 969.
- You are not enrolled in Medicare. If you have previously enrolled in Medicare or enroll in Medicare during the plan year, it is your responsibility to promptly notify BSWH of

your enrollment. Upon enrollment in Medicare, you will no longer be eligible to contribute to your HSA beginning with the month in which you enroll in Medicare. For more information on how your contributions will be affected by your enrollment in Medicare, see the section titled “Annual Contributions” below.

- You are not enrolled in TRICARE.
- You haven’t received Veterans Affairs (VA) benefits within the past three months, except for preventive care. If you have a disability rating from the VA, this exclusion doesn’t apply.
- You cannot be claimed as a dependent on someone else’s tax return.
- You do not have a healthcare flexible spending account (FSA) or health reimbursement account (HRA), with the exception of a limited purpose FSA that can be used solely for eligible dental and vision expenses.

For complete details, you can review Publication 969 on the IRS website at <https://www.irs.gov/pub/irs-pdf/p969.pdf>.

If you have other healthcare coverage in addition to BSWH’s, you should enroll in the SEQA/EQA or PPO plan because this restriction does not apply to those plans.

With the HSA, you may contribute your own money tax-free. The HSA belongs to you — you decide whether to use the money to pay current expenses or keep it in the account for future needs. You pay 100% of covered expenses until you reach your deductible. After the deductible is met, you and the plan share the costs until you reach your annual out-of-pocket maximum. Then, the plan pays 100% of any further Tier 1 and Tier 2 covered expenses for the year.

When you enroll in the HSA plan, you may visit any doctor at any time without a referral. However, when you use a provider in Tier 2, you will pay discounted fees. And if you use a Tier 1 provider, you’ll pay even less. In addition, if you use a Tier 1 or Tier 2 provider, you will not pay for charges in excess of the discounted price and, in most cases, the provider will file claims for you.

Preventive care from a Tier 1 or Tier 2 provider is always covered at 100% — with no deductible or coinsurance. To see what’s covered, see [pages 47-69](#).

If you use a provider that is not in Tier 1 or Tier 2, you may have to pay the full price at the time of service and file a claim for reimbursement. In addition, you are responsible for any charges above the recognized charges.

To locate a Tier 1 or Tier 2 provider, visit bswh.swhp.org and use the Find a Provider search tool.

HSA PLAN AT A GLANCE

Health Savings Account (HSA)

After you enroll in the HSA plan, you may open an HSA. You will receive an information packet and a Healthcare Payment Card from Optum Bank explaining how to take advantage of your HSA. All HSAs opened through Optum Bank will need to have a physical mailing address (not a P.O. Box) in the HR system. You can make pre-tax contributions to your HSA. Your HSA belongs to you, similar to an Individual Retirement Account (IRA). You decide whether to spend the money or save it for the future. It is your responsibility to keep receipts to prove that withdrawals are spent on eligible expenses. Each year that your HSA is open, you must file a Form 8889 with your federal income tax return showing contributions and withdrawals from your account.

You can also choose to open an HSA with another bank or other financial institution. However, BSWH will only deposit pre-tax payroll deductions to HSAs opened through Optum Bank.

This section explains the basic rules about the HSA. Please note, however, that once opened, the HSA itself is not part of the BSWH Plan. HSAs are not maintained or sponsored by BSWH and are not subject to the Employee Retirement Income Security Act (ERISA).

Annual HSA Contributions

You may contribute your own money to your HSA, up to IRS limits. For 2019, your contributions plus BSWH’s contribution may not exceed \$3,500 for EE coverage or \$7,000 for EF coverage. This limit applies even if you enroll after Jan. 1. If you are age 55 or older, you can make an additional HSA catch-up contribution of up to \$1,000 per calendar year. If you have previously enrolled in Medicare, you will not be eligible to contribute to your HSA. If you enroll in Medicare during the plan year, the above HSA contribution limits are pro-rated based on the number of months in the plan year prior to your Medicare enrollment.

If you stop participating in the HSA plan or become covered by a low-deductible health plan during the year, your eligibility to contribute to your HSA ceases and the maximum amount of contributions you may make will be reduced.

Please note: These amounts are indexed annually for inflation. If you make a contribution for the entire tax year — when you only have part-year coverage — then you must remain in an HDHP and subsequently be eligible for the HSA through the next full calendar year, or must include the amount of this contribution (above and beyond what you could have contributed based on a pro rata portion of the annual limit) in gross income and be subject to an additional 10% tax.

You can elect to contribute through pre-tax payroll deductions and/or electronic fund transfer (EFT) from a personal account. If you contribute through EFT, those contributions may be deductible on your federal income tax return. You can change your payroll deductions at any time.

Using Your HSA

You decide when to use the money in your HSA. You will receive a Healthcare payment card that may be used at healthcare merchants (such as a doctor's office, pharmacy, etc.) where MasterCard is accepted. The Healthcare payment card can be used at an ATM for cash withdrawals or internationally, but there is a fee associated with this type of transaction. You must have adequate funds in your HSA to pay for any expenses or your card transaction will be denied. You can also request a withdrawal/reimbursement from your account.

Your HSA can be used only for eligible expenses for you and your federal tax dependents, whether or not they are covered by a BSWH medical plan. Note that this does NOT include adult child(ren) up to age 26 who are covered by BSWH medical plan but are not claimed as dependents on your federal tax return. This rule is different than for the HRA rollover available (if any) under the SEQA/EQA or PPO, which pays benefits for adult child(ren) up to age 26 who are covered by your BSWH medical coverage.

Your HSA can be used for eligible expenses of a domestic partner only if he or she is claimed as a dependent on your federal tax return.

If you use HSA funds to pay eligible healthcare expenses, the money is not taxable when withdrawn. If used for ineligible expenses, the money is taxable as income and is subject to a 20% tax penalty if withdrawn before age 65.

Eligible healthcare expenses include your deductible, your coinsurance amounts, prescription drugs, dental and vision expenses, etc.

Out-of-network amounts that exceed the recognized charge are also eligible healthcare expenses that may be paid from your HSA. Note that although your HSA can be used for dental, vision and amounts exceeding the recognized charge, these amounts do not count toward your medical deductible. So, your HSA's impact on your deductible depends on how you decide to spend your HSA money.

To be eligible, expenses must be incurred on or after your HSA is opened. However, expenses do not have to be paid or reimbursed from your HSA in the year incurred. Expenses continue to be eligible after you no longer participate in the HSA plan. These rules provide a great deal of flexibility for using your HSA. For example, if you have a medical expense of \$500 in 2019, you can initially pay it out of pocket and save the receipt. If you decide in 2019 or a later year that you prefer to pay this expense with HSA money, you can file for reimbursement at that time, as long as you have the receipt to submit.

HSA Fees

Baylor Scott and White will pay the account maintenance fee while you are employed. If you terminate employment with BSWH, but continue to maintain your HSA with Optum Bank the monthly account maintenance fee of \$2.75 per month will be automatically deducted from your account. Once you maintain an average balance of \$3,000 in your HSA account, the \$2.75 monthly maintenance fee will be waived.

Investing Your HSA

Your HSA is an interest-bearing account insured by the FDIC, paying a tiered variable rate. Go to www.optumbank.com for current rates. As long as your HSA has a minimum balance of \$2,000, you can direct its investment among a range of investment choices with nationally-recognized fund families. The investment funds each have minimum investment levels. Optum Bank offers online investment, trade and balance reporting. Transactional and management fees apply.

Deductible

Your deductible is the amount that must be paid before the plan begins to pay coinsurance. You pay your deductible out of pocket, which can include funds from your HSA. The amount of the deductible varies based on the coverage level you select, as shown below.

Amounts that don't count toward the deductible:

- Expenses paid by the plan
- Expenses for preventive care
- Any out-of-network expenses that exceed the recognized charge

Coverage Level	HSA		
	Tier 1	Tier 2	Tier 3
(EE)	\$1,500	\$3,000	\$5,000
(EF)*	\$3,000	\$6,000	\$10,000

* Aggregate family deductible, which means the plan will provide after-deductible coverage once the total family deductible is met.

Note: A separate deductible applies for services provided under each Tier. However, Tier 1 expenses count toward meeting the Tier 2 deductible. All in-network pharmacy claims are subject to the Tier 1 deductible only.

Coinsurance

If you have additional eligible medical expenses after your deductible is paid, then coinsurance begins. Coinsurance means you pay a percentage and the plan pays a percentage of the costs. The plan generally pays a coinsurance amount of 90% of the cost for services through Tier 1 providers, 50% of the cost for services through Tier 2 providers and 30% of the cost for services through Tier 3 providers. Tier 3 amounts above the recognized charges are your responsibility. Your coinsurance amount is 10% of the cost for services at Tier 1 providers and 50% of the cost for services through Tier 2 providers, up to a limit called the out-of-pocket maximum. The out-of-pocket maximum is the most you pay in coinsurance expenses for covered services in a plan year. Your coinsurance for Tier 3 providers is 70% of the recognized charge for services, with no out-of-pocket maximum.

If you choose the HSA plan for you and your family, the Tier 1 deductible of \$3,000 must be reached by the covered expenses of any combination of family members before coinsurance begins for any family member.

Example – Tier 1:

Betty enrolls herself and her daughter in the HSA plan and contributes \$500 to her HSA. During the first six months of the year, all of the \$500 in the HSA is spent on expenses for Betty.

In July, she has an X-ray at a Tier 1 facility that costs \$700, and pays out of pocket. In August, her daughter has expenses of \$1,800, which she also pays out of pocket. She has now met her Tier 1 \$3,000 deductible, and the plan will pay coinsurance for any additional expenses for Betty and her daughter for the remainder of the plan year, until the Tier 1 out-of-pocket maximum is reached.

Recognized Charges

If you obtain covered services from a Tier 3 provider, the amount paid by the plan is based on the recognized charge. The recognized charge for a specific service or supply is determined by SWHP in its sole discretion. The plan pays only the recognized charge, not the full amount. Any portion of an expense that exceeds the recognized charge is your responsibility to pay and will not count toward your deductible amount. You may pay the recognized charge from your HSA. See the Glossary for the definition of a recognized charge.

Out-of-Pocket Maximum

The out-of-pocket maximum is the most you will pay for eligible Tier 1 or Tier 2 healthcare expenses, including your deductible and coinsurance, in a plan year. Once you reach the out-of-pocket maximum, the plan pays 100% for Tier 1 or Tier 2 covered services for the remainder of the plan year.

The annual out-of-pocket maximums for Tier 1 and Tier 2 networks are:

Coverage Level	HSA		
	Tier 1	Tier 2	Tier 3
(EE)	\$3,950	\$6,750	
(EF)*	\$7,900	\$13,500	Unlimited

* These are embedded out-of-pocket maximums, which means no one person in your family has to pay more than the individual maximum, even if together you haven't met the family out-of-pocket maximum. The individual out-of-pocket maximum equates to the employee out-of-pocket maximum.

Note: A separate out-of-pocket maximum applies for services provided under each Tier. However, Tier 1 expenses count toward meeting the Tier 2 out-of-pocket maximum. All in-network pharmacy claims are subject to the Tier 1 out-of-pocket maximum only.

There is no out-of-pocket maximum for Tier 3 network. Amounts paid for Tier 3 do not apply to Tier 1 or Tier 2 out-of-pocket maximum.

IMPORTANT! Amounts you pay toward the cost of certain medical services will not count toward your annual out-of-pocket maximum. These include any cost you pay for:

- Any service not considered to be an eligible covered service
- Expenses in excess of annual maximums and limits
- Charges over the recognized charge
- Any out-of-network expenses
- Non-covered expenses
- Expenses for non-emergency use of the emergency room
- Expenses that are not paid due to a required prior authorization for the service(s) or supply was not obtained
- Preventive care expenses
- Premiums

Preventive Care

The HSA plan pays 100% for Tier 1 or Tier 2 preventive care. Tier 3 preventive care is not covered, whether or not you have met your deductible. The cost does not apply to your deductible or out-of-pocket maximum. To be covered at 100%, expenses must be billed as preventive.

BENEFITS AT A GLANCE —HSA PLAN

Coverage Level	HSA		
	Tier 1	Tier 2	Tier 3
Preventive Care*	\$0	\$0	Not Covered
Office Visit	10%	50%	70%
Specialist Office Visit	10%	50%	70%
Urgent Care	10%	50%	50%
Lab	10%	50%	70%
X-ray	10%	50%	70%
ER	10%	10%	10%
Hospital Inpatient	10%	50%	70%
Mental Hospital	10%	50%	70%
Mental Office Visit	10%	50%	70%

* In order for your claim to be paid at 100% as a preventive care claim, make sure your physician does not submit a diagnosis when he or she submits the claim to SWHP. Preventive care must be within SWHP guidelines and age-appropriate.

HOW THE PPO PLAN WORKS

The PPO plan gives you the freedom to use any doctor or hospital you choose, any time you need care. When you use a provider in Tier 1 or Tier 2, you pay a simple copay for most services, like in-network office visits and prescription drugs. Inpatient and outpatient services, including labs and x-rays are subject to a deductible. Once you meet your deductible, you and BSWH share the cost of any additional covered expenses until you reach your annual out-of-pocket maximum. After that, the plan pays 100% of Tier 1 or Tier 2 covered expenses for the year. Some preventive care, like routine physicals, routine child and well-baby care, immunizations and preventive tests, is covered at 100%.

In addition, network providers have agreed to charge a negotiated fee for their services and will file your claims for you. Plus, when you use a provider in Tier 2, you will pay discounted fees for services. And, if you use a Tier 1 provider you'll pay even less.

If you use a provider that is not in Tier 1 or Tier 2, you might have to pay the full price at the time of service and file a claim for reimbursement. In addition, you are responsible for any charges above the recognized charge. To locate a Tier 1 or Tier 2 provider, visit bswh.swhp.org and use the Find a Provider search tool.

Deductible

You and/or your covered family member must satisfy a deductible each calendar year before the plan begins paying benefits. The family deductible is satisfied by the combined out-of-pocket expenses of two or more family members. Preventive services such as adult routine exams, mammograms, pap smears and well-child care are not subject to the deductible. The amount of the deductible varies based on the coverage level you select and whether you use Tier 1 or Tier 2 providers, as shown below.

Coverage Level	PPO		
	Tier 1	Tier 2	Tier 3
	You pay copays for doctor visits, walk-in clinics, urgent care, emergency care and prescription drugs. If you need hospital care, you pay 100% of the costs until you meet your deductible. (Copays do not count toward your deductible)		
(EE)	\$1,000	\$2,000	\$5,000
(EF)*	\$2,000	\$4,000	\$10,000

* These are embedded deductibles, which means the plan will provide after-deductible coverage once an individual has met the individual deductible, even if you haven't met the family deductible. The individual deductible equates to the employee deductible.

Note: A separate deductible applies for services provided under each Tier. However, Tier 1 expenses count toward meeting the Tier 2 deductible.

Out-of-Pocket Maximum

The out-of-pocket maximum is the most that you will pay for eligible Tier 1 or Tier 2 health expenses, including your copay, deductible and coinsurance, in a plan year. Once you reach the

out-of-pocket maximum, the plan pays 100% for Tier 1 or Tier 2 covered services throughout the remainder of the plan year. The annual out-of-pocket maximums for Tier 1 or Tier 2 networks are:

Coverage Level	PPO		
	Tier 1	Tier 2	Tier 3
	If you have paid this amount out of your own pocket (including your copays and deductible), then the plan pays 100% of the remaining eligible expenses for Tier 1 or Tier 2 care and services for the rest of the year. There is no limit on your out-of-pocket costs if you go to Tier 3.		
(EE)	\$4,000	\$6,700	Unlimited
(EF)*	\$8,000	\$13,500	

* These are embedded out-of-pocket maximums, which means no one person in your family has to pay more than the individual maximum, even if together you haven't met the family out-of-pocket maximum. The individual out-of-pocket maximum equates to the employee out-of-pocket maximum.

Note: A separate out-of-pocket maximum applies for services provided under each Tier. However, Tier 1 expenses count toward meeting the Tier 2 out-of-pocket maximum. All in-network pharmacy claims cross accumulate: Tier 1 pharmacy claims count toward the Tier 2 out-of-pocket maximum and Tier 2 pharmacy claims count toward the Tier 1 out-of-pocket maximum.

Limited Drug Distribution filled at Contracted Pharmacies is subject to the Tier 1 out-of-pocket maximum.

There is no annual out-of-pocket maximum for Tier 3 network. Amounts paid for Tier 3 do not apply toward the Tier 1 or Tier 2 out-of-pocket maximum.

IMPORTANT! Amounts you pay toward the cost of certain medical services will not count toward your annual out-of-pocket maximum. These include any cost you pay for:

- Any service not considered to be an eligible covered service
- Expenses in excess of annual maximums and limits
- Charges over the recognized charge
- Any out-of-network expenses
- Non-covered expenses
- Expenses for non-emergency use of the emergency room
- Expenses that are not paid due to a required prior authorization for the service(s) or supply was not obtained

- Preventive care expenses
- Premiums

Copays

A copayment — or “copay” — is a flat fee per visit that you pay for a medical or pharmacy service. The plan pays the rest of the cost.

Coinsurance

After the deductible is met, you and the plan share the cost of a covered service. This is called coinsurance. Percentages may vary by service and network tier.

Preventive Medical Expenses

To be covered at 100%, expenses must be billed as preventive. Out-of-network preventive expenses are not covered.

Recognized Charges

If you obtain covered services from a Tier 3 provider, the amount paid by the plan is based on the recognized charge. The recognized charge for a specific service or supply is determined by SWHP. Any portion of an expense that exceeds the recognized charge is your responsibility to pay and will not count toward your deductible and out-of-pocket maximum.

BENEFITS AT A GLANCE—PPO PLAN

	After You Meet Your Deductible, You Pay: PPO		
	Tier 1	Tier 2	Tier 3
Preventive Care*	\$0	\$0	Not Covered
Office Visit	\$35**	\$70**	70%
Specialist Office Visit	\$60**	\$100**	70%
Urgent Care	\$75**	\$100**	\$100**
Lab/X-ray	Included with office visit or 10% if billed separately***	Included with office visit or 50% if billed separately***	70%
ER	\$250**	\$250**	\$250**
Hospital Inpatient	10%	50%	70%
Mental Hospital	10%	50%	70%
Mental Office Visit	\$35**	\$70**	70%

* In order for your claim to be paid at 100% as a preventive care claim, make sure your physician does not submit a diagnosis when he or she submits the claim to SWHP. Preventive care must be within SWHP's guidelines and age-appropriate.

** Flat fee not subject to deductible.

***Included with office visit co-pay, unless billed separately. Then, deductible/coinsurance applies.

MENTAL HEALTH AND SUBSTANCE ABUSE

The medical plan options provide behavioral health coverage, which includes treatment of mental disorders and substance abuse by behavioral health providers. If you or one of your covered family members has a mental disorder or substance abuse problem requiring treatment beyond the available Employee Assistance Program (EAP) sessions, further treatment is available under the plan.

Treatment of mental disorders must meet the following criteria:

- There is a written treatment plan prescribed and supervised by a behavioral health provider
- The plan includes follow-up treatment, and
- The plan is for a condition that can favorably be changed

Benefits are payable for charges incurred in a hospital, psychiatric hospital, residential treatment facility or behavioral health provider's office for the treatment of mental disorders, as follows:

- Covered expenses include charges for room and board at the semi-private room rate and other services and supplies provided during your stay in a hospital, psychiatric hospital or residential treatment facility. Inpatient benefits are payable only if your condition requires services that are available only in an inpatient setting.
- Covered expenses include charges for partial confinement treatment provided in a facility or program for the intermediate short term or medically directed intensive treatment of a mental disorder. Such benefits are payable if your condition requires services that are available only in a partial confinement treatment setting.
- Covered expenses include charges for treatment received while not confined as a full-time inpatient in a hospital, psychiatric hospital or residential treatment facility.
- The plan covers partial hospitalization services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short term or medically directed intensive treatment. The partial hospitalization will be covered only if you would need inpatient care if you were not admitted to this type of facility.

Treatment of substance abuse must meet the following criteria:

- There is a program of therapy prescribed and supervised by a behavioral health provider.
- The program of therapy includes either:
 - A follow-up program directed by a behavioral health provider on at least a monthly basis, or
 - Meetings at least twice a month with an organization devoted to the treatment of substance abuse.

Benefits are payable for charges incurred in a psychiatric hospital or residential treatment facility, appropriately licensed by the State Department of Health or its equivalent, as follows:

- The plan covers room and board at the semi-private room rate, and other services and supplies provided during your stay. Coverage includes:
 - Treatment in a hospital for the medical complications of substance abuse. Medical complications include detoxification, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.
 - Treatment in a hospital, when the hospital does not have a separate treatment facility section
- The plan covers outpatient treatment of substance abuse.
- Covered expenses include charges made for partial confinement treatment provided in a facility or program for the intermediate short term or medically directed intensive treatment of substance abuse. The partial confinement treatment will be covered only if you would need a hospital stay if you were not admitted to this type of facility.

Admissions to behavioral health/substance abuse residential, partial hospitalization, and day programs (not office visits to contracted providers) must be pre-authorized. See the Glossary for definitions of mental disorder and substance abuse.

PRESCRIPTION DRUGS

When you enroll in one of the medical plan options, you are automatically enrolled in prescription drug coverage with the Scott & White Health Plan. To be eligible for coverage, the prescription must be for a medically necessary treatment of an injury, illness or other medical condition covered by the medical plan options.

What You Pay

You'll pay different amounts for prescription drugs, based on your medical plan option and the tier of medication you choose: preferred generic, preferred brand, non-preferred brand, non-preferred generic, and specialty drugs.

All drugs have been reviewed and approved by a group of doctors and pharmacists to be included on BSWH's formulary (approved drug list). Go to bswh.swhp.org for a complete list of formulary drugs.

- **Preferred Generic:** These drugs have the lowest copayment as they offer the greatest value compared to other drugs that treat similar conditions. Generics have the same active ingredients as a brand-name drug but usually cost less and the quality and effectiveness are the same. Generics have been FDA-approved under strict standards.

- **Preferred Brand:** Brand name drugs are produced under the original manufacturer's brand name and are often more costly than preferred generic medications. Preferred brands have been proven to be safe, effective, and offer greater value than other brand name products that treat similar conditions.
- **Non-Preferred Brand and Generic:** These are brand-name and generic drugs that are generally more costly than drugs in the preferred tiers. There are often alternative medications available in the preferred tiers that treat similar conditions but are less costly.
- **Specialty:** These are high cost medications that are used to treat complex conditions, and which usually require close monitoring. Specialty drugs may be self-administered in the home by injection (under the skin or into a muscle), by inhalation, by mouth, or on the skin. These drugs may also require special handling, special manufacturing processes, and may have limited prescribing or limited pharmacy availability.

SEQA Plan: Your Costs

	BSW Pharmacy* (30-day cost/90-day cost)	Contracted Pharmacy (30-day supply only)
Preferred generic	\$3/\$6	\$5
Preferred brand	\$25/\$50	\$50
Non-preferred brand and generic	Lesser of \$50/\$100 or 50%	Lesser of \$75 or 50%
Specialty	\$100	Not covered
Chronic/Preventive	\$10/\$20 \$0 Diabetic Treatment	\$20 \$0 Diabetic Treatment

EQA and PPO Plans: Your Costs

	BSW Pharmacy* (30-day cost/90-day cost)	Contracted Pharmacy (30-day supply only)
Preferred generic	\$3/\$6	\$5
Preferred brand	\$35/\$70	\$50
Non-preferred brand and generic	Lesser of \$50/\$100 or 50%	Lesser of \$75 or 50%
Specialty	20% (\$200 max)	Not covered
Chronic/Preventive	\$10/\$20	\$20

HSA Plan: Your Costs

	BSW Pharmacy*	Contracted Pharmacy
Preferred generic	10% after deductible	10% after deductible
Preferred brand	10% after deductible	10% after deductible
Non-preferred brand and generic	10% after deductible	10% after deductible
Specialty	10% after deductible	Not covered
Chronic/Preventive	10% after deductible	10% after deductible

*90-day supplies are only available through BSW Pharmacies

Other Drug Coverage: These drugs are covered at specific levels at all BSW and contracted pharmacies:

- Fertility drugs are covered at 20% with a maximum \$400 copayment and a \$7,500 lifetime maximum pharmacy benefit.
- Diabetic testing supplies, including meters, test strips and lancets, are covered and subject to copayments and coinsurance.

Drugs not listed on formulary require pre-authorization. If authorized, you'll pay the applicable non-preferred or specialty copay.

Chronic and Preventive Drugs: To help make some frequently prescribed preferred brand drugs for asthma, diabetes and some other chronic conditions more affordable, we've placed a select group on a special chronic and preventive medication list. Find the complete list on bswh.swhp.org.

Baylor Scott & White Pharmacies

If you fill your maintenance eligible prescription through any BSW pharmacy, both mail order and retail, you can receive a three-month supply at the cost of a two-month supply.

Mail-order is handled through the Baylor Scott & White Grapevine Pharmacy.

You will also get a 20% discount on over-the-counter drugs if you show your BSWH employee badge at a BSW pharmacy.

Drug Type	Discount
Over-the-counter drugs	20%

Step Therapy

With almost every health condition, there are several different prescription drugs from which to choose. In many cases, the medications work similarly, but some cost less. That's where step therapy comes in. Before approving certain brand name medications, your plan may ask you to try a lower-cost alternative first. If it isn't effective, you can step up to the next lowest-cost medication until you find a drug that works best. Remember, you'll pay less if you choose a generic drug instead of a brand name option.

Quantity Management

For safety and cost reasons, certain drugs have limits on the amount you receive at one time. This is often based on the manufacturer's recommended dosages.

Split-Fill Oral Oncology Program

Prescriptions for drugs included in the Oral Oncology Program are limited to a maximum 15-day supply for the first two months of therapy, at 50% of the specialty copayment. Since these medications sometimes have side effects and may be difficult to

tolerate this allows you and your doctor to try the medication for a shorter time while avoiding wasted medication and unnecessary expenses.

After the first four fills, members continuing on therapy may fill their prescription for up to a 30-day supply.

Pre-Authorization

Some drugs need approval before the plan will cover them for both safety and cost reasons. If you receive a prescription for a drug that requires pre-authorization, you, a representative, or your doctor may submit a request for coverage. If approved, you'll pay the applicable copayment or coinsurance. If not approved and you still want to take the medication, you'll pay the full cost.

Compounds

Compounds costing greater than \$100 require pre-authorization. Bulk chemicals and non-FDA approved products such as topical pain patches are excluded from coverage.

What's Not Covered under the Pharmacy Benefit

Weight management, drugs used for cosmetic alteration, photo-aged skin products, depigmentation products, injectable cosmetics, hair growth agents, legend homeopathic medications, serums/toxoids, diagnostic agents, durable medical equipment, legend supplemental vitamins, over-the-counter equivalents, medical foods and over-the-counter products are not covered under the pharmacy benefit.

Additionally, the following are not covered:

- Non-sedating antihistamines, prescription and over-the-counter
- Nasal corticosteroids, prescription and over-the-counter (includes combination agents)
- Drugs not approved by the Food and Drug Administration (FDA) for use in humans or for the condition, dose, duration, route, and frequency being treated
- A prescription that has an over-the-counter alternative
- Drugs, medications and supplies:
 - Over-the-counter drugs, biological or chemical preparations, and supplies that may be obtained without a prescription, including vitamins
- Any services related to dispensing, injecting or applying a drug
- Any prescription drug purchased outside the United States, even if otherwise covered under this plan within the United States
- Needles and other injectable aids, except as covered for diabetic supplies
- Drugs related to the treatment of non-covered expenses
- Performance-enhancing steroids
- Outpatient prescription drugs

- Experimental or investigational drugs, devices, treatments or procedures, except as described in the What's Covered by the Medical Options section
- Bulk chemicals
- Drugs used for sexual dysfunction unless listed on the drug formulary

Questions?

Contact the Scott & White Health Plan at 800-728-7947 or bswh.swhp.org for more information about your prescription benefits.

Prescription drug exclusions that apply to the pharmacy plan will apply to the medical expense coverage.

WHAT'S COVERED BY THE MEDICAL OPTIONS

All services are covered according to the schedule below, unless otherwise indicated:

	SEQA	EQA	PPO			HSA		
	Tier 1	Tier 1	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3
Preventive Care*	\$0	\$0	\$0	\$0	Not covered	\$0	\$0	Not covered
Primary Care Office Visit	\$10**	\$30**	\$35**	\$70**	70% after deductible	10% after deductible	50% after deductible	70% after deductible
Specialist Office Visit	\$40**	\$50**	\$60**	\$100**	70% after deductible	10% after deductible	50% after deductible	70% after deductible
Urgent Care Office Visit	\$50**	\$75**	\$75**	\$100**	\$100**	10% after deductible	50% after deductible	50% after deductible
Diagnostic Lab	20%	30%	Included with office visit***	Included with office visit***	70% after deductible	10% after deductible	50% after deductible	70% after deductible
Diagnostic X-ray	\$75**	\$75**	Included with office visit***	Included with office visit***	70% after deductible	10% after deductible	50% after deductible	70% after deductible
Advanced Imaging – Ex: PET, CT, CAT	\$100**	\$100**	10% after deductible	50% after deductible	70% after deductible	10% after deductible	50% after deductible	70% after deductible
Advanced Imaging – Ex: MRI, MRA	\$150**	\$150**	10% after deductible	50% after deductible	70% after deductible	10% after deductible	50% after deductible	70% after deductible
ER	\$250** waived if admitted	\$250** waived if admitted	\$250** waived if admitted	\$250** waived if admitted	\$250** waived if admitted	10% after deductible	10% after deductible	10% after deductible
Ambulance/ Emergency Transportation	\$250**	\$250**	\$250**	\$250**	\$250**	10% after deductible	10% after deductible	10% after deductible
Inpatient Hospitalization	\$150** per day (max of 5 days)	\$150** per day (max of 5 days)	10% after deductible	50% after deductible	70% after deductible	10% after deductible	50% after deductible	70% after deductible

	SEQA	EQA	PPO			HSA		
	Tier 1	Tier 1	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3
Mental Office Visit	\$10**	\$30**	\$35**	\$70**	70% after deductible	10% after deductible	50% after deductible	70% after deductible
Outpatient Care	\$150**	\$150**	10% after deductible	50% after deductible	70% after deductible	10% after deductible	50% after deductible	70% after deductible
Skilled Nursing	10%	10% after deductible	10% after deductible	50% after deductible	70% after deductible	10% after deductible	50% after deductible	70% after deductible
Home Healthcare	10%	10% after deductible	10% after deductible	50% after deductible	70% after deductible	10% after deductible	50% after deductible	70% after deductible
Hospice Care	10%	10% after deductible	10% after deductible	50% after deductible	70% after deductible	10% after deductible	50% after deductible	70% after deductible
Durable Medical Equipment	10%	10% after deductible	10% after deductible	50% after deductible	70% after deductible	10% after deductible	50% after deductible	70% after deductible
Private Duty Nursing	10%	10% after deductible	10% after deductible	50% after deductible	70% after deductible	10% after deductible	50% after deductible	70% after deductible
Hearing Aids	10%	10% after deductible	10% after deductible	50% after deductible	70% after deductible	10% after deductible	50% after deductible	70% after deductible

* In order for your claim to be paid at 100% as a preventive care claim, make sure your physician does not submit a diagnosis when he or she submits the claim to SWHP. Preventive care must be within SWHP guidelines and age-appropriate.

** Flat fee not subject to deductible.

***Included with office visit co-pay, unless billed separately. Then, deductible/coinsurance applies (10% for Tier 1 and 50% for Tier 2).

NOTE: There is no out-of-network coverage on the SEQA/EQA plan except for urgent/emergency care or in rare situations when an in-network provider (Tier 1) is not available and authorization is provided. In these cases, coverage will be at the applicable in-network (Tier 1) benefit level.

Medically Necessary

Coverage is provided only for services and supplies that are medically necessary. To be considered medically necessary, a service or supply must be provided by a physician or other healthcare provider, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. The provision of the service or supply must be:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease
- Not primarily for the convenience of the patient, physician or other healthcare provider, and

- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Acupuncture

Benefits under each option are limited to 20 visits per person per calendar year for acupuncture therapy. There are no restrictions to diagnosis for acupuncture coverage, all diagnoses are covered.

Adult Immunizations — Preventive

Preventive immunizations include influenza (flu); pneumococcal; tetanus/toxoid; diphtheria; measles/mumps/ rubella (individuals under age 50 without previous immunization); and hepatitis A and B, chickenpox and Lyme disease (for high-risk groups). Adult immunizations are for individuals over age 18 and are covered at 100%. For a complete list of preventive immunizations, visit bswh.swhp.org.

Adult and Children Immunizations — Non-Preventive

Immunizations for travel, such as those for yellow fever and typhoid, are covered.

Allergy Care

Allergy injections (immunotherapy) and allergy tests (skin test, scratch test and R AST) are covered if administered by a physician, allergist or specialist. Serum is also covered.

Ambulance/Emergency Transportation

The plan covers emergency transportation by a professional ambulance service to and from the closest hospital that can provide the necessary services. Travel by a regularly scheduled airline or railroad is covered only if the necessary services aren't available at a hospital closer to the patient and if other transportation is inappropriate for the patient's condition. The plan covers charges for an air ambulance to and from the nearest hospital equipped to provide appropriate care if no ground or regularly scheduled domestic airline transportation is available and suitable and if the patient's condition warrants immediate evacuation. See Emergency Room Care for details on emergencies.

If you require a medically necessary transfer from a non-local facility to a Tier 1 hospital, contact SWHP. If an injury or illness occurs while you are traveling outside the United States, contact SWHP.

Amino Acid-Based Elemental Formulas

Regardless of the formula delivery method, medically necessary amino acid-based elemental formulas provided under the written order of a treating physician is covered for treatment and diagnosis as outlined by the Texas Mandate - <http://www.statutes.legis.state.tx.us/Docs/IN/htm/IN.1377.htm>.

Ancillary Charges (Facility)

Coverage includes necessary services and supplies such as admission fees; use of operating, delivery and treatment rooms; prescribed drugs; whole blood, administration of blood, blood processing and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced); anesthesia,

anesthesia supplies and the administration of anesthesia by an employee of the facility; medical and surgical dressings, supplies, casts and splints; and diagnostic services.

Anesthesia

The plan covers the administration of anesthesia, other than local infiltration anesthesia, in connection with a covered surgical procedure, provided the anesthesia is administered and charged by a physician other than the operating surgeon or his assistant. Anesthesia means the administration of spinal anesthetic, rectal anesthetic, or the administration of a drug or other anesthetic agent by injection or inhalation, if the purpose is to obtain muscular relaxation, loss of sensation or loss of consciousness.

Assistant Surgeon

Coverage is provided for the services of a physician who actively assists the operating surgeon when the condition of the patient or the type of surgical service requires such assistance.

Biofeedback

Biofeedback is considered medically necessary for the following conditions:

- Chronic constipation
- Fecal incontinence
- Irritable bowel syndrome
- Levator ani syndrome
- Migraine and tension headaches (muscle, skin or thermal biofeedback; EEG biofeedback is considered experimental and investigational for this indication)
- Neuromuscular rehabilitation of stroke and traumatic brain injury (TBI)
- Refractory severe subjective tinnitus
- Temporomandibular joint (TMJ) syndrome
- Urinary incontinence

Blood Transfusions

Coverage is provided for blood transfusions to maintain or replace blood volume, to provide deficient blood elements and improve coagulation, to maintain or improve transport of oxygen and in exchange for blood removed in the treatment of Rh incompatibility in a newborn. In addition, blood transfusion coverage is provided for liver failure in which toxins accumulate in the blood and in some other types of toxemia. Coverage includes autologous, direct donation, regular administration and whole blood.

Chiropractic Care

Coverage is provided for charges for detection and correction by manual or mechanical means of nerve interference resulting from or related to misalignment or partial dislocation of or in the vertebral column. Coverage includes initial consultation and treatment. Benefits under each option are limited to 20 visits per person per calendar year.

Consultation Services

The plan includes coverage for inpatient consultation provided in a covered facility, if requested by the attending licensed provider. Coverage does not include staff consultations required by a facility provider's rules and regulations.

Cosmetic/Reconstructive Surgery

The plan covers charges made by a physician, hospital or surgery center for reconstructive services and supplies, including:

- Surgery needed to improve a significant functional impairment of a body part.
- Surgery to correct the result of an accidental injury, including subsequent related or staged surgery, provided that the surgery occurs no more than 24 months after the original injury. For a covered child, the time period for coverage may be extended through age 18.
- Surgery to correct the result of an injury that occurred during a covered surgical procedure provided that the reconstructive surgery occurs no more than 24 months after the original injury (Note: Injuries that occur as a result of a medical (i.e., non-surgical) treatment are not considered accidental injuries, even if unplanned or unexpected.)
- Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an illness or injury) when the defect results in severe facial disfigurement or in significant functional impairment and the surgery is needed to improve function.

Covered expenses include reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. Also included is surgery on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of a mastectomy, including lymphedema.

To ensure coverage for any cosmetic surgery, you should contact SWHP to confirm if you need prior authorization for your care through your medical plan. None of the medical plan options cover elective cosmetic surgery.

Dental Services

See *Oral and Maxillofacial Treatment*.

Emergency Room Care (for emergency conditions as defined below)

Coverage is provided for treatment within 48 hours of a recent and severe medical condition, including (but not limited to) severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, illness, or injury is of such a nature that failure to get immediate medical care could result in:

- Placing the covered person's health in serious jeopardy
- Serious impairment to bodily function
- Serious dysfunction of a body part or organ

- In the case of a pregnant woman, serious jeopardy to the health of the fetus

Note: It is understood that in an emergency you can't always choose your location for care. However if you (an employee) or a covered dependent, such as a child away at college, are admitted to an out-of-network facility as a result of an emergency, the service will result in an inpatient stay and apply the Tier 2 benefit level (as opposed to Tier 3). For the SEQA/EQA plan options, you will pay the applicable copay for emergency care, and the rest will be covered at 100%

Non-emergency care in an emergency room is not covered.

E-Visits

As a participant in the medical plan, you and your covered dependents may now access E-Visits, an online diagnosis and treatment service that lets you skip a trip to the doctor's office. To qualify, you (or your covered dependent, as the case may be) must have seen an E-Visit qualifying provider (a HealthTexas Provider Network physician in North Texas or a Baylor Scott & White Health physician in Central Texas) in the last 12 months. If you or your covered dependent just need help with a simple medical condition, an E-Visit may be just right. For participants and covered dependents in the SEQA/EQA or PPO Plan, we are waiving the co-pay for the allowed amount that would otherwise apply to an office visit to your physician. Participants and covered dependents in the HSA Plan will be charged the allowed amount until the deductible has been met.

Effective April 1, 2019, benefit coverage was expanded to include video visits.

Conditions treated through E-Visits* include:

- acne
- canker or cold sore
- cold
- sinus infection or sore throat
- constipation and/or diarrhea (irritable bowel syndrome)
- female bladder infection (UTI)
- hay fever/allergies
- influenza (the flu)
- influenza prevention
- pink eye (conjunctivitis)
- vaginal yeast infection
- quitting tobacco

*Conditions treated may vary slightly by region.

To learn more about E-Visits and video visits, go to mybswhealth.com.

Family Planning

Covered expenses include charges for certain family planning services, even if not provided to treat an illness or injury, including:

- Voluntary sterilization
- Voluntary termination of pregnancy when the life of the mother is endangered or complications arise

The plan does not cover the reversal of voluntary sterilization procedures, including related follow-up care.

Contraception Services

Covered expenses include charges for contraceptive services and supplies provided on an outpatient basis, including:

- Contraceptive drugs and contraceptive devices prescribed by a physician provided they have been approved by the Federal Drug Administration
- Related outpatient services such as:
 - Consultations
 - Exams
 - Procedures
 - Other medical services and supplies
- As required by the Patient Protection and Affordable Care Act, the plan covers most generic contraceptive drugs at no cost to you. If your doctor determines that a generic contraceptive drug is medically inappropriate for you, we will work with you to accommodate your specific needs. If you have a question about whether a particular contraceptive drug or device is covered, contact SWHP customer service at the number listed on your medical ID card.

Not covered are:

- Charges for services which are covered to any extent under any other part of the plan or any other group plans sponsored by your employer, and
- Charges incurred for contraceptive services while confined as an inpatient.

Foot Care/Podiatry

Coverage is provided for surgical podiatry services, including incision and drainage of infected tissue of the foot, removal of lesions of the foot, removal or debridement of infected toenails and treatment of fractures and dislocations of bones of the foot. The plan does not cover procedures considered part of routine foot care or those of a cosmetic nature.

Hearing Care

Coverage is included for both routine care (one exam per year) and for medical conditions and accidents. Hearing aids limits - 1 'Binaural Hearing Aid' or 2 'Monaural hearing aids' are covered every 36 months.

Home Healthcare

Home healthcare expenses are charges for:

- Part-time or intermittent home health aide services provided in conjunction with and in direct support of care by an RN or by an LPN/LVN
- Physical, occupational and speech therapy
- The following to the extent they would have been covered if the person had been confined in a hospital or convalescent facility:
 - Medical supplies
 - Drugs and medicines authorized by a physician
- Lab services provided by a home healthcare agency

Expenses are covered if:

- The charge is made by a home healthcare agency
- The care is given under a home healthcare plan
- The care is given to you in your home while you are homebound (see glossary for homebound definition/criteria)

The following expenses are not covered under home healthcare:

- Services or supplies not part of the home healthcare plan
- Services of a person who usually lives with the patient or who is a member of the patient's family
- Part-time or intermittent medical social services by a social worker when provided in conjunction with, and in direct support of, care by an RN or an LPN
- Transportation
- Services that are custodial care

Home healthcare benefits for each medical plan option are limited to 120 visits per person per calendar year. Home healthcare must be pre-authorized.

Hospice Care

Hospice services consist of medically necessary hospice care that is recommended by a physician and provided by a licensed hospice agency.

For purposes of the plan, "hospice" means a healthcare program providing a coordinated set of services rendered at home, in outpatient settings, or in institutional settings for participants suffering from a condition that has a terminal prognosis. A hospice must have an interdisciplinary group of personnel which includes at least one physician and one registered nurse, and it must maintain central clinical records on all patients. A hospice must meet the standards of the National Hospice Organization (NHO) and applicable licensing requirements.

Although pre-authorization is not required for hospice services, Claim Administrator notification is requested for admissions to network inpatient or outpatient hospice programs.

Infertility

Even though not incurred for treatment of a disease or injury, covered medical expenses include costs incurred by a covered female meeting the following qualifications:

Having one of the following conditions:

- A demonstrated cause of infertility not caused by voluntary sterilization or a hysterectomy
- Under age 35 and demonstrated inability to conceive after one year or more of timed, unprotected coitus or 12 cycles of artificial insemination
- Over age 35 and demonstrated inability to conceive after six months or more of timed, unprotected coitus or six cycles of artificial insemination
- FSH levels less than or equal to 19 MIU on day three of menstrual cycle
- Cannot attain a successful pregnancy through less costly treatment covered by the medical plan

The plan covers the following fertility services expenses:

- Consultative services
- Diagnostic services
- Surgical procedures (to treat the cause of infertility)
- Assisted reproductive technologies, including artificial insemination, in vitro fertilization (IVF) and ovulation induction
- Oocyte retrievals
- Frozen embryo transfers, including thawing
- Gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT) and intracytoplasmic sperm injection

The plan also covers fertility preservation services (which may include donor egg, donor embryo or frozen embryo cycle) for covered females who have (or whose partner has) a diagnosis of cancer and cancer treatment is planned that is demonstrated to result in infertility, including:

- Bilateral orchiectomy (removal of both testicles)
- Bilateral oophorectomy (removal of both ovaries)
- Hysterectomy (removal of the uterus)
- Chemotherapy or radiation therapy that is established in medical literature to result in infertility

The covered female must be:

- Under 35 years of age with a day three FSH test in the prior 12 months, or
- 35 years of age or older with a day three FSH test in the prior six months, with a result that is less than 19 MIU/ml in any (past or current) menstrual cycle regardless of the type of infertility services planned.

Covered expenses include only those assisted reproductive

technology services that have a reasonable likelihood of success.

Covered expenses for fertility preservation will be paid on the same basis as infertility benefits for individuals who are infertile and not diagnosed with cancer.

The total infertility benefit available under all medical plan options is \$7,500 medical and \$7,500 pharmacy per lifetime. Your lifetime benefit will be determined as of 01/01/2013. No benefits are paid under any medical plan option, including prescription drugs, once the lifetime maximum is met (even if you enroll in a different medical option the following year). Charges for consultative and diagnostic services are excluded from the lifetime maximum. All coverage is subject to the terms and conditions of the plan for both males and females.

The following charges are not covered:

- Purchase of donor sperm or storage of sperm
- Care of donor egg retrievals or transfers
- Gestational carrier programs
- Home ovulation prediction kits

Pre-authorization is not required for infertility services. Contact SWHP for a pre-determination of benefits.

Inpatient Hospital Visits

Inpatient hospital admission at a non-Tier 1 BSWQA facility will result in a lower coverage level.

Coverage is provided for visits for observation, care, diagnosis and/or treatment. Covered expenses for room and board are limited to the semi-private room rate. Private room, intensive care, coronary care and other specialized care units of a facility are covered when such special care or isolation is consistent with professional standards for the care of the patient's condition. When room and board for care other than semi-private is at the convenience of the patient, payment will be made only for semi-private accommodations.

Inpatient Rehabilitation Facility

An inpatient rehabilitation facility is a facility used to aid in the recovery from an injury or illness that severely impairs a patient's physical functioning or understanding. These include strokes, spinal cord injuries, traumatic brain injuries, chronic pulmonary problems, neurological disorders and other debilitating conditions. Care is covered if medically necessary and if patient recovery is progressing according to medically accepted guidelines. Custodial care is not covered. Please contact SWHP for pre-authorization requirements.

Lab and X-ray Services

Coverage is provided for diagnostic radiology, consisting of X-rays, ultrasound, nuclear medicine and magnetic resonance imaging (MRI); diagnostic laboratory and pathology tests; diagnostic medical procedures consisting of EKG, EEG and other electronic medical procedures; and pre-admission, pre-surgical tests. Total body scans are not covered by the medical plan options.

Advanced Imaging such as PET, CT, CAT, MRI, MRA, etc. requires pre-authorization

Durable Medical Equipment

The plan covers charges for rental (or purchase, if less costly) of medical equipment prescribed by a professional provider and required for therapeutic use. If purchased, charges for repair or medically necessary replacement of medical equipment will be considered a covered expense. Maintenance and repairs needed due to misuse or abuse are not covered. Claims for equipment containing features of an aesthetic nature or features of a medical nature not required by the patient's condition will be paid based on the usual charge for equipment meeting the patient's medical needs. Likewise, if a reasonable, feasible and medically appropriate alternative piece of equipment exists and is less costly than the equipment furnished, the claim will be paid based on the lesser charge at SWHP's discretion.

Durable Medical Equipment — all of which must be prescribed by a physician — includes artificial limbs, braces, cleft palate obturators, diabetic devices, eye prostheses, stump stockings, ambulatory uterine monitors (Tokos), apnea monitors, bilirubin lights, canes, continuous airway pressure devices, crutches, commodes, glucose monitors, Holter monitors, ambulatory EKG, hospital beds, nebulizers (hand-held puff and electronic), pacemaker monitors, walkers and wheelchairs.

Coverage is provided for medical supplies prescribed by a licensed provider, and unavailable over the counter, for a medical condition or diagnosis. Examples of medical supplies are diabetic supplies (e.g. insulin pumps), and ostomy supplies (including medical equipment and supplies directly related to ostomy care when surgery creates an opening for drainage from the kidney, the small intestines or the colon). Syringes, test strips and lancets are covered under the prescription drug benefit. Contact SWHP for pre-authorization requirements.

Nutritional Counseling

Obesity preventive counseling is categorized as preventive care designed to aid in the managing and treatment of obesity. Primary care physicians may perform assessments and provide results, handle outreach, and provide educational resources for the participant. This benefit will only be included whenever the plan provides coverage for adult preventive care. There is no change for in-network service and it is covered the same as adult routine physical exams. Unlimited visits are allowed until age 20. For age 21 and over, up to 26 visits per person per calendar year are allowed. Out-of-network service is not covered.

Medical nutritional counseling for patients with chronic disease including, but not limited to, diabetes, hyperlipidemia and other known risk factors for cardiovascular disease in which dietary adjustment has a therapeutic role, when it is prescribed by a physician and furnished by a provider (e.g., licensed nutritionist, registered dietician, or other qualified licensed health professionals such as nurses who are trained in nutrition) is

recognized under the plan. Services are covered at the applicable primary care physician or specialist office visit cost sharing level.

Obesity Treatment

Covered expenses include charges made by a physician, licensed or certified dietician, nutritionist or hospital for the non-surgical treatment of obesity for the following outpatient weight management services:

- An initial medical history and physical exam
- Diagnostic tests given or ordered during the first exam

Morbid Obesity Surgical Expenses

Covered medical expenses include charges made by a hospital or a physician for the surgical treatment of morbid obesity of a covered person. Coverage includes the following expenses:

- One morbid obesity surgical procedure (Coverage is limited to one lifetime maximum under this plan. If you had the surgical procedure done on or after 01/01/2013 and the surgical procedure was covered by this plan, you have exhausted the lifetime maximum. If you had the surgical procedure covered by a different plan other than this plan, you are eligible to be considered for coverage) including complications directly related to the surgery
- Pre-surgical visits
- Related outpatient services
- One follow-up visit

One follow-up visit within 30 days is included as part of the procedure. Any additional visits beyond the one follow-up will be covered as an office visit at the applicable member cost share.

Obesity surgery may be covered when ALL of the following criteria are met:

1. Body Mass Index (BMI) \geq 35 (morbid obesity), AND one or more high risk co-morbid conditions:
 - a. Type 2 diabetes
 - b. Refractory hypertension in spite of adequate pharmacotherapy
 - c. Refractory hyperlipidemia in spite of diet and pharmacotherapy
 - d. Obesity induced cardiomyopathy
 - e. Clinically significant obstructive sleep apnea
 - f. Obesity related hypoventilation
 - g. Pseudotumor cerebri
 - h. Severe arthropathy of spine and/or weight bearing joints where obesity precludes appropriate surgical management
 - i. Hepatic steatosis without evidence of active inflammation
 OR, Body Mass Index (BMI) \geq 40 with no co-morbidities
2. The patient has failed to achieve or maintain a healthy weight despite participation in, and compliance with, a supervised dietary program.

3. The patient has either no psychiatric disorder or a managed psychiatric disorder, no drug or alcohol abuse or is alcohol-free and drug-free for at least one year, and has not smoked for at least 6 weeks.
4. Pre-operative evaluation by a mental health professional (psychiatrist or psychologist) experienced in the evaluation and management of bariatric surgery candidates to exclude patients who are unable to personally provide informed consent, who are unable to comply with a reasonable pre- and postoperative regimen, or who have a significant risk of postoperative decompensation is recommended. The mental health professional, the surgeon and the patient should be in agreement that the patient is an appropriate candidate for the surgery.

A patient undergoing bariatric surgery should undergo preoperative evaluation that is medically reasonable and necessary based upon his comorbid medical conditions and medical/surgical history. All underlying medical conditions that will likely impact or complicate the patient's surgical and postoperative course must be adequately controlled before surgery.

Covered procedures include:

- Laparoscopic adjustable gastric banding
- Open or laparoscopic Roux-en-Y gastric bypass
- Laparoscopic sleeve gastrectomy
- Open or laparoscopic biliopancreatic diversion with or without duodenal switch

Limited to in-network coverage.

Complications, other than those directly related to the surgery, will be covered under the related medical plan's covered medical expenses, subject to plan limitations and maximums.

Unless specified above, not covered under this benefit are charges incurred for:

- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions; except as provided in this SPD
- Services which are covered to any extent under any other part of this plan

Contact SWHP for pre-authorization requirements.

Office Visit for Illness or Injury

The plan provides coverage for visits made by patients to health service providers' offices for diagnosis, treatment and follow-up.

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

Covered expenses include charges made by a physician, dentist or hospital for:

- Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues (this includes bones, muscles and nerves) for surgery needed to:
 - Treat a fracture, dislocation or wound
 - Cut out teeth that are partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth; cysts, tumors or other diseased tissues
 - Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth
 - Alter the jaw, jaw joints or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement
- Hospital services and supplies received for a stay required because of your condition
- Dental work, surgery and orthodontic treatment needed to remove, repair, restore or reposition:
- Natural teeth damaged, lost or removed (teeth must have been free from decay or in good repair, firmly attached to the jaw bone at the time of the injury, and the treatment must be completed in the calendar year of the accident or in the next calendar year), or
- Other body tissues of the mouth fractured or cut due to injury.

If crowns, dentures, bridges or in-mouth appliances are installed due to injury, covered expenses only include charges for:

- The first denture or fixed bridgework to replace lost teeth
- The first crown needed to repair each damaged tooth, and
- An in-mouth appliance used in the first course of orthodontic treatment after the injury.

Contact SWHP for pre-authorization requirements.

Outpatient Surgical Facility

Services at a surgical center or hospital outpatient clinic are covered if they are performed along with a surgical procedure. See pre-authorization and pre-notification information on [pages 33-34](#); the employee pays 10% at Tier 1 facilities.

Prenatal Care

Prenatal care visit includes specific blood tests, ultrasounds, specific assessments, screenings and counseling (e.g., blood pressure, weight, urine test, uterine size and fetal heart rate assessment, glucose tolerance testing, and screening for specific sexually transmitted infections), as well as topics for counseling and

guidance (e.g., tobacco avoidance and nutrition). Services must be billed with a prenatal diagnosis code to be covered at 100%. Urine tests, blood tests and imaging tests, such as ultrasound to detect pregnancy or monitor a medical condition are not considered as a prenatal care service.

Preventive Care

Participants are entitled to in-network preventive care services without being subject to a copayment, deductible or coinsurance when billed as preventive service. Participants may access preventive health services and health education programs as determined by the plan.

Preventive Health Benefits

Based on United States Preventive Services Task Force (USPSTF) A and B Recommendations:

- Grade A - The USPSTF recommends the service. If services are rendered without a pre-authorization, it may result in a failure of payment from the plan. There is high certainty that the net benefit is substantial.
- Grade B - The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.
- Grade D - The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.
- Grade I - The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.

Other sources:

- Bright Futures Recommendations for Pediatric Preventive HealthCare
- Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children
- Guidelines specifically issued for women and adopted by HRSA
- Texas Mandates (in table below, TX mandate requirements take precedence over USPSTF requirements, e.g. an age range that differs from USPSTF, a benefit not on USPSTF list, etc.)

For immunization recommendations and schedules, see Center for Disease Control and Prevention: <https://www.cdc.gov/vaccines/schedules/>

Preventive services are those performed on a person who has:

- Not had the preventive screening done before and does not have symptoms or other abnormal studies suggesting abnormalities; or
- Had the screening done within the recommended interval with the findings considered normal; or

- Had diagnostic services results that were normal after which the physician recommendation would be for future preventive screening studies at recommended preventive services intervals.
- A preventive service done that results in a therapeutic service done at the same encounter and as an integral part of the preventive service (e.g. polyp removal during preventive colonoscopy), the therapeutic service would still be considered a preventive service.

Examples include, but are not limited to:

- A woman had an abnormal finding on a preventive screening mammography and the follow-up study was found to be normal, and the patient was returned to normal mammography screening protocol, then future mammography would be considered preventive.
- If a polyp is encountered during preventive screening colonoscopy, the colonoscopy, removal of the polyp, and associated fees done at the same encounter are covered under the Preventive Care Services benefit.

When a service is done for diagnostic purposes it will be adjudicated as a non-preventive medical benefit.

Diagnostic services are done on a person who had:

- Abnormalities found on previous preventive or diagnostic studies that require further diagnostic studies; or
- Abnormalities found on previous preventive or diagnostic studies that would recommend a repeat of the same studies within shortened time intervals from the recommended preventive screening time intervals; or
- A symptom that required further evaluation.

Examples include, but are not limited to:

- A patient had a polyp found and removed at a prior preventive screening colonoscopy. All future colonoscopies are considered diagnostic because the time intervals between future colonoscopies would be shortened.
- A patient had an elevated cholesterol on prior preventive screening. Once the diagnosis has been made, further testing is considered diagnostic rather than preventive. This is true whether or not the patient is receiving pharmacotherapy.

Medical Plan Preventive List

Service	Description	Sex	Age	Frequency	Grade
Wellness visits (General)	<p>Preventive medicine comprehensive evaluation and management services include:</p> <ul style="list-style-type: none"> • An age-and gender-appropriate history • Physical examination • Counseling/anticipatory guidance • Risk factor reduction interventions • The ordering of appropriate immunization(s) and laboratory/screening procedures <p>Codes G0402,G0438, G0439, G0513, and G0514 are the Medicare initial preventive PE and wellness visit (one time) with no copays.</p>				
Wellness visit for young children	<p>This is a comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/ risk factor reduction interventions.</p> <p>Frequency according to AAP Bright Futures</p>		0-4y	Varies	
Wellness visit beyond age 5y	<p>This is a comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/ risk factor reduction interventions</p> <p>May include administration and interpretation of health risk assessment instrument (99420) Medicare codes for initial preventive PE and wellness visit (one time) with no copays: G0402, G0438, G0439, G0513, and G0514</p>		5+y	One per year	
Wellness Visits may include the following services:					
Alcohol misuse: screening and counseling	The USPSTF recommends that clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.		11+y		B
Aspirin for preeclampsia prevention:	The USPSTF recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.	Female		Pregnant	B

Medical Plan Preventive List

Service	Description	Sex	Age	Frequency	Grade
Aspirin preventive medication counseling: adults	The USPSTF recommends initiating low-dose aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years who have a 10% or greater 10-year cardiovascular risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.	Male Female	50-59y		B
Autism/ Developmental Screening	Bright Futures		18-24m		
Blood pressure screening in adults	The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.		18+y		A
BRCA risk assessment and genetic counseling and testing	The USPSTF recommends that primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). (Testing below) Testing requires Prior Authorization. Not a Medicare preventive benefit.	Female			B
Breast cancer preventive counseling	The USPSTF recommends that clinicians engage in shared, informed decision making with women who are at increased risk for breast cancer about medications to reduce their risk. For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene. Must have no prior diagnosis of breast cancer. Not a Medicare preventive benefit.	Female			B
Dental caries prevention: infants and children age 6 mo to 5 yrs	The USPSTF recommends primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.		6 mo to ≤ 5y		B
Dental caries prevention: application of fluoride varnish to primary teeth	The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.		≤ 5y		B

Medical Plan Preventive List

Service	Description	Sex	Age	Frequency	Grade
Depression screening: adolescents	The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. (TX mandated ages)		12-18y		B
Depression screening: adults	The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.				B
Developmental Screening	Bright Futures		≤3y		
Healthy diet and physical activity counseling to prevent cardiovascular disease: adults with cardiovascular risk factors	The USPSTF recommends offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.				B
Hearing loss screening	Bright Futures		0- 20yr		
Intimate partner violence screening	The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.				B
Obesity screening and counseling: adults	The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m ² or higher to intensive, multicomponent behavioral interventions. Nutrition therapy limited to 26 visits per year.		21+		B
Obesity screening and counseling: children	The USPSTF recommends that clinicians screen children age 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.		6-21y		B

Medical Plan Preventive List

Service	Description	Sex	Age	Frequency	Grade
Sexually transmitted infections counseling	The USPSTF recommends intensive behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections.		11+y		B
Skin cancer behavioral counseling	The USPSTF recommends counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.		10-24y		B
Statin preventive medication: adults ages 40–75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater	The USPSTF recommends that adults without a history of cardiovascular disease (CVD) (i.e., symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are ages 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults ages 40 to 75 years.	Both	40-75y		
Tobacco use counseling and interventions: all (<i>Expanded counseling for pregnant tobacco users.</i>)	The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)–approved pharmacotherapy for cessation to adults who use tobacco.		18+y and during pregnancy		A
Tobacco use interventions: children and adolescents	The USPSTF recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.		6-18y		B
Tobacco, Alcohol, or Drug Use Assessment	Bright Futures		11+y		
Visual acuity screening in children	The USPSTF recommends vision screening for all children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.		<5y	Once	B

Medical Plan Preventive List

Service	Description	Sex	Age	Frequency	Grade
Newborn-specific Wellness services:					
Critical congenital heart disease screening	Bright Futures Screening for critical congenital heart disease with pulse oximetry for newborns, after 24 hours of age, before discharge from the hospital.		Newborn	0-30 days	-
Bilirubin screening	Bright Futures		Newborn	0-30 days	
Gonorrhea prophylactic medication: newborns	The USPSTF recommends prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.		Newborn		A
Hearing loss screening: newborns	Recommended screening for hearing loss in all newborn infants. Necessary diagnostic follow-up care to the screening test for a child from birth through the date the child is 24 months old		Newborn	0-30days	-
Hypothyroidism and Metabolic disease screening: newborns	Advisory Committee on Heritable Disorders in Newborns and Children recommends that every newborn screening program include a Uniform Screening Panel that screens for 32 core disorders and 26 secondary disorders; the disorders' selection was based on the "Newborn Screening: Towards a Uniform Screening Panel and System." The USPSTF does not wish to duplicate the significant investment of resources made by others to review new evidence in a timely fashion and make recommendations.		Newborn	0-30days	-
Hemo-globinopathies screening: newborns	The USPSTF recommends screening for sickle cell disease in newborns.		Newborn	0-30days	-
Maternal Depression Screening	Bright Futures recommends screening for maternal depression		Newborn	0-6mo	

Medical Plan Preventive List

Service	Description	Sex	Age	Frequency	Grade
Phenylketonuria and Metabolic Screening: newborns	Part of Texas Newborn Screening Program NOTE: Part of Texas Newborn Screening Program		Newborn	0-30days	B
Preventive Care Screenings and Interventions					
Abdominal aortic aneurysm	The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.	Male	65-75y	Once	B
Anemia Screening: pregnant women	The USPSTF recommends routine screening for iron deficiency anemia in asymptomatic pregnant women	Female		Pregnant	I
Anemia in Young Children: Screening	Bright Futures		1y		-
Bacteriuria screening: pregnant women	The USPSTF recommends screening for asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.	Female		Pregnant	A
BRCA risk assessment, genetic counseling and testing	The USPSTF recommends that primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.	Female			B

Medical Plan Preventive List

Service	Description	Sex	Age	Frequency	Grade
Breast cancer screening mammography	<p>The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older (TX mandated ages). Includes Tomosynthesis (3D Mammography).</p> <p>In addition to the USPSTF recommendation for screening mammography, if you have certain risk factors, screening mammography will be available to you as often as once a year regardless of your age. Risk factors include:</p> <ul style="list-style-type: none"> • A family member (a parent, sibling, or child) with breast cancer • A close family member with a genetic mutation (BRCA) known to increase the risk of breast cancer • Your first pregnancy occurred after age 30 • A personal history of breast cancer • A history of radiation therapy to the chest 				
Breastfeeding Support, Supplies, and Counseling	The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.	Female		Up to 6 lactation consultant visits	B
Breast pump (one electric) & supplies	This benefit is limited to one pump per completed pregnancy but no more than one pump in a calendar year. In the event of a birth resulting in multiple infants, only one breast pump will be provided. Requires Prior Authorization.			One per year	B
Extra supplies	Additional supplies, if needed.			One per year	
Cervical cancer screening (Pap Smear)	The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years. (TX mandated ages)	Female	18+y	Every 3 years	A
Chlamydia screening: women	The USPSTF recommends screening for chlamydia in sexually active women age 24 years or younger and in older women who are at increased risk for infection.	Female			B

Medical Plan Preventive List

Service	Description	Sex	Age	Frequency	Grade
Cholesterol/ cholesterol screening Dyslipidemia Screening Children	Bright Futures For children at higher risk of lipid disorders (one screening for each of the following age ranges): Ages: 2y, 4y, 6, 8, 9-11, 12-16, 17-21		10 & 20 y (varies)		-
Cholesterol abnormalities screening: men 35+ years old	The USPSTF strongly recommends screening men age 35 years and older for lipid disorders.	Male	35+y		A
Cholesterol abnormalities screening: younger men at increased risk	The USPSTF recommends screening men aged 20-35 for lipid disorders if they are at increased risk for coronary heart disease.	Male	20-35y		A
Cholesterol abnormalities screening: women at increased risk:	The USPSTF strongly recommends screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease.	Female	45+y 20-45y		A B
Colorectal cancer screening	The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 85 years. Fecal occult blood testing (FOBT) annually Fecal immunochemical test (FIT) annually Sigmoidoscopy every five years (Medicare: every 4 years) Colonoscopy every 10 years CT colonography (virtual colonoscopy) every five years Double contrast barium enema (DCBE) every five years In addition to the USPSTF recommendation for colorectal cancer screening, if you have certain risk factors, colonoscopy for colorectal cancer screening is available to you as often as every 5 years regardless of your age. Risk factors include: <ul style="list-style-type: none"> • A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp • A family history of familial adenomatous polyposis • A family history of hereditary nonpolyposis colorectal cancer • A personal history of adenomatous polyps • A personal history of colorectal cancer 				

Medical Plan Preventive List

Service	Description	Sex	Age	Frequency	Grade
Contraceptive Methods	Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs coverage of contraception may be subject to step therapy and preauthorization requirements.	Female			-
Diabetes screening during pregnancy	The USPSTF recommends screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation.	Female	Pregnant		B
Diabetes screening in adults	The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.		40-70y		B
Falls prevention in older adults: exercise or physical therapy	The USPSTF recommends exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls. Not a Medicare preventive benefit.		65+y		B
Folic acid supplementation	The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.	Female	Fertile		A
Gonorrhea screening: women	The USPSTF recommends screening for gonorrhea in sexually active women age 24 years or younger and in older women who are at increased risk for infection.	Female			B
Hepatitis B screening: pregnant women	The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.	Female		Pregnant	A
Hepatitis B screening: those at high risk	The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection.				B
Hepatitis C virus infection screening: adults	The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.		Born 1945-1965		B

Medical Plan Preventive List

Service	Description	Sex	Age	Frequency	Grade
HIV screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.	Female		Pregnant	A
HIV screening: adolescents and adults at increased risk	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.				A
Lead Screening	Bright Futures: assess risk at 6mo, 9mo, 12mo, 18mo, 2y, 3y, 4y, 5y, 6y. At 12mo and 2 y: "Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas."		0-21y		-
Lung cancer screening	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.		55-80y 55-77y for Medicare lines	One per year	B
Osteoporosis screening: women	The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in: <ul style="list-style-type: none"> women 65 years and older postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool 	Female	65+y <65y		B

Medical Plan Preventive List

Service	Description	Sex	Age	Frequency	Grade
Prostate Cancer Screening: men	<p>The U.S. Preventive Services Task Force (USPSTF) recommends against prostate-specific antigen (PSA)-based screening for prostate cancer.</p> <p>TX Mandate: provides for an annual screening exam to detect prostate cancer. The benefits provided under this subparagraph include the following once per year: (1) a physical examination to detect prostate cancer, (2) a prostate-specific antigen test for a male Member who is at least 50 years of age with no symptoms or who is at least 40 years of age and has a family history of prostate cancer or another prostate cancer risk factor.</p> <p>Medicare: copay and deductibles may apply for prostate digital exam (G0102)</p>	Male	50+		D
Rh incompatibility screening: first pregnancy visit	The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.	Female		Pregnant	A
Rh incompatibility screening: 24–28 weeks' gestation	The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.	Female		Pregnant	B
Syphilis Screen in those at increased risk	The USPSTF recommends screening for syphilis infection in persons who are at increased risk for infection.				A
Syphilis Screen in pregnancy	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.	Female	Pregnant		A
Rh incompatibility screening: first pregnancy visit	The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.	Female		Pregnant	A
Tuberculosis screening: children	<p>Bright Futures</p> <p>Tuberculin testing for children at higher risk of tuberculosis one test for each of the following age ranges: Ages: 1m, 6m, 1y and annually ages 3-21y.</p>		Various		B
Tuberculosis screening: adults at increased risk	The USPSTF recommends screening for latent tuberculosis infection in populations at increased risk.				B

Medical Plan Preventive List

Service	Description	Sex	Age	Frequency	Grade
Vitamin D for falls prevention in older adults	The USPSTF recommends vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.		65+y		B
Wellness Examinations child and adult	These codes also include the following Health & Human Services requirements for Women: <ul style="list-style-type: none"> Breastfeeding support and counseling Contraceptive methods counseling Domestic violence screening Annual HIV counseling Sexually Transmitted Infections counseling Well-woman visits 				
Venipuncture for preventive tests	Depending on preventive service				

The determination of whether a service is a preventive health service may be influenced by the type of service for which a physician or provider submits a claim. A service that was initially considered a preventive health service may transform into a diagnostic service if a medical condition is discovered. In such a case, the copayment for the applicable medical service may apply, rather than the treatment being deemed a preventive health service. Other medical services rendered in connection with a preventive health service may result in the participant being subject to additional copayments as medical services.

Private Duty Nursing

Private duty nursing is an outpatient nursing service rendered by a nurse who does not reside in your home and is not a member of your immediate family. To be covered, the physician in charge of the case must certify that the patient's condition requires the requested care and that the care can be provided only by an RN or LPN/LVN. Private duty nursing applies only to care given in the patient's home and does not apply to care provided as part of a home healthcare agency's plan of treatment. Benefits under each medical plan option are limited to 120 visits per person per calendar year. Contact SWHP for pre-authorization requirements.

Second Surgical Opinion

Coverage is provided for an opinion given by a second physician when one physician recommends surgery to an individual.

Skilled Nursing Facility

Covered expenses include charges made by a skilled nursing facility during your stay for the following services and supplies:

- Room and board, up to the semi-private room rate. The plan will cover up to the private room rate if it is needed due to an infectious illness, or a weak or compromised immune system
- Use of special treatment rooms
- Radiological services and lab work
- Physical, occupational or speech therapy
- Oxygen and other gas therapy
- Other medical services and general nursing services usually given by a skilled nursing facility (this does not include charges made for private or special nursing, or physician's services), and
- Medical supplies.

Benefits under each medical plan option are limited to 120 days per person per calendar year. Contact SWHP for pre-determination of benefits.

Sleep Apnea

Coverage is provided for sleep apnea studies and the treatment of the condition. Coverage is provided for diagnosis and treatment of obstructive sleep apnea in adults and children, subject to medical necessity. Contact SWHP for pre-determination of benefits.

Surgeons/Anesthesiologists

The plan covers charges for the treatment of illness, injury and sterilization procedures. Surgery must be pre-authorized or pre-certified as discussed later in this section. See [page 69-73](#) for medical/surgical procedures not covered.

Temporomandibular Joint Disorder (TMJ)

Coverage for medically necessary diagnostic or surgical treatment of conditions affecting the temporomandibular joint, including the jaw and craniomandibular joint, is available, where the condition is the result of an accident trauma, a congenital defect, or a developmental defect. Charges for TMJ appliances may be covered as well. Contact SWHP for pre-authorization requirements.

Therapy Services

The plan covers charges for therapy services when used in treating an illness or injury to promote the recovery of the covered person. The plan also covers therapy services for Autism Spectrum Disorder, Pervasive Developmental Delay, and Congenital Disorders. Therapy services must be rendered in accordance with a physician's written plan. Therapy services include:

- Physical therapy is covered for non-chronic conditions and acute illnesses and injuries, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute illness, injury or surgical procedure. Physical therapy does not include educational training or services designed to develop physical function.
- Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute illnesses and injuries, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute illness, injury or surgical procedure, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop physical function.
- Speech therapy is covered for non-chronic conditions and acute illnesses and injuries, and expected to restore the speech function or correct a speech impairment resulting from illness or injury or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.
- Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.
- Applied Behavior Analysis (ABA) is covered.

The therapy should follow a specific treatment plan that:

- Details the treatment and specifies frequency and duration, and
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.

Benefits under each medical plan option are limited to a total of 60 visits per person per calendar year for speech therapy and combined 60 visits per person per calendar year for physical therapy/occupational therapy. A "visit" consists of no more than one hour of therapy. Covered expenses include charges for two therapy visits of no more than one hour in a 24-hour period.

Therapy services provided in your home are covered if you are homebound; however, home visits for therapy count toward the home healthcare limitation of 120 visits per person per calendar year as well as the therapy limitations.

There is no limit to the number of ABA therapy visits for the treatment of autism spectrum disorders and other similar developmental disorders when determined to be medically necessary.

Transplants

Covered expenses include charges incurred during a transplant occurrence. The following will be considered one transplant occurrence once it has been determined that you or one of your dependents may require an organ transplant. Organ means solid organ, stem cell, bone marrow and tissue.

- Heart
- Lung
- Heart/lung
- Simultaneous pancreas kidney (SPK)
- Pancreas
- Kidney
- Liver
- Intestine
- Bone marrow/stem cell
- Multiple organs replaced during one transplant surgery
- Re-transplant of same organ type within 180 days of the first transplant
- Any other single organ transplant unless otherwise excluded under the plan

The following will be considered more than one transplant occurrence:

- Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant)
- Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant)
- Re-transplant more than 180 days after first transplant
- Pancreas transplant following a kidney transplant
- A transplant necessitated by an additional organ failure during the original transplant surgery/process
- More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g., a liver transplant with subsequent heart transplant)

The plan covers:

- Charges made by a physician or transplant team
- Charges made by a hospital, outpatient facility or physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program
- Related supplies and services provided by the facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home healthcare expenses; and home infusion services.
- Charges for activating the donor search process with national registries
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an “immediate” family member is defined as a first-degree biological relative. These are biological parents, siblings or children.
- Inpatient and outpatient expenses directly related to a transplant

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either 180 days from the date of the transplant, or upon the date you are discharged from the hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one transplant occurrence and a summary of covered transplant expenses during each phase are:

- **Pre-transplant evaluation/screening:** Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility’s transplant program
- **Pre-transplant/candidacy screening:** Includes human leukocyte antigen (HLA) typing/compatibility testing of prospective organ donors who are immediate family members
- **Transplant event:** Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during your inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient stay or outpatient visit(s); cadaveric and live donor organ procurement, and
- **Follow-up care:** Includes all covered transplant expenses; home healthcare services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

Contact SWHP for pre-authorization requirements.

Urgent Care Centers

Coverage is provided for services performed by stand-alone facilities devoted exclusively to providing urgent care and not attempting to provide ongoing medical care. Urgent care facilities that are part of an emergency room are excluded from this benefit.

Video Visits

As a participant in the medical plan, you and your covered dependents may now access Video Visits. For participants and covered dependents in the SEQA/EQA or PPO Plan, we are waiving the co-pay for the allowed amount that would otherwise apply to an office visit to your physician. Participants and covered dependents in the HSA Plan will be charged the allowed amount until the deductible has been met.

Conditions treated include:

- acne
- canker or cold sore
- cold
- sinus infection or sore throat
- constipation and/or diarrhea (irritable bowel syndrome)
- female bladder infection (UTI)
- hay fever/allergies
- influenza (the flu)
- influenza prevention
- pink eye (conjunctivitis)
- vaginal yeast infection
- quitting tobacco

**Conditions treated may vary slightly by region.*

Vision Exam

A vision exam is covered under the plan only for a medical condition (i.e., glaucoma) or accidental injury.

Wigs

Wigs are approved under the plan when hair loss is the result of injury, disease or treatment of disease.

WHAT’S NOT COVERED

Although the plan covers most necessary medical expenses, some expenses are not covered, even if prescribed, recommended or approved by your physician or dentist. The plan covers only those services and supplies that are medically necessary and included in the What’s Covered by the Medical Options section. The list below includes examples only and is not intended to be a complete list. If you have any questions about specific eligible medical coverage, it is your responsibility to contact your medical plan provider by calling the customer service number listed on your ID card.

The following are not covered:

- **Abortions:** Elective abortions, which are not necessary to preserve the participant or covered dependent's health, are excluded.
- **Allergy:** See "Home and mobility" and "Therapies and tests."
- **Anesthesia:** Anesthesia for procedures which are not covered by the plan is not a covered benefit.
- **Behavioral health services:** See "Therapies and tests."
- **Biofeedback:** Not covered for any indications except as described in the What's Covered by the Medical Options section.
- **Christian Science:** Charges by a Christian Science facility, practitioner, or nurse are not covered.
- **Contraceptive services and supplies:** The reversal of an elective sterilization procedure; condoms, foams, contraceptive jellies and ointments are excluded.
- **Cosmetic services and plastic surgery:** Expenses will not be paid for:
 - The implantation, removal, and replacement of breast implants are not covered benefits, unless related to reconstruction following a medically necessary mastectomy;
 - Excision of excessive skin and subcutaneous tissue of the leg, hip, buttock, arm, or submental fat pad;
 - Suction assisted lipectomy of the head and neck, leg, hip, buttock, or arm;
 - Insertion, removal or care of complications of breast implants unless such implants were otherwise covered under the plan;
 - Dermabrasion;
 - Cryotherapy for acne; or
 - Chemical exfoliation for acne.
- **Counseling:** See "Sex change" and "Sexual dysfunction/enhancement."
- **Court-ordered services:** Healthcare services provided solely because of the order of a court or administrative body, which healthcare service would otherwise not be covered under this plan, are excluded. Charges for a provider to appear in court are also excluded.
- **Criminal act(s):** Services received because of an injury incurred while engaged in an activity for which the participant is convicted of a felony or Class A misdemeanor are not covered.
- **Custodial care:** Custodial care as follows is excluded:
 - Any service, supply, care, or treatment that the medical director determines to be incurred for rest, domiciliary, convalescent or custodial care;
 - Any assistance with activities of daily living which include activities such as walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking drugs; or
- Any care that can be performed safely and effectively by a person who does not require a license or certification or the presence of a supervisory nurse. Such services will not be covered expenses no matter who provides, prescribes, recommends, or performs those services. The fact that certain covered expenses are provided while participant is receiving custodial care does not require the plan to cover custodial care.
- **Dental services:** Excluded except to the extent specifically listed as covered in the plan.
- **Disaster or epidemic:** In the event of a major disaster or epidemic, services shall be provided insofar as practical, according to the best judgment of health professionals and within the limitations of facilities and personnel available; but neither the plan, nor any health professional shall have any liability for delay or failure to provide or to arrange for services due to lack of available facilities or personnel.
- **Disposable outpatient supplies:** Any outpatient disposable supply or device, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, home test kits, splints, neck braces, compresses and other devices not intended for reuse by another patient.
- **Educational services/therapy:** Services related to the diagnosis, treatment, or management of education or school problems are not covered.
- **Eligibility:** Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the plan.
- **Excess charges:** No payment will be made for any portion of the charge for a service or supply in excess of the allowable amount for such service or supply.
- **Experimental or investigational drugs:** See "Pharmacy benefit/prescription drugs."
- **Facility charges for care services or supplies:** No payment will be made for services, except emergency care, received in federal facilities or for any items or services provided in any institutions operated by any state, government or agency when participant has no legal obligation to pay for such items or services; except, however, payment will be made to the extent required by law provided such care is approved in advance by the plan medical director. Benefits furnished, paid for, or required by reason of service in the armed services of any country are not covered.
- **Food items:** Food products and guest meals except to the extent specifically listed as a covered benefit under the plan..
- **Foot care:** Services for foot care, including, but not limited to, care of corns, calluses, bunions, and nails, except those services related to systemic conditions and surgical procedures, are excluded. Also, orthopedic shoes (except

those which are an integral part of a corrective brace), corrective shoes, arch supports, and foot orthotics are excluded.

- **Gender Reassignment Surgery:** Any procedures or treatments designed to alter physical characteristics of a participant from the participant's biologically determined sex to those of another sex, regardless of any diagnosis of gender role disorientation or psychosexual orientation, and any studies, treatment, or counseling related to sex transformation, are excluded.
- **Genetic testing:** Genetic tests are excluded unless approved by the FDA, ordered by a participating physician, and approved by the medical director.
- **Growth/height:** Any treatment, device, drug, service or supply solely to increase or decrease height or alter the rate of growth, including surgical procedures and devices to stimulate growth and growth hormones.
- **Health examinations:** Physical, psychiatric, psychological, other testing or examinations and reports, therapy, and training for the following are excluded:
 - Obtaining or maintaining employment;
 - Obtaining or maintaining licenses of any type;
 - Obtaining or maintaining insurance;
 - Otherwise relating to insurance purposes and the like;
 - Education purposes;
 - Services for special education and developmental programs;
 - Premarital and pre-adoptive purposes by court order;
 - Relating to any judicial, regulatory, or administrative proceeding or purpose;
 - Medical research; or
 - Camp.
- **Hearing:** Excluded except to the extent specifically listed as covered in the plan.
- **Home and mobility:** The purchase or rental of household equipment which has a customary purpose other than medical, such as, but not limited to: exercise cycles, air purifiers, central or unit air conditioners, humidifiers, water purifiers, allergenic pillows, mattresses or waterbeds is excluded. Also, household fixtures including, but not limited to, the purchase or rental of escalators or elevators, saunas, swimming pools or other household fixtures are excluded.
- **Home births:** Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.
- **Immunizations:** Immunizations for travel, such as those for yellow fever and typhoid, are covered. Those not recommended for routine use by the ACIP and CDC are not covered.
- **Infertility:** Excluded except to the extent specifically listed as covered in the plan.
- **Maintenance care:** Services or supplies furnished mainly to maintain, rather than to improve, a level of physical or mental function, or to provide a surrounding free from exposures that can worsen the person's physical or mental condition.
- **Medicare:** Payment for that portion of the charge for which Medicare or another party is the primary payer.
- **Miscellaneous charges for services or supplies:** Heating pads, hot water bottles, cold pads, electronically controlled thermal therapy units/equipment/supplies, elastic bandages, blood pressure devices, first aid kits, transcutaneous electrical nerve stimulators, pulsed electronic stimulation units for osteoarthritis, over-the-counter products, batteries other than for covered specialized medical equipment, dressing, syringes (except for insulin syringes), and dentures, are excluded.
- **Non-emergency medical charges:** Non-emergency/non-urgent care received outside the United States.
- **Non-medically necessary and non-covered benefits/ services:** Any treatment, procedure, or service considered not medically necessary by the plan medical director will not be considered a covered benefit, unless specifically mentioned as a covered benefit herein. This clause shall also apply to any service furnished without the recommendation and approval of a physician or other qualified healthcare professional acting within the scope of their license. Also, treatments and services which are excluded from coverage under the plan and complications of such treatments and services are excluded. Charges for services determined not to be covered expenses based on the plan's medical policies are excluded. Also excluded are treatments and services for complication arising from non-medical body enhancements, e.g. body piercing and tattooing.
- **Nursing and home health aide services:** See "Private duty nursing."
- **Orthognathic surgery:** Orthognathic surgery for malocclusion, orthodontic, dental, and cosmetic, indication is excluded; except as reconstructive craniofacial surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal craniofacial structure cause by congenital defects, developmental deformities, trauma, tumors, infection or disease for a participating eligible dependent younger than 18 years.
- **Personal comfort and convenience items:** Personal items, comfort items, food products, guest meals, accommodations, telephone charges, private rooms unless medically necessary, take home supplies, barber and beauty services, radio, television or videos of procedures, vitamins, minerals, dietary supplements and similar products except to the extent specifically listed as covered under the plan, are excluded.
- **Pharmacy benefit/prescription drugs:** Any procedures, treatments, services, supplies, and drugs that are considered

to be experimental or investigational are excluded, but may be appealed under the Claims and Appeals Procedures section. Procedures, treatments, services, supplies, and drugs subject to approval by the Federal Food and Drug Administration of the United States (FDA), which have not been so approved; or approved by the FDA, but not for the specific condition being treated. The plan will cover routine patient costs as required by PPACA for approved clinical trials. Also, vitamins, minerals, dietary supplements and similar products except to the extent specifically listed as covered under the plan. Also, over-the-counter drugs are not covered. Unless covered by a prescription drug benefit rider, coverage for drugs is limited to:

- Those pharmaceutical products prescribed or ordered by a physician or other provider, utilized by the participant while in the hospital, approved by the FDA to sell for use in humans, and used for the purpose approved by the FDA;
 - Specialty pharmacy drugs as provided in the Prescription Drugs section; and
 - Non-specialty pharmacy drugs that are dispensed and administered in the office of a provider, or other outpatient setting, pursuant to the Prescription Drugs section.
- **Private duty nursing:** During your stay in a hospital and outpatient private duty nursing services, except as specifically described under Private Duty Nursing in the What's Covered by the Medical Options section.
 - **Reimbursement:** The plan shall not pay any provider or reimburse participant for any healthcare service for which participant would have no obligation to pay in the absence of coverage under this plan.
 - **Self-injectable prescription drugs and medications:** Excluded except to the extent specifically listed as covered in the plan.
 - **Service providers:** Treatment or services furnished by a physician or provider who is related to participant, by blood or marriage, and who ordinarily dwells in participant's household, or any services or supplies for which participant would have no legal obligation to pay in the absence of the plan or any similar coverage; or for which no charge or a different charge is usually made in the absence of healthcare coverage, are excluded.
 - **Sexual dysfunction/enhancement:** Any treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling that do not have a physiological or organic basis.
 - **Specific programs:** LEAP, TEACCH, Denver and Rutgers programs.
 - **Speech therapy:** For treatment of delays in speech development, except as specifically provided in the What's Covered by the Medical Options section. For example, the plan does not cover therapy when it is used to improve speech skills that have not fully developed.
- **Spinal disorder:** Including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine including manipulation of the spine treatment, except as specifically provided in the What's Covered by the Medical Options section.
 - **Storage of body fluids and body parts:** Storage of blood and blood products is excluded. Storage of semen, ova, bone marrow, stem cells, DNA, or any other bodily fluid or body part is excluded unless approved by medical director.
 - **Strength and performance:** Services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including:
 - Exercise equipment, memberships in health or fitness clubs, training, advice or coaching;
 - Drugs or preparations to enhance strength, performance or endurance; and
 - Treatments, services and supplies to treat illnesses, injuries or disabilities related to the use of performance-enhancing drugs or preparations.
 - **Submitted services:** Hospital confinement charges incurred in a facility other than a licensed hospital, admissions primarily for check-ups and testing, and charges for convenience items including TV, telephone, and guest beds are not covered.
 - **Therapies and tests:** The following therapies and treatments are not covered: recreational therapy, exercise programs, hypnotherapy, music therapy, reading therapy, sensory integration therapy, vision therapy, vision training, orthoptic therapy, orthoptic training, behavioral vision therapy, integration visual therapy, orthotripsy, massage therapy, oral allergy therapy, hair replacement and hair removal regardless of indication.
 - **Timely claims filing:** Claims for services made more than 12 months after the expense is incurred are not covered, unless the plan is secondary payer, in which the time frame may be extended 6 months.
 - **Tobacco use:** Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including counseling, hypnosis and other therapies, medications, nicotine patches and gum except as specifically provided in the *What's Covered by the Medical Options* section.
 - **Transplant(s):** Solid organ, stem cell, and bone marrow transplants and associated donor/procurement costs for a participant are excluded except to the extent specifically provided in the *What's Covered by the Medical Options* section.
 - **Transportation costs:** Expenses for travel, whether or not recommended by a physician or other provider, are

not covered. Also excluded are all treatments and services received outside of the United States, its protectorates, Canada, or Mexico, except in the case of a medical emergency.

- **Treatment of mental retardation, defects and deficiencies:** See “Orthognathic surgery.”
- **Unauthorized services:** Including any service obtained by or on behalf of a covered person without pre-authorization when required. This exclusion does not apply in a medical emergency or in an urgent care situation.
- **Vision-related services and supplies:** Examinations, tests, and procedures related to vision correction; eye glasses and contact lenses are excluded unless otherwise specifically stated as a covered benefit herein. Also, all surgical procedures for the purpose of correcting visual acuity are excluded.
- **War, insurrection, or riot:** Treatments for injuries or sickness as a result of war, riot, or civil insurrection, or act of terrorism are excluded.
- **Weight:** Any treatment, drug, service or supply intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, regardless of the existence of comorbid conditions, except as provided in the Obesity Treatment section of What’s Covered by the Medical Options or as may be covered as preventive services, including but not limited to:
 - Liposuction, banding, gastric stapling, gastric bypass and other forms of bariatric surgery, surgical procedures, medical treatments, weight control/loss programs, and other services and supplies that are primarily intended to treat or are related to the treatment of obesity, including morbid obesity;
 - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
 - Counseling, coaching, training, hypnosis or other forms of therapy; and
 - Exercise programs, exercise equipment, membership in health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.
- **Work-related:** Services rendered for the diagnosis and treatment of an injury or illness for which benefits are available under worker’s compensation or employer liability law, or services rendered for any occupation injury or illness sustained as a result of any work for wage or profit are not covered.

Note: For more specific information about pharmacy and drug-related exclusions, see What’s Not Covered under the Pharmacy Benefit section on [page 72](#).

SITUATIONS AFFECTING MEDICAL PLAN BENEFITS

The situations summarized here could affect the benefits you receive from the medical plan:

- No benefits are paid for services or supplies received before coverage begins or after coverage ends
- The plan pays benefits only for eligible charges — those services and supplies listed as covered expenses
- Benefits are paid only to the extent the service or supply is necessary to treat your condition and the charge is reasonable
- If you choose no coverage during any enrollment period, no benefits are payable from the plan

SUBROGATION AND RIGHTS OF RECOVERY PROVISION

Subrogation

If a participant sustains an illness or injury for which benefits are payable under the terms of the plan, and a third party is or may be liable with respect to such illness or injury, the plan shall have the right of recovery (the “Right of Recovery”). The plan shall have the Right of Recovery with respect to any recovery, right of recovery, claim, cause of action or other rights that any or all interested parties may have against a third party. The term “third party” means any entity or person, including but not limited to, an insurance company (e.g. the participant’s own insurance company, in the case of uninsured or underinsured motorist coverage or no-fault automobile insurance). The term “interested party” means any person or entity who has or may have a right of recovery, claim, cause of action or other right arising out or related to the illness or injury (or any loss related thereto) sustained by the participant; such term shall include but shall in no way be limited to, the participant’s estate (or personal representative of the estate), heirs, guardian or other representative.

Extent of Right of Recovery

1. The right to recover from any interested party all amounts the interested party may recover or receive from any third party with respect to the illness or injury for which benefits are payable under the terms of the plan;
2. The right to reduce the amount of covered plan benefits payable with respect to the illness or injury, by any amount or amounts recovered by an interested party from a third party with respect to or as a result of the same illness or injury; and
3. The right of subrogation to stand in the shoes of an interested party and assert any right of recovery, claim or cause of action of the interested party and assert any right of recovery, claim, or cause of action that the interested party may have against a third party arising from or related to the illness

or injury for which benefits are payable under the terms of the plan; the plan's right of subrogation includes the right to control absolutely the prosecution of the subrogated right of recovery, claim or cause of action, including, but not limited to, the selection of counsel.

Priority

The plan's Right of Recovery shall be determined as follows:

1. The plan shall have a first priority lien on any full or partial recovery by an interested party from a third party. The plan's Right of Recovery shall apply regardless of whether or not the interested party is made whole from the recovery against such third party. Any recovery amount that the plan is entitled to shall not be reduced or prorated by or on account of the interested party's attorney's fees and costs.
2. Any full or partial recovery by an interested party against a third party shall be deemed to be recovery for plan benefits with respect to the illness or injury for which the third party is or may be liable, regardless of whether or not the judgment, award, formal or informal settlement, contract or any other payment of any kind itemizes or identifies an amount awarded for plan benefits or is specifically limited to certain kinds of damages or payments; an interested party may not avoid or circumvent the plan's Right of Recovery because of the way in which the recovery from a third party is characterized. By way of example, the plan shall have a Right of Recovery even if an interested party's recovery from a third party is described as a recovery for pain and suffering, loss of consortium, emotional distress, punitive damages for vexatious refusal to pay, attorneys' fees, or medical expenses.
3. The Plan Administrator, in its sole and absolute discretion, may agree to treat a lesser percentage of an interested party's recovery from a third party as attributable to plan benefits. The amount so determined shall be binding on the plan and the interested party as the amount of plan benefits to which the plan has the Right of Recovery.

Limits on Plan Obligations

If the plan has a Right of Recovery, the plan shall not be obligated to pay any plan benefits with respect to the participant's illness or injury until all of the following conditions are fulfilled to the complete satisfaction of the Plan Administrator in its sole and absolute discretion.

1. If the Plan Administrator desires to assert the plan's right of subrogation, all interested parties (or someone legally qualified and authorized to act for an interested party) must sign all documents required by the Plan Administrator to assert such right.
2. If the Plan Administrator, in its sole and absolute discretion, decides not to assert the plan's right of subrogation, all interested parties (or someone legally qualified and authorized to act for an interest party) shall agree in writing to the following conditions:

- a. The interested party shall agree to include plan benefits in any claim or cause of action the interested party makes against a third party for the illness or injury (or any loss related thereto);
 - b. The interested party shall agree that the plan has an absolute Right of Recovery and a first priority lien upon any recovery made by the interested party related to the illness or injury for which plan benefits have or will be paid; and
 - c. The interested party shall agree not to settle a claim against a third party without prior written consent of the Plan Administrator.
3. All interested parties (or someone legally qualified or authorized to act for an interested party) shall agree in writing to cooperate fully with the plan in asserting and protecting its Right of Recovery, supply the Plan Administrator with any and all information necessary to assert and protect such Right of Recovery, and execute and deliver any and all instruments and papers in their original form.

Suspension of Plan Payment

The Plan Administrator, in its sole and absolute discretion, may suspend payment of plan benefits if any interested party has not executed or is not in compliance with the terms of any required written agreement. Payment of benefits pursuant to the plan before any required written agreement is obtained, or while an interested party is not in compliance with the terms of such a written agreement, shall not constitute a waiver by the plan of its Right of Recovery. Violation of any required written agreement shall be a violation of the terms of the plan document.

Waiver

The Plan Administrator, in its sole and absolute discretion, may agree to waive the plan's Right of Recovery. The plan's waiver of its Right of Recovery with respect to one claim shall not constitute a waiver of its Right of Recovery with respect to another claim; and the plan's waiver of its Right of Recovery with respect to one interested party shall not constitute a waiver of its Right of Recovery with respect to another interested party.

Notification of Potential Right of Recovery

An interested party shall notify the Plan Administrator, in writing, whenever an illness or injury arises that provides or may provide the plan a Right of Recovery. The plan shall be entitled to recover its attorney's fees and costs from an interested party if the plan takes legal action against the interested party to enforce its reimbursement rights.

NOTICE REGARDING WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

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

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card. For more information, you can visit this U.S. Department of Health and Human Services website, www.cms.gov, and this U.S. Department of Labor website, www.dol.gov/ebsa/consumer_info_health.html.

NOTICE REGARDING NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under this health plan, as required by the Newborns' and Mothers' Health Protection Act, the plan will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, under federal law, plans and issuers may not require a provider to obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, as applicable).

WELLNESS PROGRAMS

You already know that good health is a good thing. It is important for our company, too, because it helps slow rising healthcare costs for you and BSWH. That's why we offer incentives to reward your healthy efforts — whether you have a health issue to improve or already lead a healthy lifestyle. When you participate in these valuable programs, BSWH will reward you.

Thrive Wellness Program

All BSWH employees and spouses are eligible to participate in Thrive, regardless of whether they are enrolled in a BSWH medical plan. You just have to enroll in Thrive before you can

participate in activities. Log on to thriveforwellness.com or call the customer support line at 1-866-433-9284, 7 days a week, 24 hours a day.

GLOSSARY

Autism Spectrum Disorder — A neurobiological disorder that includes autism, Asperger's syndrome, or pervasive developmental disorder—not otherwise specified. A neurobiological disorder means an illness of the nervous system caused by genetic, metabolic, or other biological factors, except to the extent specifically listed as a covered benefit under the plan.

Custodial Care — Services and supplies that are primarily intended to help you meet personal needs. Custodial care can be prescribed by a physician or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of custodial care include:

- Routine patient care such as changing dressings, periodic turning and positioning in bed, and administering medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing)
- Watching or protecting you
- Respite care, adult (or child) day care or convalescent care
- Institutional care, including room and board for rest cures, adult day care and convalescent care
- Help with daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
- Any services that a person without medical or paramedical training could be trained to perform
- Any service that can be performed by a person without any medical or paramedical training

Experimental or Investigational Treatment — A drug, device, procedure or treatment will be determined to be experimental or investigational if:

- There is insufficient outcomes data available from controlled clinical trials published in peer-reviewed literature to substantiate its safety and effectiveness for the illness or injury involved
- Approval required by the FDA has not been granted for marketing
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or investigational, or for research purposes
- It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions

and publications of the FDA and Department of Health and Human Services, or

- The written protocol or protocols used by the treating facility, the protocol or protocols of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or investigational, or for research purposes.

Covered expenses include charges made for experimental or investigational drugs, devices, treatments or procedures, provided all of the following conditions are met:

- You have been diagnosed with cancer or a condition likely to cause death within one year or less
- Standard therapies have not been effective or are inappropriate
- SWHP determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment
- There is an ongoing clinical trial. You are enrolled in a clinical trial that meets these criteria:
 - The drug, device, treatment or procedure to be investigated has been granted as an investigational new drug (IND) or Group C/treatment IND status
 - The clinical trial has passed independent scientific scrutiny and has been approved by an Institutional Review Board that will oversee the investigation
 - The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the Food & Drug Administration or the Department of Defense) and conforms to NCI standards
 - The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI-designated cancer center, and
 - You are treated in accordance with protocol.

Homebound — We follow the Medicare definition/criteria to determine coverage eligibility.

- Medicare considers you homebound if you meet both of the following criteria.
 - You need the help of another person or medical equipment such as crutches, a walker or a wheelchair to leave your home.

OR

Your doctor believes that your health or illness could get worse if you leave your home.

AND
 - It is difficult for you to leave your home and you typically cannot do so.
- Your doctor will decide whether you qualify as homebound when they write up your plan of care for the home health benefit. Whether or not you do depends on your doctor's evaluation and knowledge of your condition over an extended

period of time, not on a daily or weekly basis.

- Leaving home for medical treatment, religious services or to attend a licensed or accredited adult day care center does not put your homebound status at risk. Leaving home for short periods of time or for special non-medical events, such as a family reunion, funeral or graduation, will also not keep you from being considered homebound. Taking an occasional trip to the barber or beauty parlor is also allowed.

Mental Disorder — An illness commonly understood to be a mental disorder, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a behavioral health provider such as a psychiatric physician, psychologist or psychiatric social worker. Any of the following conditions is a mental disorder under this plan:

- Anorexia/bulimia nervosa
- Bipolar disorder
- Major depressive disorder
- Obsessive compulsive disorder
- Panic disorder
- Psychotic disorders/delusional disorder
- Schizo-affective disorder
- Schizophrenia

Recognized Charge — Only that part of a charge which is less than or equal to the recognized charge is a covered benefit. The recognized charge for a service or supply is the lower of:

- The provider's usual charge for furnishing it, or
- The 80th percentile of the prevailing charge rate (as reported by FAIR Health, a nonprofit company, in their database) for the geographic area where the service is furnished. FAIR Health reviews and, if necessary, changes these rates periodically. SWHP updates its systems with these changes within 180 days after receiving them from FAIR Health.

In some circumstances, SWHP may have an agreement with a provider (either directly, or indirectly through a third party) that sets the rate that SWHP will pay for a service or supply. In these instances, in spite of the methodology described above, the recognized charge is the rate established in such an agreement.

SWHP may also reduce the recognized charge by applying SWHP Reimbursement Policies. SWHP Reimbursement Policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service.

Substance Abuse — A physical or psychological dependency, or both, on a controlled substance or alcohol agent [as defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association, which is current as of the date services are rendered to you or your covered dependents]. This term does not include conditions not attributable to a mental disorder that are a focus of attention or treatment (the V codes on Axis I of DSM), such as an addiction to nicotine products or food, or caffeine intoxication.

Dental

The Dental Plan helps you pay for a wide range of dental services, from preventive care and cleanings to more extensive dental work, including crowns and dentures.

PLAN HIGHLIGHTS

- You have a choice of two dental plans:
 - Standard PPO or Plus PPO — Preferred Provider Organizations, administered by MetLife
- Both plans cover preventive care at 100% along with basic care and major care. The Plus PPO covers dental implants and orthodontia for eligible children and adults.
- The plans differ in the amount you pay for coverage, how you go about getting care and what you pay when you need care.
- You can see any dentist you choose, but you'll save money if you use a MetLife network dentist.

HOW THE METLIFE STANDARD AND PLUS PPOS WORK

The MetLife Standard PPO and the MetLife Plus PPO work the same way. You can go to any dentist you choose, but you will save money by going to one in the MetLife Preferred Dental Program (PDP). You have to meet the same deductible for both PPO plans before the plan shares the cost of dental care with you. However, with the MetLife Standard PPO, you may pay a higher coinsurance and the annual maximum is lower. The MetLife Standard PPO does not cover orthodontia; the MetLife Plus PPO covers orthodontia for eligible children and adults. The Plus plan also covers dental implants.

Here's how the MetLife PPOs pay dental benefits:

- The coinsurance percentage under each plan applies whether you go to a network or non-network dentist.
- If you use in-network providers, you pay discounted rates for services.
- If you go to an out-of-network dentist, benefits are paid based on reasonable and customary charges for services. If your dentist charges more than what MetLife deems reasonable and customary for the service in your geographic area, you must pay the difference between the reasonable and customary charge and what the dentist charges, in addition to your share of the coinsurance.

Under the PPO Dental Plans, you pay coinsurance (a percentage of the cost) for each treatment. Certain treatments are subject to an annual deductible, which varies based on your level of coverage (employee only or employee plus one or more dependents).

The PPO Summary of Benefits is listed on [pages 78-79](#). It shows your coinsurance amount for each service and excluded services. The following sections apply to both the Standard and Plus PPOs, except where otherwise noted.

Find a Network Dentist

To find a provider for either PPO, go online to www.MetLife.com, click on "Find a Dentist," select your plan and enter your ZIP code.

Individual and Family Annual Deductibles

An individual annual deductible of \$50 applies to restorative and major care. The plans pay for services for each individual once that person has met the \$50 deductible. In addition, the plans will pay for services for all family members once the family's total expenses reach \$150.

Preventive care such as check-ups, cleanings and X-rays, and orthodontia are not subject to the annual deductible.

Emergency Dental Care

If you need emergency dental care, you are covered 24 hours a day, seven days a week, anywhere in the world. When a participating PPO dentist provides emergency services, your copay/coinsurance amount is based on a negotiated fee schedule. If a dentist outside the PPO network provides emergency care, the services will be subject to reasonable and customary charges as determined by MetLife. Covered emergency services may vary, based on state law.

PPO Dental Plan Coverage Rules

Replacement Rule: The replacement of, addition to or modification of existing dentures, crowns, casts or processed restorations, removable bridges or fixed bridgework is covered only if one of the following terms is met:

- The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. Dental plan coverage must have been in force for the covered person when the extraction took place.
- The existing denture, crown, cast or processed restoration, removable bridge or bridgework cannot be made serviceable and was installed at least ten years under the PPO Dental Plans before its replacement and are not abutments to a partial denture, removable bridge or fixed bridge installed during the prior ten years under the PPO Dental Plans.

- The existing denture is immediate and temporary to replace one or more natural teeth extracted while the person is covered and cannot be made permanent; replacement by a permanent denture is required. The replacement must take place within 12 months from the date of initial installation of the immediate temporary denture.

Tooth Missing But Not Replaced Rule: Coverage for the first installation of removable dentures, removable bridges and fixed bridgework is subject to the requirements that such dentures, removable bridges and fixed bridgework are (a) needed to replace one or more natural teeth that were removed while this coverage was in force for the covered person; and (b) are not abutments to a partial denture, removable bridge or fixed bridge installed during the prior ten years under the PPO Dental Plans.

Alternate Treatment Rule: If more than one service can be used to treat a covered person's dental condition, MetLife, as the Dental Claims Administrator, may decide to authorize coverage only for a less costly covered service provided that all of the following terms are met:

- The service must be listed on the Summary of Benefits,
- The service selected must be deemed by the dental profession to be an appropriate method of treatment, and
- The service selected must meet broadly accepted national standards of dental practice.

If treatment is being given by a participating dental provider and the covered person asks for a more costly covered service than one for which coverage is approved, the specific copayment for such service will consist of:

- The copayment for the approved less costly service, and
- The difference in cost between the approved less costly service and the more costly covered service.

No Guarantee of Results: All participant care and related decisions are the sole responsibility of participating providers. The insurance provider does not provide healthcare services and, therefore, cannot guarantee any results or outcomes.

Right to Review: Participants on their own behalf or on behalf of a covered family member may request an independent medical review when the participant believes that healthcare services have been improperly denied, modified or delayed by a participating dentist.

METLIFE STANDARD AND PLUS PPO SUMMARY OF BENEFITS

Visits And Exams	
Visit for Oral Examination*	Plan pays 100%
Prophylaxis, including Scaling and Polishing*	Plan pays 100% for adults and children
Fluoride*	Plan pays 100%
Sealants (permanent molars only)	Plus PPO pays 80%; Standard PPO pays 50%
Endodontics	
Root Canal Therapy, with X-rays and Cultures	Plus PPO pays 80%; Standard PPO pays 50%, for anterior and bicuspid
Root Canal Therapy, Molar Teeth, with X-rays and Cultures	Plus PPO pays 80%; Standard PPO pays 50%
Minor Restorations	
Amalgam (silver) Fillings	Plus PPO pays 80%; Standard PPO pays 50%
Composite Fillings (anterior teeth only)	Plus PPO pays 80%; Standard PPO pays 50%
Stainless Steel Crowns	Plus PPO pays 80%; Standard PPO pays 50%

Periodontics	
Scaling and Root Planing*	Plus PPO pays 80%; Standard PPO pays 50%
Gingivectomy (per tooth)	Plus PPO pays 80%; Standard PPO pays 50%
Osseous Surgery	Plus PPO pays 80%; Standard PPO pays 50%
Oral Surgery	
Incision and Drainage of Abscess	Plan pays 50%
Uncomplicated Extractions	Plus PPO pays 80%; Standard PPO pays 50%
Surgical Removal of Erupted Tooth	Plus PPO pays 80%; Standard PPO pays 50%
Surgical Removal of Impacted Tooth (soft tissue)	Plus PPO pays 50%; Standard PPO pays 50%
Surgical Removal of Impacted Tooth (partial bony)	Plus PPO pays 50%; Standard PPO pays 50%
Surgical Removal of Impacted Tooth (full bony)	Plus PPO pays 50%; Standard PPO pays 50%
Prosthodontics/Major Restorations	
Inlays	Plan pays 50%
Onlays	Plan pays 50%
Crowns	Plan pays 50%
Full and Partial Dentures	Plan pays 50%
Denture Repairs	Plus PPO pays 80%; Standard PPO pays 50%
Pontics	Plan pays 50%
Anesthesia	
General Anesthesia	Plan pays 50%
Intravenous Sedation	Plan pays 50%
Space Maintainers	Plus PPO pays 80%; Standard PPO pays 50%
Orthodontics	Not covered by Standard PPO; Plus PPO pays 50% up to \$2,000 lifetime maximum
Implants	Not covered by Standard PPO; Plus PPO pays 50%

* Frequency and/or age limitations may apply to these services.

Preventive and Diagnostic Covered Services

- Oral exams once every six months
- Full mouth or panoramic X-rays once every 60 months
- Bitewing X-rays twice once per six months for children; once per year for adults
- Cleaning of teeth (oral prophylaxis) once every six months
- Topical fluoride treatment once every six months for eligible children to age 19
- Emergency palliative treatment to relieve tooth pain

Basic Covered Services

- Intraoral-periapical and extraoral X-rays
- Amalgam or resin fillings
- Replacement of an existing amalgam or resin filling but only if a new surface of decay is identified on that tooth
- Sedative filling
- Periodontal maintenance where periodontal treatment (including scaling, root planing and periodontal surgery, such as gingivectomy, gingivoplasty, gingival curettage and osseous surgery) has been performed. Periodontal maintenance is limited to four times per calendar year, combined with routine cleanings.
- Pulp capping (excluding final restoration) and therapeutic pulpotomy (excluding final restoration)
- Pulp therapy and apexification/recalcification
- Root canal treatment, but no more than one treatment for the same tooth in any 24 month period
- Periodontal surgery, including gingivectomy and gingival curettage, but no more than one surgical procedure per quadrant in any 36-month period
- Simple extractions
- Surgical extractions
- Space maintainers to age 19
- Sealants, permanent molars, once per tooth in any 36 month period for eligible children up to age 19
- Osseous surgery one per quadrant in 36 months limit
- Relining and rebasing of existing removable dentures:
 - If at least six months have passed since the installation of the existing denture, and
 - Not more than once in any 36 month period.
- Repair of denture
- Addition of teeth to partial removable denture to replace natural teeth removed while this dental coverage was effective for the person receiving such services
- Adjustment of dentures
- Periodontal scaling and root planning but not more than once per 24 months period
- Repair or re-cementing of cast restorations

- Guided tissue regeneration (root canal treatment, including bone grafts and tissue regeneration procedures in conjunction with periradicular surgery, but not more than once in any 24 month period for the same tooth)

Major Covered Services

- General anesthesia or intravenous sedation in connection with oral surgery, extractions or other covered services when the coverage provider determines such anesthesia is necessary in accordance with generally accepted dental standards
- Injections or therapeutic drugs
- Initial installation of full or removable dentures:
 - When needed to replace congenitally missing teeth, or
 - When needed to replace natural teeth that are lost while the person receiving such benefits was enrolled for dental coverage in the Dental Plan.
- Replacement of non-serviceable denture if such denture was installed more than ten years prior to replacement
- Replacement of an immediate, temporary full denture with a permanent full denture if the immediate, temporary full denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary full denture
- Initial installation of cast restorations
- Replacement of any cast restorations with the same or a different type of cast restoration, but no more than one replacement for the same tooth surface within ten years of a prior replacement
- Prefabricated resin crown limited to once per tooth every ten years
- Prefabricated stainless steel crown limited to once per tooth every ten years
- Core buildup, but no more than once per tooth every ten years
- Posts and cores, but no more than once per tooth every ten years
- Surgical (impacted) extractions & oral surgery except as mentioned elsewhere in this document
- Repair of implant (Plus PPO Only) - supported prosthetics, but no more than one repair in any ten year period
- Application of desensitizing medications where periodontal treatment (including scaling, root planning and periodontal surgery such as osseous surgery) has been performed
- Occlusal adjustments

Orthodontic Covered Services (Plus PPO Only)

Payment of Orthodontic Covered Services:

- If orthodontic appliances are in place when coverage becomes effective, the Plan will pay monthly benefits for the remaining active treatment.
- Orthodontic treatment generally consists of initial placement of an appliance and periodic follow-up visits.
- The benefit payable for the initial placement will not exceed 20% of the Maximum Lifetime Benefit amount (\$2,000) for orthodontia.
- The benefit payable for periodic follow-up visits will be payable on a quarterly basis during the course of the orthodontic treatment (24 months) if:
 - Baylor Scott & White Health's Plus PPO dental coverage is in effect for the person receiving the orthodontic treatment each quarter, and
 - Proof is provided to the Dental Claims Administrator, that the orthodontic treatment is continuing.
- **Example:** If the orthodontic provider charges \$3,000 for the total treatment, the plan would pay the following over the 24 month period following the date of initial banding:
 - 20% at initial banding, less 50%
 - » Plan Lifetime Maximum of \$2,000 × 20% = \$400 × 50% = \$200
 - Remaining balance of \$2,800 to be paid to the orthodontic provider would then be allocated on a monthly basis and paid on a quarterly basis.
 - » \$2,800 ÷ 24 months = \$116.67 per month
 - » \$116.67 × 3 months = \$350; \$350 × 50% = \$175 would be paid each quarter for a total of 8 quarters
 - The Plan would pay a total of \$200 at initial banding + (\$175 × 8 = \$1,400 total of quarterly payments) = \$1,600 in total

Expenses Not Covered by the PPOs

The following benefit charges will not be paid by the PPOs:

- Services that are not dentally necessary, those that do not meet generally accepted standards of care for treating the particular dental condition or that are deemed by the Dental Claims Administrator, to be experimental in nature
- Occlusal guards (night guards and bruxism [teeth grinding] guards)
- Services for which the plan participant would not be required to pay in the absence of dental coverage
- Services or supplies received by the plan participant or his/her eligible dependents in the plan before the dental coverage starts for that person
- Services not performed by a dentist except for those services of a licensed dental hygienist that are supervised and billed by a dentist, and are for:
 - Scaling and polishing of teeth, or
 - Fluoride treatments
- Services that are primarily cosmetic
- Services or appliances that restore or alter occlusion or vertical dimension
- Restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease
- Restorations or appliances used for the purpose of periodontal splinting
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco
- Personal supplies or devices including, but not limited to: Waterpiks, toothbrushes or dental floss
- Initial installation of a denture to replace one or more teeth that were missing before such person was insured for dental coverage, except for congenitally missing teeth
- Decorations or inscription of any tooth, device, appliance, crown or other dental work
- Missed appointments
- Services covered under other coverage provided by Baylor Scott & White Health
- Temporary or provisional restorations
- Temporary or provisional appliances
- Prescription drugs
- Services for which the submitted documentation indicated a poor prognosis
- Services, to the extent that such services or benefits for such services, are available under a government plan. Government plan means any plan, program or coverage that is established under the laws or regulations of any government. The term does not include any plan, program or coverage provided by a government as an employer or Medicare.
 - This exclusion will apply whether or not the person receiving the services is enrolled for the government plan. The Dental Plan will not exclude payment of benefits for such services if the government plan requires that dental coverage under the group policy be paid first.
- The following when charged by the dentist on a separate basis:
 - Claim form completion
 - Infection control such as gloves, masks and sterilization of supplies
 - Local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide
- Dental services arising from accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food
- Caries susceptibility tests

- Precision attachments associated with fixed and removable prostheses
 - Adjustment of a denture made within six months after installation by the same dentist who installed it
 - Duplicate prosthetic devices or appliances
 - Replacement of a lost or stolen appliance or crown, inlay/onlay or denture
 - Replacement of an orthodontic device
 - Study models, photographs and intraoral images
 - TMJ
 - Services or supplies that are covered in whole or in part:
 - Under any other part of this Dental Plan, or
 - Under any other plan of group benefits provided by or through your employer.
 - Services and supplies to diagnose or treat a disease or injury that is not:
 - A non-occupational disease, or
 - A non-occupational injury.
 - Services not listed in the Summary of Benefits that apply unless otherwise specified in the booklet-certificate
 - Replacement of a lost, missing or stolen appliance, or those for replacement of appliances that have been damaged due to abuse, misuse or neglect
 - Plastic, reconstructive, cosmetic surgery or other dental services or supplies that are primarily intended to improve, alter or enhance appearance. This applies whether or not the services and supplies are for psychological or emotional reasons. Facings on molar crowns and pontics will always be considered cosmetic.
 - Services, procedures, drugs or other supplies that are determined by the Dental Claims Administrator to be experimental or still under clinical investigation by health professionals
 - Dentures, crowns, inlays, onlays, bridgework or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion or correction attrition, abrasion or erosion
 - Any of the following services:
 - An appliance, or modification of one, if an impression for it was made before the person became a covered person
 - A crown, bridge, cast or processed restoration if a tooth was prepared for it before the person became a covered person
 - Root canal therapy if the pulp chamber for it was opened before the person became a covered person
 - Services the Dental Plan defines as not necessary for the diagnosis, care or treatment of the condition involved. This applies even if they are prescribed, recommended or approved by the attending physician or dentist.
 - Services intended for treatment of any jaw joint disorder unless otherwise specified in the booklet-certificate
 - Orthodontic treatment unless otherwise specified in the booklet-certificate
 - Treatment by anyone other than a dentist, except for scaling or cleaning of teeth and topical application of fluoride which may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a dentist.
 - Services given by a non-participating dental provider to the extent that the charges exceed the amount payable for the services shown in the Summary of Benefits that applies
 - A crown, cast or processed restoration unless:
 - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material, or
 - The tooth is an abutment to a covered partial denture or fixed bridge.
 - Pontics, crowns, cast or processed restorations made with high noble metals unless otherwise specified in the booklet-certificate
 - Surgical removal of impacted wisdom teeth only for orthodontic reasons unless otherwise specified in the booklet-certificate
 - Services needed solely in connection with non-covered services
 - Services done where there is no evidence of pathology, dysfunction or disease other than covered preventive services
- Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.
- Pre-treatment Estimate of Benefits**
- If you expect charges for planned dental work to be \$300 or more, you or your dentist can submit a written treatment plan outlining the results of the examination (including X-rays), the suggested treatment and estimated costs. This plan can be submitted on a standard claim form. The submission of a plan is at the discretion of you and your dentist.
- After the Dental Claims Administrator, reviews the plan and considers alternate procedures, you will receive a pre-treatment estimate of benefits stating how much the plan will pay. However, this pre-treatment estimate of benefits is not a guarantee of payment. The amount of benefits paid by the plan depends on how much of your deductible has been paid and your maximum benefit limits. Under the Alternate Benefit provision, benefits may be based on the cost of a service other than the service you choose. You are still required to submit proof once the dental service is completed for the plan to pay benefits.

FILING CLAIMS

Claim forms are always required. In some cases, your dentist (if he or she participates in the PPO network) may file your claim form with the Dental Claims Administrator for you. If your dentist does not file the claim form for you, it is always your responsibility.

You have up to 90 calendar days from the last day of the calendar year to file an initial dental coverage claim. To file a claim for dental benefits, each dental bill should include all of the following:

- Employee name
- Employee Social Security number
- Patient name
- Date of service
- Type of service received
- Appropriate ADA procedure codes
- Itemized charges
- Name and tax identification number of dentist performing the service
- If appropriate, other insurance Explanation of Benefit (EOB) statement

Submit all claims to the address listed on your membership card. Plan benefits are paid directly to you unless you assigned payments to your dentist.

After you submit a claim to the Dental Claims Administrator, the carrier will review your claim and notify you of its decision to approve or deny your claim. This notification will be provided to you within 15 business days from the date the carrier receives your completed claim, except for situations when the carrier requires an extension of up to 15 additional calendar days because of matters beyond its control. If the carrier needs an extension, you will be notified prior to the expiration of the initial 15-business-day period with the reason why the extension is needed and when the carrier will make its determination.

If an extension is needed because you did not provide sufficient information or because you filed an incomplete claim, the time from the date of the notice requesting further information and an extension until the carrier receives the requested information does not count toward the time period for the claim decision. You will have 45 calendar days from the date you receive the notice to provide the requested information.

If Your Claim Is Denied

Disagreements about benefit eligibility of payment amounts can occasionally arise. In most cases, differences can be resolved quickly with a phone call.

The Dental Plan is responsible for the actual coverage and the dental care provided or arranged. All appeals regarding coverage must be made directly to the Dental Claims Administrator. They have the final authority on matters relating to their benefit coverage. Contact them directly for:

- Appeal of denied claims
- Coordination of benefits between the claim administrator and any other dental or medical coverage you or a covered dependent may have
- Rights to reimbursement and subrogation when payments are available from other insurance sources or legal settlements (including auto insurance)
- Any other benefits or administrative issues

If you can't resolve the disagreement, formal appeal procedures are in place. See the [Administrative & General Information](#) section for details.

Treatments in Progress

In certain cases, dental benefits may continue to be payable after your coverage ends if you or a covered family member have dental treatment in progress.

If you are completing the installation of a prosthetic device after your dental coverage ends, the Dental Plan will continue to pay benefits for 31 calendar days if:

- The dentist prepares the abutment teeth or makes impressions before your insurance ends, and
- The device is installed within 31 calendar days of the date the insurance ends.

If you are completing the installation of a cast restoration after your dental coverage ends, the Dental Plan will continue to pay benefits for 31 calendar days if:

- The dentist prepares the tooth for the cast restoration before your insurance ends, and
- The cast restoration is installed within 31 calendar days of the date the insurance ends.

If you are completing root canal therapy after your dental coverage ends, the Dental Plan will continue to pay benefits for 31 calendar days if:

- The dentist opens into the pulp chamber before your insurance ends, and
- The treatment is finished within 31 calendar days of the date the insurance ends

GLOSSARY

Cast Restoration — An inlay, onlay or crown

Covered Percentage — The percentage of the cost for a covered service that the Dental Plan will pay after any required deductible is satisfied. For a covered service performed by an in-network dentist, it is the percentage of the maximum allowed charge that the Dental Plan will pay for such services. For a covered service performed by an out-of-network dentist, it is the percentage of the reasonable and customary charge that the Dental Plan will pay for such services

Covered Service — A dental service used to treat the plan participant or the plan participant's dependents dental condition that is:

- Prescribed or performed by a dentist while such a person is insured for dental coverage
- Dentally necessary to treat the condition, and
- Described in the Summary of Benefits or Covered Expenses sections.

Deductible — The amount that the plan participant or his/her eligible dependent(s) must pay before the Dental Plan pays for covered services

Dental Hygienist — A person trained to:

- Remove calcareous deposits and stains from the surfaces of teeth, and
- Provide information on the prevention of oral disease.

The term does not include:

- You
- Your spouse, or
- Any member of your immediate family including your and /or your spouse's parents, children (natural, step or adopted), siblings, grandparents or grandchildren.

Dentally Necessary — A dental service or treatment that is performed in accordance with generally accepted dental standards as determined by the Dental Claims Administrator and is:

- Necessary to treat decay, disease or injury of the teeth, or
- Essential for the care of the teeth and supporting tissue of the teeth.

Dentist — Either of the following:

- A person licensed to practice dentistry in the jurisdiction where such services are performed, or
- Any other person whose services, according to applicable law, must be treated as dentist's services for purposes of the group policy. Each such person must be licensed in the jurisdiction where the services are performed and must act within the scope of the license. The person must also be certified and/or registered if required by such jurisdiction.

For the purposes of dental coverage, the term will include a physician who performs a covered service. The term does not include:

- You
- Your spouse, or
- Any member of your immediate family including your and /or your spouse's parents, children (natural, step or adopted), siblings, grandparents or grandchildren.

Dentures — Fixed partial bridgework, removable partial dentures and removable full dentures

Dependent(s) — Your spouse and/or child(ren)

In-Network Dentist — A dentist who participates in the Preferred Provider Organization (PPO) and has a contractual agreement with the Dental Claims Administrator to accept the maximum allowed charge as payment in full for a dental service

Maximum Allowed Charge — The lesser of:

- The amount charged by the dentist, or
- The maximum amount that the in-network dentist has agreed with the Dental Claims Administrator to accept as payment in full for the dental service.

Out-of-Network Dentist — A dentist who does not participate in the Preferred Provider Organization network

Reasonable and Customary Charge — The prevailing cost for a service or supply based on the level of fees normally charged by dental providers in a geographic area

Year or Yearly — For dental coverage, the 12-month period that begins on January 1.

Vision

The Vision Plan helps you pay for routine eye exams, glasses and contact lenses for you and your eligible dependents.

PLAN HIGHLIGHTS

- You can elect vision coverage for you and your eligible family members.
- The plan covers a routine eye exam once every calendar year, along with frames and lenses or contacts.
- Although you can use out-of-network providers, you get the greatest benefit from using a doctor or provider in the network.

HOW THE PLAN WORKS

The Vision Plan is administered by EyeMed and allows you to seek vision care through any provider you choose. However, you receive the highest level of benefits when you use a provider in the EyeMed network.

SUMMARY OF BENEFITS

Plan Features	In-Network	Out-of-Network Reimbursement*
Comprehensive Exam: Ophthalmologist (M.D.)	Covered in full after \$10 copay	Plan reimburses you up to \$45
Comprehensive Exam: Optometrist (O.D.)	Covered in full after \$10 copay	Plan reimburses you up to \$45
Retinal Imaging	Up to \$39	N/A
Exam Options – Contact		
• Standard Fit and Follow Up	\$25 copay; paid in full and two follow up visits	Plan reimburses you up to \$40
• Premium Fit and Follow up	\$25 copay; 10% of retail, then apply \$55 allowance	Plan reimburses you up to \$40
Standard Lenses (per pair)	Covered in full after \$10 copay	<ul style="list-style-type: none"> Plan reimburses you up to \$45 Plan reimburses you up to \$65 Plan reimburses you up to \$85
Standard Frames	\$0 copay, \$170 allowance. 20% off balance over \$170	Plan reimburses you up to \$65

In-Network Services

To receive in-network services, simply identify yourself to the in-network provider as a member of the plan. You may use your ID card for this purpose or give the provider your name, employer name and your date of birth. The ID card provided to you may be used for all covered family members. When you visit one of EyeMed's in-network providers, EyeMed takes care of all the paperwork – there is nothing you need to do on your part.

You pay the provider directly for any copays or charges that exceed amounts covered by the plan.

Out-of-Network Services

To see an out-of-network provider, you will need to pay at the time of service and submit a claim form online for reimbursement. You will need to upload an itemized paid receipt with your name included on the document.

You will be reimbursed according to the schedule of allowances for out-of-network providers, less any required copays.

Plan Features	In-Network	Out-of-Network Reimbursement*
Contact Lenses** <ul style="list-style-type: none"> • Medically Necessary • Cosmetic/Elective 	<ul style="list-style-type: none"> • Covered in full • Plan reimburses you up to \$170 	<ul style="list-style-type: none"> • Plan reimburses you up to \$210 • Plan reimburses you up to \$136
Refractive Surgery (LASIK, radial keratotomy or photorefractive keratectomy)	15% off the retail price or 5% off the promotional price	No benefit
Diabetic Services (Available for Type 1 and 2 Diabetics)		
Medical Follow up Exam	\$0 copay	N/A
Retinal Imaging***	\$0 copay	Plan reimburses you up to \$77
Extended Ophthalmoscopy****	\$0 copay	Plan reimburses you up to \$50
Gonioscopy	\$0 copay	Plan reimburses you up to \$15
Scanning Laser	\$0 copay	Plan reimburses you up to \$15

* You are responsible to pay the out-of-network provider in full at time of service and then submit an out-of-network claim for reimbursement. You will be reimbursed up to the amount shown on the chart.

** For prescription contact lenses for only one eye, the Plan will pay one-half of the amount payable for contact lenses for both eyes.

*** Not covered if Extended Ophthalmoscopy if provide within 6 months.

**** Not covered if Retinal Imaging if provide within 6 months.

COVERED EXPENSES

The plan covers a wide range of vision care services and supplies. However, certain limitations may apply. This section outlines the expenses covered under the plan.

Routine Vision Exams

The plan provides benefits for one routine comprehensive eye exam (performed by an ophthalmologist or optometrist) per covered person in a calendar year.

Diabetic Eye Care Benefit

Members who have Type 1 or Type 2 diabetes are eligible to receive supplemental coverage for additional services from their vision Provider. With this benefit, you can obtain a vision evaluation every six months to monitor for signs of diabetic complications. Subject to provider determination and benefit frequency limitations, you may also receive the following diagnostic testing: retinal imaging, extended ophthalmoscopy, gonioscopy and laser scanning. If you have questions, please contact EyeMed's Customer Care Center.

Availability of diagnostic equipment and services varies by location. Members are encouraged to call their provider to confirm availability of services.

Retinal Imaging Benefit

Retinal imaging has been provided as a discount to your vision plan. Retinal imaging is a diagnostic tool that provides high-resolution, permanent digital records of your inner eye. Please consult with your Provider to determine if you are a candidate for retinal imaging.

Lenses and Frames

The plan covers one pair of standard lenses (single, bifocal, trifocal or lenticular) and one set of standard frames in a calendar year. Additional charges may apply for special lenses; see Limitations on [page 87](#) for more information.

Please note that benefits are provided for contact lenses or eye glass lenses in a calendar year — not both. For example, if you receive insured benefits for a complete pair of eyeglasses, frames and lenses, in May, you are then eligible to receive insured benefits for eyeglasses or contact lenses the following January if you continue coverage.

In-Network Discount on Extra Pair of Eyeglasses

If you purchase an extra pair of eyeglasses or contacts during the year, participating in-network providers offer discounts. The savings are 40% off frames, 20% off lenses and coatings, and 15% off conventional contact lenses. These discounts are not available out of network.

Contact Lenses — Medically Necessary

To be considered medically necessary, lenses must be specifically prescribed by an ophthalmologist or an optometrist for one or more of the following reasons:

- Aphakia (after cataract surgery without lens implants) — a pair of prescription single-vision or multifocal eyeglass lenses and frames may be provided, along with contact lenses prescribed for this reason
- When visual acuity cannot be corrected to 20/70 in the better eye except through the use of contact lenses (must be 20/60 or better)
- Anisometropia of 4.0 diopters or more, provided visual acuity improves to 20/60 or better in the weaker eye
- Keratoconus

The narrowing of visual fields due to high minus or high plus corrections is not considered a reason for medically necessary contact lenses.

If you choose to use an in-network provider, you pay no out-of-pocket costs for medically necessary contact lenses. If you choose to use an out-of-network provider, out-of-network limits apply.

Contact Lenses — Elective or Cosmetic

Elective or cosmetic contact lenses are those worn solely for cosmetic or convenience reasons. To be covered by the plan, contact lenses must come with a prescription for correcting a vision deficiency.

Contact Lenses Exam/Fitting Fee

Most providers charge a fee for the fitting of contact lenses. This fee is separate from the comprehensive eye examination and varies depending on the provider's fee structure policies. It also varies due to circumstances or complexities involving the physiological condition of the eyes, the lens prescription and the type of lenses used. The Contact Lens Fit and Follow-Up visits are available once a comprehensive eye exam has been completed. See the schedule of benefits for a full description of the benefit.

Refractive Surgery

The plan offers a 15% off retail and 5% off the promotional price for LASIK when you use a contracted, in-network provider for these procedures. No discounts or benefits are provided for out-of-network providers.

Hearing Discount Benefit with Amplifon Hearing Healthcare

EyeMed has partnered with Amplifon – the world's largest distributor of hearing aids and services – to add affordable hearing care to your EyeMed vision benefits package.

Members receive a 40% discount off hearing exams and a low price guarantee on discounted hearing aids. For additional information, call 1-844-526-5432.

Limitations

The following vision services require an additional charge over the covered benefit. You pay any additional charges directly to the provider. For example, standard-design bifocal lenses are a covered benefit, while blended (no-line) bifocals require an additional charge.

- Replacement frames and/or lenses
- Blended (no-line) and/or multifocal lenses
- Beveled and/or faceted lenses
- Coated lenses
- Polycarbonate lenses
- Oversized lenses
- Cosmetic lenses
- Frames that cost more than the plan allowance

EXPENSES NOT COVERED

The plan is designed to provide for your basic eye care needs. Generally, it does not cover items considered cosmetic or elective. There is no benefit coverage for the following products and services:

- Non-prescription eyewear
- Vision training
- Low-vision aids
- Orthoptics
- Eye exams required by an employer as a condition of employment
- Services and materials provided by another vision plan
- Conditions covered by workers' compensation
- Frame cases

FILING CLAIMS

If you are using an in-network provider, your provider will handle all claims and paperwork.

If you are using an out-of-network provider, you must pay the full cost at the time of service and then submit your original itemized bill or provider receipt, to the claims administrator.

Disagreements about benefit eligibility or payment amounts may arise occasionally. In most cases, differences can be resolved quickly with a phone call.

EyeMed — not Baylor Scott & White Health — is responsible for the actual coverage and the vision care provided or arranged and has the final authority on matters relating to vision benefit coverage. Contact EyeMed directly for:

- Appeal of denied claims
- Coordination of benefits between this plan and any other vision coverage you or a covered dependent may have

- Rights to reimbursement and subrogation when payments are available from other insurance sources or legal settlements (including auto insurance)
- Any other benefit or administrative issues

If you have questions regarding eligibility to participate in the plan, please contact PeoplePlace as soon as possible.

If you can't resolve the disagreement, please refer to Appealing a Denied Claim for claims appeal procedures.

GLOSSARY

Aphakia — Lack or loss of the lens of the eye

Acuity — Sharpness of vision

Anisometropia — A condition in which the refractive power of one eye differs from that of the other

Keratoconus — A degenerative condition characterized by conical protrusion of the cornea and irregular astigmatism

In-Network Provider — A doctor who participates in the EyeMed Vision Care INSIGHT network and has a contractual agreement with EyeMed to accept the maximum allowed charge as payment in full for a vision service

Keratotomy — Incision of the cornea

Ophthalmologist — A doctor of medicine specializing in ophthalmology, the branch of medicine dealing with the anatomy, functions and diseases of the eye

Optometrist — A licensed professional who practices optometry, the practice or profession of examining the eyes by means of suitable instruments or appliances, for defects in vision and eye disorders in order to prescribe corrective lenses or other appropriate treatment

Orthoptics — A method of exercising the eye and its muscles in order to cure strabismus or improve vision

Out-of-Network Provider — A vision care provider who does not participate in the EyeMed Vision Care INSIGHT network

Photorefractive Keratectomy — Laser eye surgery procedures intended to correct a person's vision, reducing dependency on glasses or contact lenses

Year or Yearly — For vision insurance, the 12-month period that begins on Jan. 1

Flexible Spending Accounts

Flexible spending accounts (FSAs) allow you to set aside tax-free money to pay for eligible healthcare and dependent care expenses.

PLAN HIGHLIGHTS

Baylor Scott & White Health offers three flexible spending accounts: a Healthcare FSA, a Limited Purpose Healthcare FSA and a Dependent Care FSA.

- The type of Healthcare FSA available to you depends on which medical plan you elect.
- You can use the money in your Healthcare FSA or Limited Purpose Healthcare FSA to pay for eligible healthcare expenses for you, your dependents and your adult children to age 26, even if they are not covered under a healthcare plan. Eligible expenses include expenses not covered by the plan and copays.
- You can use the money in your Dependent Care FSA to pay for eligible child care expenses so you and your spouse (if married) can work.
- Your contributions to the FSAs are deducted from your paycheck before federal and Social Security taxes are deducted, so your taxable income is less.
- You should estimate your expenses very carefully. Any unused money remaining in either account after March 15th of the following year is forfeited.

For information on additional benefit programs or details, see the [Administrative & General Information](#) section or individual benefit sections.

HOW THE ACCOUNTS WORK

Each of the accounts works basically the same way. You decide how much to contribute and contributions are deducted from your paycheck on a pre-tax basis each pay period. Then you use the money in your account to reimburse yourself for eligible expenses.

YOUR CONTRIBUTIONS

Contributions are deducted in equal amounts from 26 paychecks each year. Because contributions are made with pre-tax dollars, the average participating employee saves 15 to 28 cents on every \$1 contributed.

When you are hired or become eligible to receive benefits, the FSA contributions you elect are deducted from your paycheck beginning with the first available paycheck after your enrollment is effective. These contributions are made before federal income and Social Security taxes are withheld.

Once you choose to participate in an FSA, your contributions will be in effect for the rest of the calendar year unless you have a qualifying event. In this case, you may enroll or change the amount of your contribution. For more information on qualifying events, see the [A Guide to Your Benefits](#) section.

Go to www.optumbank.com to track your reimbursements and check your balances.

UNUSED CONTRIBUTIONS

Your expenses must be incurred during the plan year (January 1 through December 31). If you have an unused balance in your FSA at year-end, you may submit additional covered expenses incurred during the 2 1/2-month grace period from January 1 through March 15 of the following year. Any expense you incur during this grace period will be applied to use up your remaining account balance from the prior year. Any amount remaining in your FSA for the prior year after payment of allowable expenses incurred during the grace period will be forfeited. Forfeitures are used to help offset the plans' administrative expenses. All plan year and grace period claims must be submitted by April 30, following the end of the plan year.

TRANSFERRING CONTRIBUTIONS

Your contributions to your Healthcare FSA and Dependent Care FSA are administered separately and cannot be transferred from one account to another.

How To Use the FSAs

1. Choose how much to contribute. Estimate your total healthcare and/or dependent care expenses for the upcoming year. Contributions are deducted from your paycheck in equal amounts throughout the year and are deposited to the appropriate FSA.
2. Enroll during annual enrollment, within 30 days of hire or within 30 days of a qualifying event. You cannot change your contribution amount after the initial deduction has been made, unless you have a qualifying event. Changes must correspond with the qualifying event.
3. Pay as you go and keep your receipts. You'll pay a copay or coinsurance at the time of service, then pay yourself back with pre-tax dollars.
4. Get reimbursed. You have several ways to file for reimbursement, depending on the type of expense. See [page 96](#) for more information.

How an FSA Can Save You Money

Since your FSA contributions are deducted from your paycheck before you pay federal income and Social Security taxes, participating in the FSAs reduces the amount you pay in taxes.

Suppose you make \$30,000 a year and contribute \$5,000 to a Dependent Care FSA throughout the year to pay for child care. Here's how much you could save:

	Using Pre-Tax Flexible Spending Accounts	Using After-Tax Dollars
Annual pay	\$30,000	\$30,000
What you put into the FSA	-\$5,000	\$0
Taxable pay	\$25,000	\$30,000
Taxes (15% federal, 7.65% Social Security)	-\$5,663	-\$6,795
After-tax expenses	\$0	-\$5,000
Take-home pay	\$19,337	\$18,205
Amount you save with the FSA*	\$1,132	\$0

* Based on the following taxes: 15% federal, 7.65% Social Security

HEALTHCARE FSA

The type of Healthcare FSA in which you may enroll is determined by your medical plan election, as follows:

Your Medical Option Election	Type of Healthcare FSA	What It Covers
SEQA/EQA, PPO, or no medical coverage	General Purpose Healthcare FSA	Eligible medical, pharmacy, dental and vision expenses
HSA	Limited Purpose Healthcare FSA or General Purpose Healthcare FSA (only an option if you do not contribute or receive contributions to a Health Savings Account)	Dental and vision expenses only, until you meet your deductible, then medical and pharmacy expenses, too

Eligible expenses may be reimbursed from your Healthcare FSA only if they are not covered by any other plan, insurance or reimbursement account.

Annual Contribution Limit

Minimum	Maximum
\$100	\$2,650

Eligible Dependents

You may use your Healthcare FSA to reimburse yourself for eligible expenses you pay for you, your spouse, your eligible dependents and your adult children to age 26.

Your spouse, dependents and adult children do not have to be covered by you under any of Baylor Scott & White Health's medical, dental or vision plans for expenses incurred by them to be eligible for reimbursement from your FSA.

You may include the expenses of any person who is your dependent if you can claim an exemption as a dependent for him or her on your federal income tax return. A person generally qualifies as your tax dependent if he or she meets all three of the following requirements:

1. That person lives with you for the entire year as a member of your household or is one of the following:
 - Your spouse
 - Your child (including your legally adopted child or foster child), grandchild or great-grandchild
 - Your stepchild
 - Your brother, sister, stepbrother or stepsister
 - Your parent, grandparent or other direct ancestor, but not foster parent
 - Your stepfather or stepmother
 - A brother or sister of your father or mother
 - A son or daughter of your brother or sister
 - Your father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law or sister-in-law
 - Any other person who is a “qualifying relative” under Code Section 152(d)
2. That person is a U.S. citizen or resident
3. You provide more than 50% of that person's total support for the calendar year

You can continue to be reimbursed for expenses of your children after they are no longer your tax dependents, until they reach age 26.

Special Rules for the Medical HSA

The Healthcare FSA has a grace period from January 1 to March 15 to use funds remaining in the Healthcare FSA at the end of the calendar year. If you newly enroll in the HSA option and you have funds remaining in a General Purpose Healthcare FSA from the prior year, you cannot contribute to an HSA until April 1st.

Special Rule for HRA Rollover Balances

If you have an HRA rollover balance from last year, your eligible covered medical expenses that are not paid by the Medical Plan will be paid first from your HRA rollover. After your HRA rollover is exhausted, your Healthcare FSA may begin reimbursing you for medical expenses not paid by the Medical Plan. Your Healthcare FSA can be used to reimburse you for any eligible expenses not covered by the HRA rollover (such as dental or vision expenses or the portion of out-of-network expenses that exceeds the recognized charge).

Eligible Expenses

In general, you may use a General Purpose Healthcare FSA for any expenses that qualify as medical deductions on your federal income tax return. You may use a Limited Purpose Healthcare FSA for any dental and vision expenses that qualify as medical deductions on your federal income tax return until you meet your deductible. In addition to deductible medical expenses, you may also use a Healthcare FSA for the following medical expenses:

- Over-the-counter medications (other than insulin), ONLY if you have obtained a physician's prescription for the medication
- Medical supplies, such as bandages, first aid kits, athletic braces, and diabetic supplies (a prescription is not necessary)

The services must be received in the same year in which you made the account contribution, or during the grace period until March 15 of the following year. Also, you cannot use the Healthcare FSA for expenses you had before you began participating in the account or after your participation stops, unless you continue coverage under COBRA on an after-tax basis.

Generally, expenses not paid by your insurance, such as deductibles, coinsurance, charges above recognized charges, etc., are eligible for reimbursement under your Healthcare FSA.

This section lists examples of qualifying healthcare expenses. For a complete list, visit www.irs.gov and download Publication 502 (Medical and Dental Expenses).

Acupuncture

You may include the amount you pay for acupuncture, provided it is necessary to treat a specific medical condition. If you do not submit an explanation of benefits as substantiation, then you must submit a note from an attending physician stating a medical condition exists and describing the length of the treatment plan.

Alcoholism

You may include amounts you pay for inpatient alcohol addiction treatment.

Ambulance

You may include amounts you pay for ambulance service.

Artificial Limb or Prosthesis

You may include the amount you pay for an artificial limb.

Braille Books and Magazines

You may include the amount of the cost of Braille books and magazines for use by a visually impaired person that is more than the price of regular printed editions.

Breast Pumps and Pump Supplies

Breast pumps and pump supplies are eligible medical expenses. Certain criteria must be met. Please contact your Plan Administrator for details.

Car

You may include the cost of special hand controls and other special equipment installed in a car for the use of a person with a disability. You may also include the amount of the cost of a car specially designed to hold a wheelchair that is more than the cost of a regular car. You must submit evidence of medical necessity (e.g., prescription, doctor's note) with the request for reimbursement. Note: The cost of the vehicle itself is not a qualified medical expense.

Chiropractors

You may include fees you pay to a chiropractor for healthcare. The chiropractic care must be necessary to treat a specific medical condition. If you do not submit an explanation of benefits as substantiation, then you must submit a note from an attending physician stating a medical condition exists and describing the length of the treatment plan.

Contact Lenses

You may include amounts you pay for contact lenses needed for healthcare reasons. You may also include the cost of equipment and materials for using contact lenses, such as saline solution and enzyme cleaner.

Cosmetic Surgery

You may include amounts you pay for cosmetic surgery ONLY if the surgery or procedure is necessary to correct a deformity arising from or directly related to 1) a congenital abnormality, 2) a personal injury resulting from an accident or trauma or 3) a disfiguring disease. Procedures such as face lifts, hair transplants, teeth whitening, hair removal (electrolysis) and liposuction generally are NOT qualifying healthcare expenses.

Crutches

You may include the amount you pay to buy or rent crutches.

Dental Treatment

You may include the amounts you pay for dental treatment. This includes fees paid to a dentist and fees for X-rays, fillings, braces, extractions and dentures.

Drug Addiction

You may include amounts you pay for inpatient drug addiction treatment.

Eyeglasses

You may include amounts you pay for eyeglasses and contact lenses needed for healthcare reasons. You may also include fees paid for eye examinations.

Guide Dog

You may include the cost of a guide dog for the visually impaired or hearing impaired. Amounts you pay for the care of the dog are also eligible healthcare expenses.

Hearing Aids

You may include the cost of a hearing aid and the batteries you buy to operate it.

Hospital Services

You may include amounts you pay for inpatient or outpatient care.

Laboratory Fees

You may include the amounts you pay for laboratory fees that are part of your healthcare.

Learning Disability

You may include tuition fees you pay to a special school for a child who has severe learning disabilities caused by a mental or physical handicap, including nervous system disorders. Your doctor must recommend that the child attend the school. Also see *Schools and Education, Special*.

You may also include a child's tutoring fees you pay on your doctor's recommendation. The tutoring must be performed by a teacher who is specially trained and qualified to work with children who have severe learning disabilities.

You must submit evidence of medical necessity (e.g., prescription, doctor's note) with the request for reimbursement.

Legal Fees

You may include legal fees paid to authorize treatment for mental illness. However, if part of the legal fees includes, for example, guardianship or estate management fees, you may not include that part as a healthcare expense.

Lodging

You may include the cost of meals and lodging at a hospital or similar institution. You may include the cost of lodging not provided in a hospital or similar institution while away from home if all of the following criteria are met:

- The lodging is primarily for and essential to healthcare.
- Healthcare is provided by a doctor in a licensed hospital or equivalent facility.
- The lodging is not lavish or extravagant under the circumstances.
- There is no significant element of personal pleasure, recreation or vacation in the travel away from home.

The amount may not exceed \$50 for each night for each person. Lodging may also include expenses for an individual traveling with the person receiving healthcare (for example, a parent traveling with a sick child). In this case, the limit is \$100 per night.

Medical Information Plan

You may include amounts paid to a plan that keeps your healthcare information by computer and provides information to your attending physician when needed.

Medical Services

You may include amounts you pay for legal medical services provided by physicians, surgeons, specialists or other licensed medical practitioners.

Medicines or Drugs

You may include amounts you pay for medicines and prescribed drugs requiring a prescription, or for insulin. A prescribed drug is one that **REQUIRES** a prescription by a doctor **AND** is filled by a licensed pharmacist.

You may include over-the-counter (OTC) drugs **ONLY** if you have a physician's prescription.

Mentally Disabled, Special Home For

You may include the cost of keeping a mentally disabled person in a special home to help the person adjust from living in a mental hospital to community living. A psychiatrist must recommend the home and it must not be the home of a relative.

Nursing Home

You may include the cost of healthcare, including meals and lodging, for yourself, your spouse or your dependents, in a nursing home or home for the aged, if the main reason for being there is to receive healthcare. If the main reason for being in the nursing home or home for the aged is personal, you may include in healthcare expenses only the amount of the cost that is for healthcare or nursing care.

Nursing and Other Services

You may include amounts you pay for nursing and other services. This includes services connected with caring for the patient's condition, such as giving medication or changing dressings, as well as the bathing and grooming of the patient.

You may include in healthcare expenses Social Security tax, Federal Unemployment tax, Medicare tax and state employment taxes you pay for a nurse, attendant or other person who provides healthcare.

Orthodontia Services

If payments are made in installments, the orthodontist must allocate the payments to services currently provided. The orthodontist's contract allocating the expenses must be attached to the submitted claim form.

If payment is made in a lump sum on the first visit, please contact Baylor Scott & White Health's Corporate HR Benefits office for reimbursement instructions.

Operations or Surgery

You may include amounts you pay for legal operations that are not for unnecessary cosmetic surgery.

Oxygen

You may include amounts you pay for oxygen or oxygen equipment to relieve breathing problems caused by a medical condition.

Schools and Education, Special

You may include payments to a special school for a mentally or physically handicapped person if the main reason for using the school is its resources for relieving the disability. You may include, for example, the cost of a school that meets any of the following criteria:

- Teaches Braille to a visually-impaired child
- Teaches lip reading to a hearing-impaired child
- Gives remedial language training to correct a condition caused by a birth defect

Smoking Cessation Programs

You may include the costs of smoking cessation programs. Nicotine patches and gum are covered if obtained by a prescription and are typically covered over the counter. For more information, refer to Medicines or Drugs earlier in the Eligible Expenses section.

Sterilization

You may include the cost of a legal sterilization performed to make a person unable to have children.

Telephone

You may include the cost and repair of special telephone equipment allowing a hearing-impaired person to communicate through a regular telephone.

Television

You may include the cost to modify a television to assist a hearing-impaired person (such as an adapter for a regular television) or purchase a specially equipped television. Note: Only the amount that exceeds the cost of the television without modification or special equipment is reimbursable.

Therapy or Counseling

You may include amounts you pay for therapy or counseling received as medical treatment. It must be necessary to treat a specific medical condition. If you do not submit an explanation of benefits as substantiation, then you must submit a note from an attending physician stating that a medical condition exists and describing the length of the treatment plan.

Transplants

You may include payments for surgical, hospital, laboratory and transportation expenses for a donor or a possible donor of a transplant.

Transportation

You may include certain amounts paid for transportation primarily for and essential to healthcare. You may include:

- Bus, taxi, train or plane fare, or ambulance service
- Actual car expenses, such as gas and oil. Do not include expenses for general repair, maintenance, depreciation and insurance. You may include \$.20 per mile for each mile you use your car for healthcare reasons

- Parking fees and tolls
- Parent's transportation expenses if a parent must go with a child who needs healthcare
- Transportation expenses of a nurse or other person providing healthcare to the patient
- Transportation expenses for regular visits to see a mentally ill dependent, if these visits are recommended as part of treatment
- Transportation expenses do not include:
 - Transportation expenses to and from work, even if your condition requires an unusual means of transportation
 - Transportation expenses for non-medical reasons only (e.g., you choose to travel to another city, such as a resort area)

Weight-Loss Program

You may include amounts you pay for weight-loss treatment if it is a treatment for a specific disease diagnosed by a physician (such as obesity, hypertension or heart disease). You cannot include membership dues for a gym, health club or spa. You must submit evidence of medical necessity (e.g., prescription, doctor's note) with the request for reimbursement.

Wheelchair

You may include amounts you pay for a wheelchair.

Wig

You may include the cost of a wig purchased upon the advice of a physician for the mental health of a patient who has lost all of his or her hair from disease.

X-ray

You may include amounts you pay for X-rays.

Ineligible Expenses

The following expenses are NOT qualifying healthcare expenses and may NOT be reimbursed through your Healthcare FSA. If you have any questions about eligible and ineligible expenses, go to www.optumbank.com.

- Baby-sitting, child care and nursing services for a normal, healthy child
- Controlled substances in violation of federal law
- Cosmetic surgery considered not medically necessary
- Dancing lessons
- Diaper services (For individuals with impairments or disabilities beyond infancy, or when recommended by a physician to relieve the effects of a medical condition, the cost of diapers is a qualified medical expense.)
- Electrolysis or hair removal (When recommended by a healthcare professional for a medical condition, the cost of hair removal or a hair transplant may be a qualified medical expense. Submit evidence of medical necessity

(e.g., prescription, doctor's note) with the request for reimbursement.)

- Funeral expenses
- Hair transplants (When recommended by a healthcare professional for a medical condition, the cost of hair removal or a hair transplant may be a qualified medical expense. Submit evidence of medical necessity (e.g., prescription, doctor's note) with the request for reimbursement.)
- Health club dues (When recommended by a healthcare professional for a medical condition, dues paid to a health club, YMCA or YWCA are qualified medical expenses. Submit evidence of medical necessity (e.g., prescription, doctor's note) with the request for reimbursement. Note: Reimbursement is only for the individual membership and for the component that is related to the current plan year. Any dues that carry over to a subsequent year must be submitted for that plan year of coverage.)
- Household help
- Illegal operations and treatments
- Insurance premiums
- Maternity clothes
- Non-prescription drugs and medicine, except as described under Eligible Expenses
- Nutritional supplements, vitamins and herbal supplements unless purchased through a licensed physician's prescription
- Personal-use items (such as toothpaste, sunscreen, etc.)
- Swimming lessons (When recommended by a healthcare professional for a medical condition, fees paid for lessons may be qualified medical expenses. Submit evidence of medical necessity (e.g., prescription, doctor's note) with the request for reimbursement.)
- Weight-loss programs, except as described under Eligible Expenses
- Any healthcare expenses claimed on your tax return

DEPENDENT CARE FSA

The Dependent Care FSA allows you to set aside pre-tax dollars to pay for the care of your eligible dependents while you work. Through the Dependent Care FSA, you may be reimbursed tax-free for expenses such as day care for your child or for an elderly parent or spouse who is incapable of self-care. The expenses must be incurred during the plan year or during the grace period of January 1 to March 15 of the following year.

To qualify for reimbursement, the care must be necessary to allow you to work. If you are married, this means you must work and your spouse must work outside the home, attend school full time or be disabled.

Annual Contribution Limit

Minimum	Maximum
\$100	Lesser of: <ul style="list-style-type: none"> • \$5,000 (\$2,500 if you are married and file separate tax returns) • Your earned income or your spouse's earned income

The Dependent Care FSA limits are set by the federal government. If you participate in the Dependent Care FSA, you must make sure you comply with these federal limits. You may be responsible for additional taxes if your Dependent Care FSA contributions exceed these federal limits.

Changing Your Contributions

When you enroll in the Dependent Care FSA, your contribution election is effective for the rest of the calendar year, so plan your expenses carefully. You may change your participation only if you have a qualifying event (as described in the A Guide to Your Benefits section).

Dependents

Eligible dependents include:

- A dependent child under age 13 if you claim him or her as a deduction on your federal income tax return
- Your spouse who is physically or mentally unable to care for himself or herself and lives with you for more than half the year
- Other dependents of any age if they are physically or mentally unable to care for themselves and live with you for more than half the year

To qualify, you must pay more than half the cost of these dependents' support and claim them as dependents on your federal income tax return.

Tax Deduction

Day care expenses may qualify you for a tax credit on your income tax return. You don't have to itemize expenses on your income tax return to qualify for the tax credit. You cannot claim the tax credit and be reimbursed from your Dependent Care FSA for the same expenses. However, if your day care expenses are more than the available tax credit, you may be able to use both the tax credit and the Dependent Care FSA. In general, it's more advantageous for you to use the Dependent Care FSA rather than a tax credit.

If you participate in the Dependent Care FSA, you must file Form 2441 with your federal income 1040 tax return. Please see IRS Publication 503.

To understand how these tax issues may affect you, you should consult a financial planner.

Eligible Expenses

In general, dependent day care expenses must be for the well-being and protection of an eligible dependent. The care must be needed to allow you and your spouse to work or look for work (or allow you to work if your spouse is a full-time student or disabled). Here are some other qualifications for eligible expenses:

- Care may be provided in your home, someone else's home or at a day care facility
- The care provider can be a relative who is age 19 or older, as long as this person is not also considered your dependent
- Care provided outside your home qualifies if the eligible dependent regularly spends at least eight hours a day in your home (i.e., nursing home expenses are not eligible)
- Education expenses qualify if your child is not yet in kindergarten, and the amount of education expense is incidental and cannot be separated from the cost of caring for your child
- Before- and after-school care for children in kindergarten and higher grades
- Specialized day camp programs (music, soccer, etc.)
- Cost of transportation provided by a day care center or care provider, when itemized separately on the invoice, to and from where the care is provided
- Indirect expenses related to receiving the care (i.e., application fees, deposits and agency fees). Care must be shown to have been ultimately provided
- Payments that must occur to maintain the dependent in the care facility while the taxpayer is temporarily absent from work for a minor illness or vacation when the taxpayer must pay for dependent care on a weekly or monthly basis

Ineligible Expenses

This is a list of some ineligible expenses:

- Weekend or evening babysitting when you or your spouse are not working
- Overnight camp
- Schooling in kindergarten or higher
- Your cost to transport your dependent to day care
- Transportation cost for a care provider to come to your home
- Expenses for activities or lessons when a separate fee is charged through day care

Certain other expenses also do not qualify for reimbursement from the Dependent Care FSA. If you have any questions about eligibility or expenses, go to www.optumbank.com.

FILING CLAIMS

Under the FSA, you have the following reimbursement and payment options:

1. Debit Master Card – the Baylor Scott & White Health – Health Payment Card, an electronic payment card used to pay for expenses through the Healthcare FSA, Limited Purpose FSA and Dependent Care FSA
2. Online through the Expense Journal (carriers will proactively send “Patient Responsibility Amounts” or out-of-pocket expenses to Optum)
3. Mobile App (Optum Bank App)
4. Mail, Email or Fax

Mail: Optum PO Box 30516
Salt Lake City, UT 84130

Email: optumclaims@prod.sourcehov.com
(address is for submissions only;
non-response box)

Fax: 1-855-244-5016

Filing Online

To file a reimbursement request online, take the following steps:

- Go to www.optumbank.com, log into your account
- Go to the “I Want To” section and click on “File a Claim”
- Choose Reimbursement under “Reimbursement Yourself” for an expense that was paid out-of-pocket

SPECIAL SUBSTANTIATION NOTE: Prior to submitting a request for reimbursement, please check the Expense Journal first. Optum receives claim substantiation from Baylor Scott and White Health’s carriers. They are: 1) Scott & White Health Plan (medical and Rx), 2) EyeMed (vision), and 3) MetLife (dental).

Any questions, please contact OptumBank customer service at 1-800-243-5543 (Monday-Friday from 7am - 9pm CT; Saturday-Sunday from 8am - 5:30pm CT) or you can email: accountholderservices@optum.com.

** You must, however, provide documentation. For more information about the documentation requirements and payment guidelines, visit www.optumbank.com.*

Using Your Debit Card

Your card will only work at approved merchants and should only be used for eligible products and services. Always keep all of your FSA expense receipts, including receipts for items for which you used the debit card. Optum takes a number of steps to substantiate that your purchases are for eligible products and services without contacting you. However, there may be instances in which Optum cannot substantiate your purchase. In these circumstances, you will be asked to provide documentation to verify your expenses are eligible expenses. In some cases, use of your card may be “frozen” until you

complete the requested verification steps. You will be notified when there are any questions about purchases you have made with the card. Even if Optum does not request verification, the IRS may request verification of your FSA expenses, so be sure to save all of your FSA expense receipts, regardless of whether you submit them to Optum.

Approved merchants are generally healthcare providers and pharmacies—for example, physicians, ambulance services, hospitals, optometrists and opticians, dentists, labs, Walgreens, CVS Pharmacy, hearing aid sales, and chiropractors.

Even though it operates as a debit card, select the “Credit” option when using the card at an electronic card reader. There is no PIN number.

Note that if you have an HRA rollover balance, medical expenses are paid from your Health Reimbursement Account (HRA) rollover first.

If Your Claim Is Denied

Disagreements about benefit eligibility or payment amounts may occasionally arise. In most cases, differences can be quickly resolved with a phone call.

If you have questions regarding a claim, eligibility or covered benefits, please contact PeoplePlace as soon as possible.

FSA claims may be denied for the following reasons:

- Expense not incurred within the current plan year or the grace period following the current plan year
- Expense not incurred within your dates of participation
- Expense not allowable according to IRS/plan regulations
- Dependent not eligible under IRS regulations
- Dependent’s name, date(s) and/or provider’s charges/ID number not clearly shown on documentation
- Document not signed by the participant and/or dated

You have the right to appeal the denial of your claim. Please see the All Other Claims section of the appeals procedures in the [Administrative & General Information](#) section for more details.

IF YOU LEAVE BAYLOR SCOTT & WHITE HEALTH

You may elect to continue your Healthcare FSA coverage with after-tax dollars under COBRA. By doing so, expenses incurred after your termination and through the remainder of the plan year may be reimbursed. You may elect to continue your Healthcare FSA coverage under COBRA only if as of your termination date, the amount of reimbursement you may receive for the remainder of the plan year exceeds the amount you would be required to pay to continue participation for the remainder of the plan year. You may not continue your Healthcare FSA coverage under COBRA beyond the end of the plan year in which you terminate employment with Baylor Scott & White Health. If you do not elect extended coverage under COBRA, the balance in

the Healthcare FSA may be used only for qualifying expenses incurred before your termination date.

COBRA continuation is not available for the Dependent Care FSA. The balance in the Dependent Care FSA as of the date of your termination of employment may be used only for qualifying expenses incurred before your termination date.

GLOSSARY

Out-of-pocket Expenses — Any expense that an individual incurs that is not covered under a Baylor Scott & White Health Medical Plan.

Reimbursement — To make repayment for an expense incurred.

Life Insurance

Baylor Scott & White Health's Life Insurance Program offers financial protection for you and your family if you or a dependent die while covered under the plan.

PLAN HIGHLIGHTS

- You receive free Basic Life Insurance based on your eligible employee class and annual base pay, rounded to the next higher \$1,000
 - Class 1** – Senior Executives – 3 times your annual compensation or \$1,500,000
 - Class 2** – All benefit eligible employees (not eligible in another class) – 1 times your annual compensation or \$500,000
 - Class 3** – Retirees (prior to December 31, 2015) – Flat \$5,000 or \$10,000
 - Class 4** – Physicians – 1 times your annual compensation or \$1,000,000
- If you want an extra layer of protection, you may purchase Voluntary Life Insurance for yourself equal to 1, 2, 3, 4, 5, 6 or 7 times your annual base pay, rounded to the next higher \$1,000, up to a maximum of \$5,000,000.
- You can also purchase Dependent Life Insurance for your spouse and/or children. Spouse Life Insurance is available in varying amounts up to \$250,000. Child Life Insurance is \$10,000 per child for each of your eligible children.
- If you become terminally ill, you may be able to receive part of your life insurance benefit while you are still living. See the *Accelerated Death Benefit* section for more information.

LIFE INSURANCE FOR YOU

Participating

If you're a regular, full-time employee or a part-time employee regularly scheduled to work at least 20 hours per week, you are immediately eligible to enroll in life insurance coverage. You may also cover your spouse and eligible dependent children under the plan. See the [A Guide to Your Benefits](#) section for more details about who can and cannot participate in the plan.

When you are hired or become eligible for benefits, you are automatically enrolled in Basic Life coverage. You may purchase additional coverage through the Voluntary Life program. You must elect Voluntary Life coverage within 30 days from the date of your employment or if later, the date of your initial eligibility. If you do not elect the coverage by the deadline date, you must wait until the next annual enrollment period to enroll in the plan, unless you experience a qualifying event. If you are not actively at work due to a physical or mental condition on the day your coverage would normally become effective,

coverage for you and your dependents starts as soon as you have been at work for one full day.

Each year during annual enrollment, you may change your coverage for the next calendar year. The election you make is effective the following Jan. 1 and remains in effect for the entire year. You cannot make changes to your elections during the year unless you experience a qualifying event. See the [A Guide to Your Benefits](#) section for more information about enrolling, qualifying events and when coverage begins and ends.

PAYING FOR COVERAGE

Your cost for coverage depends on the options you choose. Baylor Scott & White Health pays the full cost of Basic Life coverage but you pay the cost for Voluntary Life coverage. Prices may change each year.

When you enroll, your share of the cost for coverage will be deducted from your paycheck beginning with the first available paycheck after you enroll. Your cost is generally deducted from each paycheck during the year and is deducted on an after-tax basis. The amount deducted is part of your taxable wages before federal income and Social Security taxes are withheld. See the [A Guide to Your Benefits](#) section for more information about paying for benefits.

Your coverage amount and payroll deductions automatically change when your base salary changes. However, if you are not at work on the date your pay changes, your increase in coverage is delayed until you return to active work. "Actively at work" means you're performing all material and substantial duties of your regular job.

Basic Life Insurance

The Company pays the full cost for your Basic Life Insurance coverage. Your coverage is equal to a multiple of your annual base pay (defined below), rounded to the next higher \$1,000, up to the defined maximum based on your eligible life class.

Class	Maximum
Class 1	\$1,500,000
Class 2	\$500,000
Class 4	\$1,000,000

Any company-provided life insurance in excess of \$50,000 is considered to be taxable income by the Internal Revenue Service (IRS). The amount of taxable income for life insurance coverage in excess of \$50,000 is referred to as "imputed income."

What is Annual Base Pay?

“Annual Base Pay” means your gross annual income from your Employer in effect just prior to your date of loss. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, shift differential or any other extra compensation, or income received from sources other than your Employer.

If you are a commissioned employee with one or more years of service, “Annual Base Pay” also includes income actually received from commissions. Commissions are calculated for the period 9/1-8/31 of the previous year immediately prior to the date of loss. The calculated amount is frozen as of 8/31 and used to determine annual earnings for the following calendar year.

Voluntary Life Insurance

You may purchase additional life insurance coverage for you equal to:

- 1 times annual base pay
- 2 times annual base pay
- 3 times annual base pay
- 4 times annual base pay
- 5 times annual base pay
- 6 times annual base pay
- 7 times annual base pay

Not sure how much life insurance you need? Be sure to consider your home mortgage payments, college tuition and any other large expense your family might not be able to afford without your income.

How Voluntary Coverage is Rounded

Here are some examples of how your Voluntary Life Insurance is rounded if your pay is not an even multiple of \$1,000.

If your annual base pay is...	Your coverage is...						
	1x pay	2x pay	3x pay	4x pay	5x pay	6x pay	7x pay
\$19,500	\$20,000	\$39,000	\$59,000	\$78,000	\$98,000	\$117,000	\$137,000
\$24,100	\$25,000	\$49,000	\$73,000	\$97,000	\$121,000	\$145,000	\$169,000
\$32,600	\$33,000	\$66,000	\$98,000	\$131,000	\$163,000	\$196,000	\$229,000
\$41,800	\$42,000	\$84,000	\$126,000	\$168,000	\$209,000	\$251,000	\$293,000

Age Reduction

The amount of life insurance available to you and your spouse reduces at certain ages while insured:

- If you have reached age 65, but not age 70, you and your spouse’s amount of life insurance will be 65% of the amount of life insurance you had prior to age 65.
- If you have reached age 70 or more, you and your spouse’s amount of life insurance will be 50% of the amount you had prior to the first reduction.

No further increases in your or your spouse’s amount of life insurance are available once you reach age 65.

Voluntary Life Insurance Maximum Coverage Amount

Your Voluntary Life insurance coverage through Baylor Scott & White Health cannot exceed the maximum coverage amount listed below based on your eligible class. If you want to increase your coverage amount after your initial enrollment, you may only increase it by one level of coverage, without Evidence of Insurability, each year. You may reduce your coverage to any level.

Class	Maximum
Class 1	\$5,000,000
Class 2	\$2,000,000
Class 4	\$5,000,000

DEPENDENT LIFE INSURANCE

You may elect Dependent Life Insurance for your spouse and eligible dependent children. Here's a look at your options:

For your dependent...	You may elect coverage in one of the following amounts...
Spouse	\$10,000, \$25,000, \$50,000, \$75,000, \$100,000, \$125,000, \$150,000, \$175,000, \$200,000, \$225,000, or \$250,000 not to exceed 100% of the employee approved amount
Child(ren)	\$10,000 per eligible child

Eligible Children

Eligible children include any child from live birth to age 26 who is:

- Your natural child
- Your stepchild born to the Employee's spouse provided the child is living with, and is financially dependent upon the employee
- Your legally adopted child, beginning with any waiting period pending finalization of child's adoption, or
- The legally adopted child of the Employee's spouse provided the child is living with, and is financially dependent upon the employee
- Child for whom the Employee is the Court Appointed legal guardian and who resides with and is financially dependent on the employee
 - If your dependent child's life insurance coverage ends when he or she no longer meets the eligibility

requirements (for example, by turning age 26) you must contact PeoplePlace to drop dependent life insurance coverage. Your level of coverage will not change automatically.

Any child age 26 or older and disabled* who:

- Is primarily dependent on you for financial support and maintenance and
- Became disabled before age 26 and was your dependent at that time and
- Incapable of self-sustaining employment by reason of mental or physical incapacity

* You must submit satisfactory proof of disability to Cigna

If you and your spouse both work for Baylor Scott & White Health and both are eligible for benefits, your spouse cannot be covered under Spouse Life coverage. Only one of you may enroll your child(ren) for Child Life coverage.

If you are not in Active Service on the date that coverage would normally begin, coverage will begin on the date you return to Active Service.

An Employee will be considered in Active Service with his employer on any day that is either of the following:

- One of the Employer's scheduled work days on which the Employee is performing his regular duties on a full-time basis, either at one of the Employer's usual places of business or at some other location to which the Employer's business requires the Employee to travel;
- A scheduled holiday, vacation day or period of Employer-approved paid leave of absence, other than sick leave, only if the Employee was in Active Service on the preceding scheduled workday.

A person other than an Employee is considered in Active Service if he is none of the following:

- An Inpatient in a Hospital or receiving Outpatient care for chemotherapy or radiation therapy;
- Confined at home under the care of Physician for Sickness or injury;
- Totally Disabled.

EVIDENCE OF INSURABILITY

Evidence of Insurability is required if the amount of your Voluntary Life insurance exceeds the lesser of \$1,000,000 or 3x annual base pay.

Evidence of Insurability is required if the amount of your Spouse Voluntary Life insurance exceeds \$75,000.

CHOOSING A BENEFICIARY

When you become eligible for coverage, you must choose a beneficiary [a person(s), trust or estate] to receive plan benefits. If you name more than one beneficiary without specifying how they should share in the benefit, they will share equally. You may also name contingent beneficiaries in the event your beneficiary is not living at the time of your death.

You may change your beneficiary designation at any time by contacting PeoplePlace at 1-844-417-5223.

If there is no beneficiary on record or if no named beneficiary survives you Cigna will pay benefits to the first surviving class of the following living relatives:

- Your spouse
- Your child(ren) (in equal shares)
- Your parent(s) (in equal shares)
- Your siblings (in equal shares)
- The executors or administrators of your estate

You are automatically the beneficiary for any Dependent Life Insurance you elect.

Stay Up to Date

It's a good idea to review your beneficiary designation from time to time, especially if you have a change in family status, such as marriage, divorce or the birth of a child.

ACCELERATED DEATH BENEFIT

If you are diagnosed with a terminal illness you can request an accelerated payment of your life insurance benefits. You may request that up to 75% of your Life Insurance be paid while you are still living. The maximum amount available for an accelerated benefit payment is \$500,000. Under the plan, you are considered terminally ill if your doctor determines you have an illness or physical condition, including a physical injury, that can reasonably be expected to result in death in less than 12 months.

The benefit payable to your beneficiary when you die will be reduced by the amount of the accelerated benefit you receive. Any amount you receive through the accelerated benefit may be considered taxable income.

To request a living benefit payment, contact PeoplePlace to request an accelerated death benefits claim form. To be approved, you must provide Cigna with satisfactory proof of your life expectancy.

This accelerated benefit is designed to help pay the medical bills frequently associated with terminal illness. However, there are no restrictions on how the money can be used. You should consult a tax attorney for information on the tax treatment of this benefit.

FILING CLAIMS

You or your beneficiary should notify PeoplePlace, as soon as possible after a covered person dies. PeoplePlace will forward information to Cigna for processing. Cigna will mail instructions to the beneficiaries requesting written proof of death (Death Certificate from a government agency) and any additional information needed for processing.

When Benefits are Paid

If the claim is approved, benefits are payable as soon as administratively possible and issued in a "check book" method. This will allow you to use the benefit in a single lump sum or as needed. If you have not named a beneficiary or your beneficiary is not living when you die, benefits are paid according to the order shown in the *Choosing a Beneficiary* section or as mandated by state law.

If the beneficiary is a minor child, the life insurance benefits will be paid to the legal guardian or custodian of such child to be managed for the child's legal benefit until he or she reaches adulthood.

Any insured death benefit you or your beneficiary receive from the plan is generally not considered taxable income. Any benefit you receive through the living benefit may be considered taxable income. See your personal tax advisor for more information.

When Benefits are Not Payable

Voluntary and Dependent Life Insurance benefits are not payable where death is caused by, contributed to by, or results from:

- Suicide occurring within 24 months after your or your dependent's initial effective date of insurance; and
- Suicide occurring within 24 months after the date any increases or additional insurance become effective for you or your dependent.
 - The suicide exclusion will apply to any amounts of insurance for which you pay all or part of the premium. This also will apply to any amount that is subject to evidence of insurability requirements and Cigna approves the evidence of insurability form and the amount you or your dependent applied for at that time.

If Your Claim is Denied

Disagreements about benefit eligibility or payment amounts may arise occasionally. In most cases, differences can be resolved quickly with a phone call. If you have questions regarding benefit payment amounts, please contact Cigna as soon as possible. If you have questions regarding eligibility to participate in the plan or amount of coverage, please contact PeoplePlace as soon as possible. If you can't resolve the disagreement, formal appeal procedures are in place. See the [Administrative & General Information](#) section for details.

IF YOU LEAVE BAYLOR SCOTT & WHITE HEALTH

If you leave Baylor Scott & White Health for any reason, including retirement, your life insurance coverage ends on the last day of the month in which you terminate. Your paycheck deductions for Voluntary, Spouse and Child(ren) Life Insurance coverage will continue and include any hours accredited through your final paycheck.

Converting Coverage to an Individual Policy

If you would like to continue your coverages, you may be eligible to convert your Basic and Voluntary Life Insurance coverage to an individual policy. To convert your coverage, you must apply for the coverage with Cigna and pay the initial premium within 62 days following the date your coverage through Baylor Scott & White Health ends. Coverage conversion is limited to the amount of coverage in effect at the time of conversion. Contact PeoplePlace for information on how to convert your Life Insurance coverage and for coverage details.

Electing Portability Coverage

Another option might be to “port” your coverage. If you leave Baylor Scott & White Health for any reason prior to retirement and/or prior to age 70 you are no longer benefit eligible, you may be eligible to continue your Basic Life Insurance, Voluntary Life Insurance and Dependent Life Insurance coverage under a group portability policy. To elect portability, you must apply for coverage with Cigna and pay the initial premium within 62 days following the date your coverage through Baylor Scott & White Health ends.

You may elect to port the amount of coverage you had on the date your employment ended, up to the following limits:

- Employee (combined Basic and Voluntary life) - \$750,000
- Spouse - 100% of your amount up to \$250,000
- Child - 100% of your amount up to \$10,000

Portability Age reductions for Employee and Spouse are as follows:

- 65% at age 65
- 50% at age 70

Contact Cigna at 1-800-547-5515.

Accidental Death and Dismemberment Coverage

Accidental Death and Dismemberment (AD&D) coverage gives you and your family financial protection if there is an injury or death due to an accident.

PLAN HIGHLIGHTS

- Baylor Scott & White Health provides Basic AD&D coverage at no cost to you, equal to a multiple of your annualized base pay, up to a maximum based on your eligible employee class:
 - **Class 1** – Senior Executives – 3 times your annual compensation or \$1,500,000
 - **Class 2** – All benefit eligible employees (not eligible in another class) – 1 times your annual compensation or \$500,000
 - **Class 3** – Physicians – 1 times your annual compensation or \$1,000,000
- You can choose to purchase additional AD&D coverage for yourself or your dependents.
- Special additional benefits may be available if a covered death occurs.

PARTICIPATING

If you're a regular, full-time employee or a part-time employee regularly scheduled to work at least 40 hours per pay period, you are immediately eligible to enroll in AD&D coverage. You may also cover your spouse and eligible dependent children under the plan. See the [A Guide to Your Benefits](#) section for more details about who can and cannot participate in the plan.

When you are hired or become eligible for benefits, you are automatically enrolled in Basic AD&D coverage. You must enroll in Voluntary AD&D coverage within 30 days from the date of your employment or if later, the date of your initial eligibility. If you do not enroll by the deadline date, you must wait until the next annual enrollment period to enroll in the plan, unless you experience a qualifying event. If you are not actively at work due to a physical or mental condition on the day your coverage would normally become effective, coverage for you and your dependents starts as soon as you have been at work for one full day.

Each year during annual enrollment, you may change your coverage for the next calendar year. The election you make is effective the following Jan. 1 and remains in effect for the entire year. You cannot make changes to your elections during the year unless you experience a qualifying event. See the [A Guide to Your Benefits](#) section for more information about enrolling, qualifying events and when coverage begins and ends.

PAYING FOR COVERAGE

Your cost for coverage depends on the options you choose. Baylor Scott & White Health pays the full cost of Basic AD&D coverage but you pay the cost for Voluntary AD&D coverage. Prices may change each year.

When you enroll, your share of the cost for coverage will be deducted from your paycheck beginning with the first available paycheck after you enroll. Your cost is generally deducted from each paycheck during the year and is deducted on an after-tax basis. The amount deducted is part of your taxable wages before federal income and Social Security taxes are withheld. See the [A Guide to Your Benefits](#) section for more information about paying for benefits.

Your coverage amount and payroll deductions automatically change when your base salary changes. However, if you are not at work on the date your pay changes, your increase in coverage will be delayed until you return to your regularly scheduled work.

BASIC AD&D INSURANCE

Basic AD&D coverage is free for you and equals a multiple of your annualized base pay (based on authorized hours in a primary position), rounded to the next higher \$1,000, up to the defined maximum based on your eligible life class.

Annualized Base Pay

“Annualized Base Pay” means your gross annual income from your Employer in effect just prior to your date of loss. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, shift differential or any other extra compensation, or income received from sources other than your Employer.

If you are a commissioned employee with one or more years of service, “Annualized Base Pay” also includes income actually received from commissions. Commissions will be based on the period of September 1st through August 31st of the previous year immediately prior to the date of the loss. The calculated amount will be frozen as of August 31st and will be used to determine your annual earnings for the following calendar year.

VOLUNTARY AD&D INSURANCE

You can purchase Voluntary AD&D coverage in order to provide extra AD&D coverage for yourself. The following Voluntary AD&D coverage options are available to you:

- 1 times annualized base pay
- 2 times annualized base pay
- 3 times annualized base pay
- 4 times annualized base pay
- 5 times annualized base pay
- 6 times annualized base pay
- 7 times annualized base pay

You pay a flat rate for each \$1,000 of Voluntary AD&D coverage you select. The maximum amount of Voluntary AD&D coverage you can have is:

- Class 1: \$5,000,000
- Class 2: \$2,000,000
- Class 3: \$5,000,000.

What is Annual Base Pay?

“Annual Base Pay” means your gross annual income from your Employer in effect just prior to your date of loss. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, shift differential or any other extra compensation, or income received from sources other than your Employer.

If you are a commissioned employee with one or more years of service, “Annual Base Pay” also includes income actually received from commissions. Commissions are calculated for the period 9/1-8/31 of the previous year immediately prior to the date of loss. (The calculated amount is frozen as of 8/31 and used to determine annual earnings for the following calendar year.)

AD&D INSURANCE

The chart below shows the death benefit for each eligible dependent. Your cost is a flat rate per \$1,000 of coverage.

For your dependent...	You may elect coverage in one of the following amounts...
Spouse	\$10,000, \$25,000, \$50,000, \$75,000, \$100,000, \$125,000, \$150,000, \$175,000, \$200,000, \$225,000, or \$250,000 Not to exceed 100% of the employee approved amount
Child(ren)	\$10,000 per eligible child

If you and your spouse both work for Baylor Scott & White Health and both are eligible for benefits, your spouse cannot be covered under Spouse AD&D coverage. Only one of you may enroll your child(ren) for Child AD&D coverage.

ELIGIBLE CHILDREN

Eligible children include any child from live birth to age 26 who is:

- Your natural child
- Your stepchild born to the Employee's spouse provided the child is living with, and is financially dependent upon the employee
- Your legally adopted child, beginning with any waiting period pending finalization of child's adoption,
- The legally adopted child of the Employee's spouse provided the child is living with, and is financially dependent upon the employee
- Your grandchild who is your dependent for tax purposes,
- A child for whom you are required to provide medical support under court order, or
- Child for whom the Employee is the Court Appointed legal guardian and who resides with and is financially dependent on the employee
 - If your dependent AD&D insurance coverage ends when he or she no longer meets the eligibility requirements (for example, by turning age 26, you must contact PeoplePlace to drop dependent AD&D insurance coverage. Your level of coverage will not change automatically.

Any child age 26 or older and disabled* who:

- Is primarily dependent on you for financial support and maintenance and
- Incapable of self-sustaining employment by reason of mental or physical incapacity

* You must submit satisfactory proof of disability to Cigna.

DISABLED means that, as a result of an injury, a sickness or a disorder:

1. Inability of a covered person who is currently employed to do any type of work for which he is or may become qualified by reason of education, training or experience; or
2. Inability of a covered person who is not currently employed to perform all of the activities of daily living including eating, transferring, dressing, toileting, bathing, and continence, without human supervision or assistance

If you or your eligible dependent are not in active service on the date coverage would normally begin, coverage will begin on the later of the date you or your eligible dependent return to active service and the date the coverage would otherwise have become effective. This provision does not apply to a newborn child while dependent insurance is in effect.

AGE REDUCTION

The amount of AD&D insurance available to you and your spouse reduces at certain ages while insured:

- If you have reached age 65, but not age 70, you and your spouse's amount of AD&D insurance will be 65% of the amount of AD&D insurance you had prior to age 65.
- If you have reached age 70 or more, you and your spouse's amount of AD&D insurance will be 50% of the amount you had prior to the first reduction.
- No further increases in your or your spouse's amount of AD&D insurance are available once you reach age 65.

WHAT THE PLAN COVERS

The plan pays benefits if you or a covered family member either dies or experiences an eligible injury due to an accident while insured.

Who Receives Payment

If you or a covered family member experiences an eligible injury while insured, the plan pays a benefit to you. If you or a covered family member dies due to a covered accident, the plan pays a benefit to the appropriate beneficiary. You are automatically the beneficiary for any Family AD&D coverage you elect.

Naming a Beneficiary

You are required to name a death beneficiary when you first become eligible for coverage. Your beneficiary can be an individual(s), trustee or estate. You may name anyone as your beneficiary, and you may change your beneficiary at any time by going to PeoplePlace.

You are automatically the beneficiary in the case of the death of your covered dependents. This beneficiary designation may not be changed.

Covered Losses

The chart below shows the plan benefit paid if you or a covered family member suffers accidental injuries resulting in death or a covered loss within one year of an accident. If you experience more than one loss in an accident, you will receive the largest single amount payable. All coverage amounts are subject to applicable maximum dollar amounts.

For Loss of:	Plan Pays This Percentage of the Coverage Amount
Life	100%
Both hands or both feet	100%
Entire sight in both eyes	100%
One hand and one foot	100%
One hand and the entire sight in one eye	100%
One foot and the entire sight in one eye	100%
One hand or one foot	50%
Speech and hearing in both ears	100%
Entire sight in one eye	50%
Speech or hearing in both ears	50%
Quadriplegia (total paralysis of both upper and lower limbs)	100%
Paraplegia (total paralysis of both lower limbs)	75%
Hemiplegia (total paralysis of upper and lower limbs on one side of the body)	50%
Uniplegia	25%
Thumb and index finger of the same hand	25%
Uniplegia	25%

For Loss of:	Plan Pays This Percentage of the Coverage Amount
Four fingers (on the same hand)	25%
All toes (on the same foot)	20%

Injuries due to exposure to the elements will be considered eligible injuries for payment of benefits if the exposure results from a covered accident. You or a covered dependent will be presumed to have died and a death benefit will be payable if the body is not found within one year after the wrecking, sinking or disappearance of a conveyance in which you, he or she was traveling, and would otherwise be covered.

ADDITIONAL BENEFITS

The Voluntary AD&D plan also pays a number of special benefits.

Education Benefit

Dependent Child(ren)

If you elect dependent AD&D coverage and then you die in a covered accident, your covered dependent child(ren) may receive some education benefits in addition to your AD&D benefits. Each covered dependent child may receive reimbursement for tuition if the child is:

- Currently enrolled as a full-time student in any institution of higher learning beyond the 12th grade, or
- Currently a 12th grade student and enrolls in an institution of higher learning within 365 days of the covered accident.

The annual benefit is payable for up to four years, provided the dependent remains in school. The annual benefit amounts are:

- 6% of the Employee's principal sum for Dependent Child coverage not to exceed \$6,000, up to four payments to a maximum of \$24,000

Spouse

If you elect Spouse Voluntary AD&D coverage and then die in a covered accident, your covered spouse may be eligible for the Spouse Training benefit. Eligible reimbursement includes the cost of any professional or trade-training program assisting the development of an independent source of support and maintenance. Your spouse must enroll in the program within three years following your date of death. The benefit amount is:

- 5% of the Employee's AD&D amount not to exceed \$5,000

Child Care Benefit

If a covered dependent is under age 13 and is enrolled in an accredited day care center within 90 days from the date of the covered accident, the plan will pay an annual day care benefit

for up to four years. The annual benefit will be the lesser of these amounts:

- \$3,000 per child each year, or
- 5% of the AD&D coverage amount of the deceased parent.

Seat Belt Benefit

If you or your covered dependent sustains an injury in an automobile accident that results in payment of an AD&D benefit under this plan, an additional amount is paid if a police accident report states that the injured covered individual was wearing a seat belt when the accident occurred. The additional benefit for you is equal to 10% up to \$25,000 of your AD&D coverage.

Air Bag Benefit

If a seat belt benefit is payable, an air bag benefit is also payable if the injured person was:

- Positioned in a seat equipped with a factory-installed air bag, and
- Properly strapped in the seat belt when the air bag inflated.

The additional benefit is 5% up to \$5,000 of your AD&D coverage.

Coma Benefit

The plan pays a monthly benefit up to 1% of you or your dependent's AD&D coverage amount for each month up to 11 months if you or a covered family member remain in a coma after a 31-day waiting period if you or your covered family member meets both of the following conditions:

- Become comatose within 31 days of the date of the accident, and
- Remain continuously comatose for at least 31 days.

Accidental Burn and Disfigurement Benefit

The plan pays a benefit if a covered person suffers a covered injury that leaves them Disfigured, and that covered injury resulted directly and independently of all other causes from a covered accident. The Disfigurement must satisfy all of the conditions below. Disfigurement for purposes of this benefit means a spoiled or deformed appearance that can be corrected by means of reconstructive or cosmetic surgery.

- Reconstructive or cosmetic surgery is required to restore the covered person's physical abilities or correct Disfigurement, and must be performed within twelve months of the covered accident
- A Physician must determine that the burn satisfies all of the following:
 - Involves the minimum percentage shown in the Schedule of Benefits;
 - Be classified as shown in the Schedule of Benefits; and
 - Results in Disfigurement or loss of physical abilities

Bereavement and Trauma Counseling

The plan will pay for counseling sessions, up to the maximum

benefit amount shown in the Schedule of Benefits and subject to the following conditions and exclusions, when the covered person or immediate family member (a person who is related to the covered person in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent, step-parent, brother, sister, step sibling, child or step-child) required bereavement and trauma counseling because the covered person suffered a covered loss that resulted directly and independently of all other causes from a covered accident. Such counseling must meet all of the following conditions:

- Covered bereavement and trauma counseling expenses must be incurred within one year from the date of the covered accident causing the covered loss
- Expense is charged for a bereavement or trauma counseling session for the covered person or one or more of his immediate family members
- Counseling is provided under the care, supervision or order of a physician
- A charge would have been made if no insurance existed

Covered bereavement and trauma counseling benefits do not include any expense for which the covered person is entitled to benefits under any Worker's Compensation Act or similar law.

When Benefits Are Not Payable

In addition to any benefit-specific exclusions, benefits will not be paid for any Covered Injury or Covered Loss which, directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the Description of Benefits Section:

- Suicide, self destruction while sane, intentionally self-inflicted injury while sane, or self-inflicted injury while sane, or self-inflicted injury while insane
- Commission of or active participation in a riot or insurrection
- Commission or attempt to commit a felony or an assault
- Bungee jumping; parachuting; skydiving; parasailing; hang-gliding
- Flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface
 - except as a passenger on a regularly scheduled commercial airline
 - being flown by the Covered Person or in which the Covered Person is a member of the crew
 - being used for:
 - » crop dusting, spraying or seeding, giving and receiving flying instruction, firefighting, sky writing, sky diving or hang-gliding, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying
 - » any operation that requires a special permit from the FAA, even if it is granted (this does not apply if

the permit is required only because of the territory flown over or landed on)

- designed for flight above or beyond the earth's atmosphere
- an ultra-light or glider
- being used for the purpose of parachuting or skydiving
- being used by any military authority, except an Aircraft used by the Air Mobility Command or its foreign equivalent
- Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food
- a Covered Accident that occurs while engaged in the activities of active duty service in the military, navy or air force of any country or international organization. Covered Accidents that occur while engaged in Reserve or National Guard training are not excluded until training extends beyond 31 days
- in addition, benefits will not be paid for services or treatment rendered by a Physician, Nurse or any other person who is:
 - employed or retained by the Policyholder
 - providing homeopathic, aroma-therapeutic or herbal therapeutic services
 - living in the Covered Person's household
 - a parent, sibling, spouse or child of the Covered Person
- The use of any prescription or non-prescription drug, poison, fume, or other chemical substance unless used according to the prescription or direction of your or your dependent's physician. This exclusion will not apply to you or your dependent if the chemical substance is ethanol.
- Disease of the body or diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders
- Operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Covered Person has been provided a written warning against operating a vehicle while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Accident occurred
- War, declared or undeclared, or any act of war

APPLYING FOR BENEFITS

You or your beneficiary should notify PeoplePlace, as soon as possible after a covered person dies. PeoplePlace will forward information to Cigna for processing. Cigna will mail instructions to the beneficiaries requesting written proof of death (Death Certificate from a government agency) and any additional information needed for processing.

If a claim is approved, plan benefits generally are paid in a lump sum.

If there is no beneficiary on record or if no named beneficiary survives you, your benefits will be paid to following individuals in the following order of priority:

- Your spouse
- Your child(ren) (in equal shares)
- Your parent(s) (in equal shares)
- Your siblings (in equal shares)
- The executors or administrators of your estate

The insurance carrier — not Baylor Scott & White Health — is responsible for the actual coverage and the AD&D benefits they provide or arrange. All appeals regarding benefits must be made directly to them. The insurance carrier has the final authority on matters relating to AD&D benefits. Contact the insurance carrier directly for:

- Appeal of denied claims
- Rights to reimbursement and subrogation when payments are available from other insurance sources or legal settlements (including auto insurance)
- Any other benefit or administrative issues

IF YOUR CLAIM IS DENIED

Disagreements about benefit eligibility or payment amounts can occasionally arise. In most cases, differences can be resolved quickly with a phone call.

If you have questions regarding benefit payment amounts or benefits covered, please contact the insurance carrier as soon as possible. If you have questions regarding eligibility to participate in the plan, please contact PeoplePlace as soon as possible.

If you can't resolve the disagreement, formal appeal procedures are in place for your use.

Appeal Process If a Benefit Is Denied

If all or part of a benefit is denied, you, your beneficiary or your legal representative must submit a written appeal of the denial directly to the insurance carrier. Please see the All Other Claims section of the appeals procedure in the [Administrative & General Information](#) section for more details.

Appeal Process If Eligibility for Participation Is Denied

If your claim is for a determination as to your eligibility or your dependent's eligibility to participate in the plan, you must submit it in writing to PeoplePlace. Your claim will be determined by the Benefit Plan Administrator of Baylor Scott & White Health. The decision of the Benefit Plan Administrator will be final and will not be subject to review. All determinations as to eligibility to participate in the plan made in connection with a claim for benefits under the plan will be made in accordance with the claims procedure described above. See the [Administrative & General Information](#) section for more information.

IF YOU LEAVE THE COMPANY

If you leave the Company, your AD&D coverage ends on the last day of the month in which you terminate employment. Your Voluntary AD&D paycheck deductions continue and include any hours accredited through your final paycheck.

Electing Conversion Coverage

If your employment or eligibility with the Company end or you are under the age of 70, you are eligible to continue your AD&D coverage under a conversion policy. Eligible dependents covered on this policy the day this coverage ceases may also port coverage to a group portability policy. This portability election does not require a medical examination. To port your coverage, you must apply for the ported group policy with the insurance carrier and pay the initial premium within 30 days following the date your coverage ends.

To elect portability, you must apply for coverage with Cigna and pay the initial premium within 62 days following the date your coverage through Baylor Scott & White Health ends.

You may apply for an amount of coverage that is:

- In \$1,000 increments;
- not less than \$25,000, regardless of the amount of insurance under the group policy; and
- Not more than the amount of insurance he had under the group policy, except as provided above, up to a maximum amount of \$250,000

Contact PeoplePlace for information on how to convert your coverage and for coverage details.

Disability Coverage

Disability benefits help protect your income if you have an illness or injury that keeps you from working.

PLAN HIGHLIGHTS

- If you enroll in the STD benefit timely, you will be eligible for STD benefits as of your hire date.
- STD benefits begin after you have been absent from work for a non-occupational illness, injury or pregnancy for seven consecutive calendar days.
- You become eligible for LTD benefits after you have been disabled (as defined by the plan) for 180 consecutive days. Benefits may continue for as long as you remain totally disabled (as defined by the plan) up to normal retirement age. See the chart on [page 114](#).
- Baylor Scott & White Health pays the full cost of Basic LTD coverage and you are automatically enrolled as of your hire date.
- In addition to the Company paid Basic LTD benefit, you may purchase Voluntary STD coverage and/or Voluntary LTD buy-up coverage. You pay the full cost of both voluntary disability plans. Voluntary LTD buy-up is paid on an after-tax basis and STD benefits are paid pre-tax.

- Continuously unable to perform the material and substantial duties of your regular occupation as a direct result of a non-work related injury, illness or pregnancy
- Unable to earn more than 80% of your covered earnings from working in your regular occupation
- Receiving appropriate care and treatment for your condition from a licensed medical provider, and
- Not working for pay in any occupation for an employer, other than Baylor Scott & White, for which you are or become qualified by education, training or experience.

If you are required to have a professional license or certification for your occupation, loss of the professional license or certification does not by itself qualify as a disability.

Who Can Participate

See the [A Guide to Your Benefits](#) section for information about who can and cannot participate in the plan.

SHORT-TERM DISABILITY (STD)

Short-Term Disability (STD) coverage provides income replacement if you suffer a non-work related injury, illness or pregnancy that prevents you from performing the material and substantial duties of your regular occupation for more than seven consecutive calendar days. STD benefits are payable for up to 180 calendar days as long as you continue to be disabled. The date you are considered disabled is the first missed scheduled date of work due to a “disability” as defined by this Plan. For purposes of this plan, “disabled” means you are:

Benefit Amount and Overview

Your benefit amount will vary based on the benefit plan for which you are eligible, after you have satisfied a seven consecutive calendar day elimination period.

STD Plan Name	Benefit Percentage	Duration	Maximum Weekly Amount
STD Plan	60%	Day 8 – 180 (calendar days)	\$3000
Physician CTX STD Plan	100%	Day 8 – 90 (calendar days)	N/A
	60%	Day 91 – 180 (calendar days)	
Maternity Leave Plan*	100%	5 weeks	N/A
Parental Leave Plan**	100%	1 week	N/A
Adoption Leave Plan**	100%	3 weeks	N/A

* *Maternity Leave Plan applies to any female employee who initiates a continuous leave due to childbirth and elected STD coverage. The benefit will begin as of the child's date of birth assuming the seven consecutive calendar day elimination period has already been met and will continue for up to five(5) weeks, which will count toward the 180 calendar day maximum entitlement under the STD Plan, should additional maternity disability time be required. Eligible employees may not receive more than 100% of the base salary when the maternity and the short-term disability plan benefits are added together.*

** *An employee must have elected STD coverage and be enrolled in the plan before the date of birth or placement in order to be eligible for the Parental and Adoption leave benefits. The parental leave is only applicable to the non-birthing parent of the newborn and the adoption leave is only applicable to the adoptive parent who legally adopts a child (not biologically related to either parent) under the age of 18. Time must be taken all at once on a continuous basis, and employees will be required to satisfy a seven (7) consecutive calendar day elimination period before any paid benefit is issued. Employees may use the benefit within the first twelve (12) months of the child's birth or adoption.*

When STD Benefits Begin and How They Are Paid

You are eligible to begin receiving STD benefits on the eighth consecutive calendar day that you are disabled.

For any work you miss during the first seven consecutive calendar days you are disabled, you must use your Paid Time Off (PTO) benefit. You will only be paid during this seven day period to the extent of your unused PTO up to your standard hours. If PTO is not available or exhausted, this time may be absent without pay.

STD benefits are paid through the Baylor Scott & White Health time and attendance system for each scheduled day approved. If you are eligible for benefits for only part of a work week, your benefits will be prorated based on your work schedule reported at the time of your claim. These benefits are taxable when you receive them assuming you elected the STD coverage. If you receive an STD benefit less than 100% of your base pay, you are required to supplement that STD benefit with any available PTO.

When Benefits End

Your STD benefit payments end at the earliest of:

- The date you are no longer disabled as defined by the plan
- The date you fail to provide satisfactory proof of your continuing disability
- The date you are no longer under the continuing care of a doctor
- The end of the 180-day benefit period (which includes a seven calendar day waiting period prior to the commencement of benefits)
- The date the Plan is canceled
- The date You are no longer an eligible regular Full-Time Staff Member or Part-Time Staff Member
- The last day you are in active employment, or
- Your death

If you are still disabled after 180 days, you may be eligible to continue receiving disability payments through the Long-Term Disability (LTD) plan. See [page 113](#) for more information.

Disability Payments from Other Sources

Your STD plan is one of several sources that could pay benefits while you're disabled. Your STD benefit from this plan is based on your pre-disability weekly base pay, less any other sources of income you receive. It works together with other sources to replace 60% of the base weekly pay you were earning before you became disabled. This means that benefits you receive from the following sources may be deducted from your gross weekly STD benefit:

- [Baylor Scott & White Health Safe Choice](#)
- [Social Security Disability and Retirement benefits, including any benefit for which your dependents are eligible due to your disability or retirement](#)
- [Veterans Administration](#)
- [An occupational disease act or law](#)
- [Pay you receive from a rehabilitation program or modified work duty program](#)
- [No-fault auto motor vehicle coverage](#)
- [Any other state or government agency providing similar benefits](#)
- [Compensation you receive if you suffer a disability because of the act or omission of a Third Party*](#)

**What are Baylor Scott & White's subrogation rights?*

If You:

1. *suffer a Disability because of the act or omission of a Third Party;*
2. *become entitled to and are paid benefits under The Plan in compensation for lost wages; and*
3. *do not initiate legal action for the recovery of such benefits from the Third Party in a reasonable period of time; then We will be subrogated to any rights you may have against the Third Party and may, at our option, bring legal action against the Third Party to recover any payments made by us in connection with the Disability*

What Is Not Covered

The STD plan does not pay benefits for a disability that results from:

- [A cause other than an injury, sickness or pregnancy](#)
- [War or an act of war, insurrection or rebellion, whether declared or undeclared](#)
- [Service in the armed forces of any country, except for membership in the reserves or a call to active duty for a period of less than three months](#)
- [Commission of or attempt to commit a felony in the jurisdiction in which the act occurred](#)
- [Active participation in a riot](#)
- [Intentionally self-inflicted injury or illness, or attempted suicide, whether sane or insane](#)

- Cosmetic surgery, except to correct congenital deformities or to treat a condition that results from injury or sickness (except where disability benefits are mandated by applicable law)
- Conditions that are not supported by objective medical findings, including tests, investigational treatments, procedures and clinical exams not generally accepted as standard medical practice for the disabling condition
- A disability for which you are not receiving appropriate care and treatment from a medical provider
- Working for another employer or from self-employment
- On-the-job injury or illness while you are working for Baylor Scott & White Health and all of its subsidiaries
- Pre-Existing Conditions. If You Have a Pre-Existing Condition:

Benefits will not be payable under the STD Plan for any disability that results from or is caused or contributed to by a pre-existing condition. You have a pre-existing condition if:

- You received medical treatment, medical advice, care or services including diagnostic measures, or took prescribed drugs or medicines in the three (3) months just prior to your effective date of coverage and the disability begins in the first 12 months after your effective date of coverage.
- You are exempt from limitations due to a pre-existing condition if you enroll in the plan within 30 days of hire or eligibility or were enrolled in the plan prior to 1/1/2019.

What if you have a work-related injury or illness?

The STD plan does not cover a work-related injury or illness. Disability due to a work-related injury or illness is covered by Baylor Scott & White Health Safe Choice. If you are approved for STD and you also receive benefits from Baylor Scott & White Health Safe Choice, or any other occupational disease act or law for the same disability, those benefits will offset your STD benefit, unless you are required to repay them and you do repay them. If there is uncertainty about whether your illness or injury is work-related, you may receive STD benefits while your claim is being evaluated, but if your claim is ultimately determined to be work-related and you receive work-related benefits, you must repay any STD benefits you received.

If Your Disability Recurs

If during the first six months after the end of the initial disability period you return to work and within less than 30 consecutive calendar days experience a relapse of the same medical condition for which you were previously receiving STD benefits, you will not have to complete another waiting period; benefits will resume immediately and your current disability will be treated as a continuation of the same claim, subject to the same 180-day maximum period payable.

If you experience a relapse 30 days or more after you return to work, your current disability will be treated as a new claim with a new waiting period and a new 180-day maximum period payable.

After six months from the end of the initial disability period, any disability that occurs within less than 30 consecutive calendar days (whether or not related to the prior disability) will be eligible for STD benefits only if you are disabled for longer than the waiting period of seven consecutive calendar days.

If you experience a second disability that is unrelated to your prior disability and you return to work (full-time or part-time) for less than one full day, it will be treated as part of your previous disability and you will not be required to complete another waiting period. However, if you return to work for a full day or more, it will be considered a new disability and you will have to complete a new waiting period for benefits.

Postponing Enrollment

If you do not elect STD coverage when you are first eligible, you will have to wait until the next annual enrollment period or when you have a qualifying status change. In addition, you will be subject to the pre-existing condition exclusion, as defined in the "What Is Not Covered" section of this plan.

Filing Claims

To receive STD benefits in a timely manner, it's important to follow these steps:

1. Contact your manager immediately as soon as you know you will be absent from work. All department absence policies remain in effect while you receive STD benefits.
2. As soon as you know you will be absent from work, you need to make a request for a leave of absence from work and STD benefits by contacting the Absence Center at 844-511-5762, Monday through Friday, 7 a.m. to 7 p.m., Central Time, except holidays. You may also visit www.mysedgwick.com/BSWH
3. When you file a claim for STD benefits, your physician or medical provider is required to provide information to substantiate your claim. You should contact your medical care provider so that he or she can provide an accurate and up-to-date health status report.
4. You must authorize your physician or medical provider to provide information about your medical condition to Baylor Scott & White Health. Your medical provider may require you

to provide written authorization. Once you've filed your claim for STD benefits, contact your medical provider directly and tell him or her you have filed a claim and that a designated case manager will be requesting medical information from your provider's office. Claim processing may be suspended or delayed without medical information to support your claim. You may need to stay in touch with your medical provider's office until the necessary documentation has been submitted for review and a claim decision has been rendered.

- Once your claim has been established, you can communicate directly with the Baylor Scott & White Health Absence Center.
- Claims must be filed no later than 180 days after a covered loss occurs. Claims received outside of this timeframe will be denied, unless additional time is required by law or regulation. This time limit will not apply while the person making the claim lacks legal capacity.

Expecting a baby or scheduling surgery?

To file an STD claim if you're planning to be out for childbirth or a scheduled surgery, you should submit your claim within 30 days prior to your due date or surgery date.

STD Definitions

Appropriate Care and Treatment means the determination of an accurate and medically supported diagnosis of the employee's disability by a medical provider, and a plan established by a medical provider of ongoing medical treatment and care of the disability that conforms to generally accepted medical standards, including frequency of treatment and care.

Actively Employed or Active Employment means a Staff Member who is working for an Employer for earnings that are paid regularly and who is performing the Material and Substantial Duties of his or her regular occupation. You must be working at least the number of hours per week as required by Your Employer. Individuals whose employment status is being continued under a severance or termination agreement will not be considered in Active Employment.

Disability or Disabled means, with respect to a Staff Member, that due to an Illness or Injury or a pregnancy-related condition, such Staff Member cannot perform the Material and Substantial Duties of his or her Regular Occupation, and is under the regular care of a Doctor who is practicing within the scope of his or her license during the entire period of Disability. Disability must begin while You are Actively Employed and covered under the Plan.

Approved Leave of Absence means that Baylor Scott & White Health has excused you from work solely because you are absent in accordance with (i) the employee medical, family, or discretionary leave policies of Baylor Scott & White Health; or (ii) any Baylor Scott & White Health authorized leave designed to

comply with the Family and Medical Leave Act or the Americans with Disabilities and ADA Amendment Act (ADAAA), as such are amended from time to time.

Elimination Period means a period of seven continuous calendar days which must be satisfied before You are eligible to receive benefits under the Plan.

Regular Occupation means the occupation you routinely perform at the time your disability begins. In evaluating the disability, the claims administrator will consider the duties of the occupation as it is normally performed in the general labor market in the national economy, which may differ from the work tasks that are performed for a specific employer or at a specific location.

Illness means any disorder of Your body or mind, but not an Injury. Disability must begin while You are Actively Employed and covered under the Plan.

Injury means a bodily injury that is the direct result of an accident and not related to any other cause. Disability must begin while You are Actively Employed and covered under the Plan.

Material and Substantial Duties means duties that:

- are normally required for the performance of Your Regular Occupation; and
- cannot be reasonably omitted or modified, except for example, if You are required to work on average in excess of 30 hours per week, You will be considered able to perform that requirement if You are working or have the capacity to work 30 hours per week.

You or Your means, or refers to, a person who satisfies all eligibility requirements for coverage under the Plan.

Medical Provider means a person who: (i) is legally licensed to practice medicine; or (ii) has a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction and (iii) is not related to You in any way, including but not limited to You, Your spouse, or a child, brother, sister, or parent of You or Your spouse. Such individual will not be recognized as a Doctor for a claim that You submit. You also cannot be under your own care if you are a physician. A licensed medical practitioner will be considered a Medical Provider:

- If applicable state law requires that such practitioner be recognized for the purposes of certification of disability; and
- The care and treatment provided by the practitioner is within the scope of his or her license.

LONG-TERM DISABILITY (LTD)

Long-Term Disability (LTD) coverage provides income replacement benefits if you are still disabled from an occupational or non-occupational illness or injury after the later of 180 days or the end of the Short Term Disability Benefit. Basic LTD coverage is provided by Baylor Scott & White Health at no cost to you. You may purchase Voluntary LTD coverage if you want a higher level of protection.

Benefit Amounts and Overview

Basic LTD coverage replaces percentage of your current salary when combined with any other sources of disability payment you are eligible to receive. Baylor Scott & White Health pays the full cost of this coverage.

- For non-executive employees, the core benefit is 50% of current salary when combined with any other sources of disability payment.
- For executive-level employees and physicians, the core benefit is 60% of current salary when combined with any other sources of disability payment.

You have a Voluntary LTD coverage option which replaces an additional 10% of your pay. You pay the full cost of any Voluntary LTD coverage you elect. Your LTD benefits are coordinated with any other sources of income you may receive as a result of your disability so your total benefit from all sources does not exceed the benefit percentage you are eligible to receive.

Maximum Benefits

The maximum monthly benefit depends on your employment classification.

- For non-executive employees, the maximum monthly benefit is \$15,000.
- For executive-level employees and physicians, the maximum monthly benefit is \$25,000.

When LTD Benefits Are Paid

LTD benefits become payable if:

- You become disabled while you're covered under the plan
- You are under the regular care of a physician, and
- You remain continuously disabled (as defined by the plan) during and after the 180-day waiting period.

The waiting period is the later of 180 days or the end of the Short Term Disability Benefit. During this time, you may be eligible to receive STD benefits. Your disability is considered "continuous" if you temporarily recover and return to work for less than 30 consecutive days during the waiting period. However, the days you are back at work will not count toward the waiting period. Any increases in your monthly earnings during your return to work will not be considered when calculating your LTD benefit amount.

What is "Current Salary"?

All non-commissioned employees and commissioned employees with less than 1 year of service: Covered Earnings means an Employee's gross annual income from the Employer in effect just prior to the date Disability begins. It includes the Employee's total income before taxes. It is income prior to any deductions made for pre-tax contributions to a qualified deferred Section 125 plan, or flexible spending account. It does not include income received as commissions, bonuses, overtime pay, shift differential or any other extra compensation, or income received from sources other than the Employer.

All commissioned employees with 1 or more years of service:

Covered Earnings means an Employee's gross annual income from the Employee's total income before taxes. It is income prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It includes income received as commissions but not bonuses, overtime pay, shift differential or any other extra compensation, or income received from sources other than the Employer.

Commissions will be calculated for the period of September 1st through August 31st of the previous year just prior to the date Disability begins. The calculated amount will be frozen as of August 31st and used to determine the Employee's annual earnings for the following calendar year.

How LTD Benefits Are Paid

Before LTD benefits can be paid, your disability will need to be medically verified. This may mean a medical exam by a doctor selected by the insurance company, at the Company's expense.

Age at Disability	Maximum Period of Payment
Age 62 or under	Your 65th birthday or the date the 42nd Monthly Benefit is payable, if later
63	The date the 36th Monthly Benefit is payable
64	The date the 30th Monthly Benefit is payable
65	The date the 24th Monthly Benefit is payable
66	The date the 21st Monthly Benefit is payable
67	The date the 18th Monthly Benefit is payable
68	The date the 15th Monthly Benefit is payable
69 or older	The date the 12th Monthly benefit is payable

*SSNRA means the Social Security Normal Retirement Age in effect under the Social Security Act on the Policy Effective Date.

Once the insurance company has all the necessary documentation and has approved your claim, you will receive monthly benefit payments that are paid within the month due. The insurance company will mail the check directly to you, or you may elect to have your check direct deposited into your bank account. While receiving benefit payments, you will no longer be required to make Voluntary LTD premium payments if you had previously elected this coverage.

If your LTD benefit is overpaid for any reason, the insurance company will determine how the overpayment is to be repaid. In this case, you will receive a form from the insurance company stating the reason for overpayment, the payment amount and the method for repayment.

What does it mean to be "Disabled"?

For executives

You are disabled when the insurance company determines that:

- you are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury; and
- you have a 20% or more loss in your indexed monthly earnings due to the same sickness or injury

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

For physicians

You are disabled when the insurance company determines that either:

- you test positive for an Infectious Disease (as defined below) and solely as a result of the positive results, you are restricted by a state licensing board, other governing board, or your Employer's written employment policy from performing the material duties of your regular occupation or you are required to disclose your status to patients before performing certain procedures; and
- you have a 20% or more loss in your indexed monthly earnings due to the same positive results.

Or:

- you are limited from performing the material and substantial duties of your **specialty and sub specialty occupation** due to your sickness or injury; and
- you have a 20% or more loss in your indexed monthly earnings due to the same sickness or injury

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

For all other employees

You are disabled when the insurance company determines that:

- you are limited from performing the material and substantial duties of your **regular occupation** due to your sickness or injury; and
- you have a 20% or more loss in your indexed monthly earnings due to the same sickness or injury.

After 24 months of payments, you are disabled when the insurance company determines that due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

Taxes on Your Benefits

Baylor Scott & White Health pays for your Basic LTD, which means you will pay income and Social Security taxes on any Basic LTD payments you receive. However, you pay the cost of Voluntary LTD on an after-tax basis. This means that you will not pay income or Social Security taxes on the Voluntary LTD portion of your benefit payment.

When Payments End

Benefits will end on the earliest of the following dates:

1. The date the Employee earns from any occupation, more than the percentage of Indexed Earnings set forth in the definition of Disability applicable to him or her at that time;
2. The date the Insurance Company determines he or she is not Disabled;
3. The end of the Maximum Benefit Period;
4. The date the Employee dies;
5. The date the Employee is no longer receiving Appropriate Care;
6. The date the Employee fails to cooperate with the Insurance Company in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due;
7. The date you reach the later of Social Security Normal Retirement Age (SSNRA) or the Maximum Age Limits in the chart below.

If You Have More Than One Period of Disability

You will not have to satisfy another 180-day waiting period if you recover from a disability after the waiting period, return to work and the same or a related disability recurs within six months of your return-to-work date.

If you recover from your disability, return to work and have a new disability, this second condition will be treated separately. LTD benefits will begin after a new 180-day waiting period.

Disability Payments from Other Sources

Your LTD plan is one of several sources that could pay benefits while you're disabled. Your LTD benefit from this plan is based on the definition of "current salary", less any other sources of income you receive. It works together with other sources to replace your core benefit of 50% or 60%, as well as the additional 10%, of the pay you were earning before you became disabled if you have opted to enroll in the Voluntary LTD. The insurance company has the right to require proof that you, your spouse and dependent children have filed for all other income benefits for which you or they may be eligible. You will also be required to provide proof of any income you receive from any work while receiving disability payments.

Cigna does not provide formal written notice that the employee does not need to apply for Social Security Disability Benefits. The employee would apply through our vendor advocacy service that provides Cigna updates on the status of the SSDI claim. The cases where an employee will not need to apply are: expected to return to work within a nine-month time frame, working part time and exceeding the maximum SSDI wage allowance per month, will reach full retirement age within 6 months, or they didn't meet the quarters earned to be eligible for SSDI. Cigna will refer the employee to apply for SSDI if something changes in their status by reaching out to them and starting the referral process so they can apply.

If you do not provide proof of other income sources, the insurance company may suspend or adjust benefits by an estimated amount.

This means that benefits you receive from the following sources may be deducted from your monthly LTD benefit:

- Texas Workers' Compensation or any other occupational disease act or law (Baylor Scott & White Health Safe Choice)
- Social Security disability and retirement benefits, including any benefit for which your dependents are eligible due to your disability or retirement
- Occupational accident coverage provided through Baylor Scott & White Health
- Group insurance benefits provided through Baylor Scott & White Health, including retirement plan benefits (except those attributable to your contributions) and sick leave or salary continuance provided through Baylor Scott & White Health
- Any statutory disability benefit law
- The Railroad Retirement Act
- Canada Pension Plan, Quebec Pension Plan or any other similar pension plan or act
- The Canada Old Age Security Act
- Governmental retirement system
- The Veterans Administration
- The amount you receive as disability income payments from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise
- The amount you receive as disability income payments under the Pennsylvania Motor Vehicle Financial Responsibility Law

It is your responsibility to contact the insurance company if there is a change in your disability income from other sources or if your dependents' Social Security benefits change.

Estimating Other Benefits

Unless you have completed and returned a reimbursement agreement to the insurance company regarding payments from other sources, the insurance company will estimate any other benefits it believes you are eligible to receive. Then, your payment from this plan is adjusted based on that estimated amount.

You will be reimbursed for any underpayment in your monthly benefit that results from this process. You are required to repay any overpayment as well. If you do not, the insurance company has the right to pursue legal action to recover the overpayment. You are responsible for the insurance company's legal fees and court costs if the court finds in the insurance company's favor.

If you are paid other income benefits in a lump sum or settlement, you must provide proof satisfactory to the insurance company of:

- The amount attributed to loss of income, and
- The period of time covered by the lump sum or settlement.

The insurance company will pro-rate the lump sum or settlement over this period of time. If you cannot or do not provide this information, the insurance company will assume the entire sum to be for loss of income, and the time period to be 24 months. The insurance company may make a retroactive allocation of any other retroactive income benefit. A retroactive allocation may result in an overpayment of your claim, which would require you to repay the amount of the overpayment you received.

LTD Benefit Payment Examples

Example 1: In this example, let's assume you have Basic LTD coverage only and you earn \$30,000 annually, or \$2,500 per month ($\$30,000 \div 12 \text{ months} = \$2,500$). Let's assume you are also eligible for a Social Security disability benefit equal to \$600 per month. Here's how your monthly benefit from the Baylor Scott & White Health plan is calculated:

Monthly pay	\$2,500
LTD plan replacement percentage	x 50%
Total replacement amount	\$1250
Social Security disability payment	– \$600
Total LTD benefit from the insurance company	\$ 650

Example 2: Assume you elected Voluntary LTD coverage with the extra 10% benefit (60% total income replacement when combined with Basic LTD) and earn \$48,000 annually (\$4,000 monthly). You are eligible for a \$1,000 monthly benefit from Social Security disability. Here's how your monthly benefit from is calculated:

Monthly pay	\$4,000
LTD plan replacement percentage	x 60%
Total replacement amount	\$2,400
Social Security disability payment	– \$1,000

Total LTD benefit from the insurance company \$1,400

What Is Not Covered and Limitations on Benefits

Certain events (listed below) may affect your LTD benefit amount.

If You Have a Pre-Existing Condition

Benefits will not be payable under the Basic or Voluntary LTD Policy for any disability that results from, or is caused or contributed to by a pre-existing condition. You have a pre-existing condition if:

For executives and physicians:

- You incurred expenses, received medical treatment, care or services including diagnostic measures, or took prescribed drugs or medicines in the 6 months just prior to your effective date of coverage and the disability begins in the first 12 months after your effective date of coverage.
- This also applies to any increase in your coverage made at annual enrollment or change in status.

For all other employees:

- You incurred expenses, received medical treatment, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage and the disability begins in the first 12 months after your effective date of coverage.
- This also applies to any increase in your coverage made at annual enrollment or change in status.

If You Have a Mental Illness

If you are totally disabled due to a mental or emotional illness or disorder, including substance abuse, LTD benefits are payable as follows:

- Benefits may continue for as long as you are confined in a hospital or other facility licensed to provide medical care for the disabling condition, or
- If not confined, or after you are discharged and still disabled, for a total of 24 month(s) for all such disabilities during your lifetime.

The LTD plan does not pay benefits for a disability that is caused by, contributed to by, or resulting from:

- Pre-existing conditions
- War or an act of war, whether declared or undeclared
- Active participation in a riot
- Commission of a felony
- Loss or restriction of a professional license, occupational license or certification unless otherwise covered by the LTD plan
- Suicide, attempted suicide, or self-inflicted injury while sane or insane
- No benefit will be paid for any period of disability during which you are incarcerated.

Additionally, you will not receive benefit payments if:

- Baylor Scott & White Health is willing to make reasonable modifications to allow you to return to your regular job with a loss of income no greater than 20% of your pre-disability earnings, but you refuse to return to work.

Special Benefit Provisions

The LTD plan offers special benefits to help assist you financially in certain situations. Contact the insurance company for more information on these benefits:

- The **Worksite Modification Benefit** helps you and Baylor Scott & White Health identify worksite modifications that will allow you to return to work.
- The **Vocational Rehabilitation Service** helps provide job modification, retraining, placement or other activities so that you can find a job in another position or occupation. This benefit is available when your disability prevents you from performing your regular occupation.
- **Social Security Assistance** provides an advocate to help you apply for and secure Social Security disability benefits when the insurance company determines that Social Security benefits may be available for you.
- Child Care Benefit, if:
 - You are a participant in an approved rehabilitation program and
 - You have a dependent child;
 - This benefit payable under this plan may be increased starting after the first 6 months of a disability. In no event will the increase in any one month be more than:
 - » \$350 for each dependent child; or
 - » \$1,000 per month for all dependent children expenses combined

Postponing Enrollment

If you do not elect Voluntary LTD when you are first eligible, you will have to wait until the next annual enrollment period or enroll when you have a qualifying change in status.

Filing Claims

It is important that you file your claim for LTD benefits before the end of the 180-day waiting period for benefits so the insurance company can make a timely decision. If you file an STD claim, the information from that claim will automatically be transferred to your LTD claim.

Written Proof of Loss

The insurance company will provide you with the necessary claim forms within 15 calendar days of being notified in writing of your disability. You and your doctor must complete and sign the claim form. You will have met the requirements for written proof of loss when the insurance company receives written information describing the occurrence, extent and nature of your disability (see below).

The following items, supplied at your expense, must be a part of your proof of loss. Failure to do so may delay, suspend or terminate your benefits.

- The date, cause and prognosis of your disability
- Proof that you are receiving appropriate and regular care for your condition from a doctor who is someone other than you or a member of your immediate family, whose specialty or expertise is the most appropriate for your disabling condition(s)
- Objective medical findings which support your disability, including restrictions and limitations that are preventing you from performing your regular occupation
- Appropriate documentation of your monthly earnings; if applicable, regular monthly documentation of your disability earnings. If you were contributing to the premium cost by electing Voluntary LTD coverage, Baylor Scott & White Health must supply proof of your appropriate payroll deductions.
- The name and address of any hospital or healthcare facility where you have been treated for your disability, and
- If applicable, proof of incurred costs covered under other benefits included in this plan.

Continuing Proof of Disability

You may be asked to submit proof that you continue to be disabled and are continuing to receive care from a doctor at the insurance company's request. This will be at your expense and must be received within 30 calendar days of the request. Failure to do so may delay, suspend or terminate your benefits.

Required Authorization and Documentation

As part of your LTD benefits claim, you are required to supply the following:

- Signed authorization for the insurance company to obtain all reasonably necessary medical, financial or other non-medical information that supports your claim. Failure to submit this information may deny, suspend or terminate your benefits.
- Proof that you have applied for other disability income benefits such as Worker's Compensation or Social Security disability benefits, when applicable.
- Notification when you receive or are awarded other disability income. You must provide the insurance company with the nature of the income benefit, the amount received, the period to which the benefit applies and the duration of the benefit, if it is being paid in installments.

Fraud

Any person who files an application for insurance or statement of claim containing intentionally false information, or conceals for the purpose of misleading, information concerning any fact, commits an insurance fraud. This is a crime and may subject the person to criminal and civil penalties. Such penalties include, but are not limited to: fines, denial or termination of insurance benefits, recovery of any amounts paid, civil damages, criminal prosecution and confinement in state prison.

If Your Claim Is Denied

Disagreements about benefit eligibility or payment amounts may arise occasionally. In most cases, differences can be resolved quickly with a phone call. If you have questions regarding payment amounts, please contact the insurance company as soon as possible. If you have questions regarding eligibility to participate in the plan or amount of coverage, please contact PeoplePlace as soon as possible. If you can't resolve the disagreement, formal appeal procedures are in place. See the [Administrative & General Information](#) section for details.

Other Benefits

Baylor Scott & White Health offers you other benefits for protection and support, whether you're on the job or away from work.

PLAN HIGHLIGHTS

- The Employee Assistance Program (EAP) gives you access to advice about a variety of issues.
- Group Business Travel and Accident Benefits cover you if you are injured or die in an accident while traveling on company business.
- The Legal Services Plan provides access to legal advice and representation at reduced costs.
- Employee-Paid Accidental Injury insurance helps you pay out-of-pocket costs that you may incur after an accidental injury.
- Employee-Paid Critical Illness insurance provides a cash benefit if you are diagnosed with certain critical illnesses.

For information on additional benefit programs or details, see the [Administrative & General Information](#) section or individual benefit sections of this booklet.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The Baylor Scott & White Health EAP is a free, confidential service available to you and your family members. This program provides brief, solution-focused counseling and referrals for a variety of work and life issues. You and your family members can access the program 24 hours a day, 365 days a year.

The EAP is available free of charge to all Baylor Scott & White Health employees and their eligible dependents. You can receive up to three face-to-face visits per issue with an EAP provider each year at no cost to you. You must call the Employee Assistance Program (EAP) line at 1-800-538-3543 prior to seeking treatment.

Telephone consultations with financial and legal advisors are also offered free of charge. You may receive referrals to community resources and other programs, if appropriate. Your personal information is not shared with Baylor Scott & White Health. The EAP benefit is fully paid by Baylor Scott & White Health.

Eligibility

When you are hired, you are automatically enrolled in the EAP. Your spouse and eligible dependent children are also immediately eligible to participate, and you may access your benefits at any time. See the [A Guide to Your Benefits](#) section for more details about who is eligible to participate in the program.

Paying for Coverage

Baylor Scott & White Health pays for the entire cost of your EAP participation; you pay nothing. Additionally, you and your eligible dependents pay nothing for services provided directly by the EAP, provided that you call the EAP line prior to seeking treatment and use a network provider. You may receive referrals for additional services outside of the EAP, and certain services may be covered under the Baylor Scott & White Health Medical Plan. However, you are responsible for the cost of any additional services.

Plan Benefits

Help for personal challenges, big and small. Keeping your work and personal life in balance can sometimes be tricky. Stressful situations can affect your health, well-being and ability to focus on what's important. That's when you can pick up the phone and speak confidentially to a master's-level consultant who can help you or a family member to:

- Speak with financial experts by phone regarding issues such as budgeting, controlling debt, teaching children to manage money, investing for college, and preparing for retirement
- Work through complex, sensitive issues such as personal or work relationships, depression or grief, or issues surrounding substance abuse
- Get a referral to a local attorney for a free, 30-minute in-person or telephonic legal consultation

You'll have access to an attorney for state-specific legal information and services. If you decide to retain the attorney, you may be eligible to receive a 25% discount on additional services (with the exception of employment law). You also have unlimited website access at www.cingalap.com where you can:

- Find resources for child care, elder care, pet care and more
- View videos and online seminars, as well as listen to podcasts
- Find information on parenting, retirement, finances, education and more

Privacy Information

Any and all contact you or your dependents have with the EAP is strictly confidential. Employee names, records and other confidential information are not shared with the Company.

Using Your Benefits

Expert assistance and referral is just a phone call away at 1-800-538-3543. You may make your toll-free call anytime — 24 hours a day, 365 days a year.

When you call the EAP, you will speak with a trained professional who will discuss your question, problem or concern. The counselor will help you find the right resources to meet your needs.

Depending on your situation, the EAP counselor may refer you to an EAP affiliate in your community for up to three in-person visits, link you to available resources in your community or give you counseling over the phone. You pay nothing for these services and file no claims.

BUSINESS TRAVEL ACCIDENT BENEFITS

You are covered by Baylor Scott & White Health's Business Travel and Accident Benefits for additional financial protection if you are injured or die in an accident while traveling on company business. Group Business Travel and Accident coverage is in addition to Workers' Compensation insurance or Occupational Injury Plan benefits that Baylor Scott & White Health provides. This benefit is also in addition to your Accidental Death and Dismemberment (AD&D) Insurance provided by Baylor Scott & White Health (up to \$50,000) and any Voluntary AD&D benefit you elect. This plan is provided by Baylor Scott and White Health at no cost to you. References to "Baylor Scott & White Health" include Baylor Scott & White Holdings and any corporation under the control of Baylor Scott & White Holdings that has adopted this plan.

The Business Travel and Accident plan offers:

- A death benefit if you die, within one year of an accident, while on Business Travel for Baylor Scott & White Health
- A dismemberment benefit if you should lose a limb, within one year of an accident, while on Business Travel for Baylor Scott & White Health
- A disability income benefit if you should become temporarily totally disabled, within 30 calendar days of an accident, while on Business Travel for Baylor Scott & White Health
- Accidental Medical Expense benefit if you suffer an injury while on Business Travel for Baylor Scott & White Health

Eligibility

You are automatically covered, as an Insured Person, by this plan if you are:

- **Class 1 Employees:** A regular, full-time employee working 30 hours or more per week
- **Class 2:** All non-employee members of the Board of Trustees
- **Class 3 Employees:** A part-time employee of the neonatal transport team
- **Class 4:** The spouse of a primary insured person
- **Class 5:** The dependent child(ren) of a primary insured person

Effective and Termination Dates

You are automatically ineligible for this plan if:

- You terminate employment with Baylor Scott & White Health
- You are no longer in an eligible group as described above, or
- Baylor Scott & White Health terminates this plan

Termination of coverage will not affect a claim for a covered loss that occurred while this plan's coverage was in force.

Covered Travel

This plan covers you while on Business Travel for Baylor Scott & White Health. Business Travel means travel by you when you are:

- Away from your regular place of employment
- At the authorization and direction of Baylor Scott & White Health
- On business for Baylor Scott & White Health, and
- For periods of 365 days or less.

This plan covers you on trips when you leave your residence or place of regular employment (whichever occurs last) for the purpose of going on the trip. It also includes coverage for Personal Excursion, which means travel or activities that are unrelated to Baylor Scott & White Health business but coincide with Baylor Scott & White Health Business Travel. Personal Excursion is limited to any consecutive seven-day period immediately prior to, during or immediately following Business Travel. Coverage under this plan ends when you return from the trip to your residence or place of regular employment (whichever occurs first). Coverage is extended for full-time employees attending meetings on Baylor Scott & White Health premises with the Board of Trustees. Coverage is also extended to the Board of Trustees.

Plan Benefits

Hazards

The Principal Sum is the basis for calculating other benefits provided by this plan, as described below. Principal Sums for each class as referenced in the Eligibility section:

Class	Hazard	Principal Sum
1	24-Hour Business Travel All circumstances, subject to the terms and conditions of this plan, arising from and occurring while you are on Business Travel or Relocation Travel.	5 times Salary subject to a maximum of \$1,500,000 for full-time employees
1	Hijacking or Skyjacking All circumstances, subject to the terms and conditions of this plan, arising from and occurring due to, or attempts at, a Hijacking/Skyjacking and resulting exposure.	5 times Salary subject to a maximum of \$1,500,000
1	Extraordinary Commutation All circumstances, subject to the terms and conditions of this plan, arising from and occurring during commutation by you using any form of Conveyance when a strike, major breakdown or catastrophe causes the discontinuance of service of one or more public transportation systems regularly used by you for commutation.	5 times Salary subject to a maximum of \$1,500,000
1	Felonious Assault All circumstances, subject to the terms and conditions of this plan, arising from and occurring due to a Felonious Assault committed or attempted against you while you are working on Baylor Scott & White Health's premises.	5 times Salary subject to a maximum of \$1,500,000
1	Bomb All circumstances, subject to the terms and conditions of this plan, arising from and occurring if you suffer an injury caused by or resulting from a Bomb scare, Bomb search or Bomb explosion while you are on Baylor Scott & White's premises.	5 times Salary subject to a maximum of \$1,500,000
2	24-Hour Business Travel All circumstances, subject to the terms and conditions of this plan, arising from and occurring while you are on Business Travel or Relocation Travel.	\$250,000
2	Hijacking or Skyjacking All circumstances, subject to the terms and conditions of this plan, arising from and occurring due to, or attempts at, a Hijacking/Skyjacking and resulting exposure.	\$250,000
2	Extraordinary Commutation All circumstances, subject to the terms and conditions of this plan, arising from and occurring during commutation by you using any form of Conveyance when a strike, major breakdown or catastrophe causes the discontinuance of service of one or more public transportation systems regularly used by you for commutation.	\$250,000
2	Felonious Assault All circumstances, subject to the terms and conditions of this plan, arising from and occurring due to a Felonious Assault committed or attempted against you while you are working on Baylor Scott & White Health's premises.	\$250,000
2	Bomb All circumstances, subject to the terms and conditions of this plan, arising from and occurring if you suffer an injury caused by or resulting from a Bomb scare, Bomb search or Bomb explosion while you are on Baylor Scott & White Health's premises.	\$250,000

Class	Hazard	Principal Sum
3	24-Hour Business Travel All circumstances, subject to the terms and conditions of this plan, arising from and occurring while you are on Business Travel or Relocation Travel.	5 times Salary subject to a maximum of \$500,000
3	Hijacking or Skyjacking All circumstances, subject to the terms and conditions of this plan, arising from and occurring due to, or attempts at, a Hijacking/Skyjacking and resulting exposure.	5 times Salary subject to a maximum of \$500,000
3	Extraordinary Commutation All circumstances, subject to the terms and conditions of this plan, arising from and occurring during commutation by you using any form of Conveyance when a strike, major breakdown or catastrophe causes the discontinuance of service of one or more public transportation systems regularly used by you for commutation.	5 times Salary subject to a maximum of \$500,000
3	Felonious Assault All circumstances, subject to the terms and conditions of this plan, arising from and occurring due to a Felonious Assault committed or attempted against you while you are working on Baylor Scott & White Health's premises.	5 times Salary subject to a maximum of \$500,000
3	Bomb All circumstances, subject to the terms and conditions of this plan, arising from and occurring if you suffer an injury caused by or resulting from a Bomb scare, Bomb search or Bomb explosion while you are on Baylor Scott & White Health's premises.	5 times Salary subject to a maximum of \$500,000
4	Business Travel Family Hazard All circumstances, subject to the terms and conditions of this plan, to which a Dependent of a Primary Insured Person may be exposed while traveling in connection with the Primary Insured's Person's Business Travel or Relocation Travel, provided that all such travel is authorized by, and at the expense of, Baylor Scott & White Health.	\$50,000
5	Business Travel Family Hazard All circumstances, subject to the terms and conditions of this plan, to which a Dependent of a Primary Insured Person may be exposed while traveling in connection with the Primary Insured's Person's Business Travel or Relocation Travel, provided that all such travel is authorized by, and at the expense of, Baylor Scott & White Health.	\$25,000

Accidental Dismemberment and Paralysis Benefits

If you are injured in an accident that results in a covered loss, within one year after the accident, this plan will pay the percentage of the Principal Sum shown below for the following:

Accidental Loss of:	Benefit Amount
Life Death, including clinical death	100%
Speech and Hearing Permanent, irrevocable and total loss of the capability to speak; and permanent, irrevocable and total deafness	100%
Speech and Hand Permanent, irrevocable and total loss of the capability to speak; and complete severance of at least 4 fingers at or above the metacarpal phalangeal joint or at least 3 fingers and the thumb on the same hand	100%
Speech and Foot Permanent, irrevocable and total loss of the capability to speak; and complete severance of a foot through or above the ankle joint	100%
Speech and Sight of One Eye Permanent, irrevocable and total loss of the capability to speak; and permanent loss of vision of one eye	100%
Hearing and Hand Permanent, irrevocable and total deafness; and complete severance of at least 4 fingers at or above the metacarpal phalangeal joint or at least 3 fingers and the thumb on the same hand	100%
Hearing and Foot Permanent, irrevocable and total deafness; and complete severance of a foot through or above the ankle joint	100%
Hearing and Sight of One Eye Permanent, irrevocable and total deafness; and permanent loss of vision of one eye	100%
Both Hands, Both Feet or Sight Complete severance of at least 4 fingers at or above the metacarpal phalangeal joint or at least 3 fingers and the thumb on the same hand; and complete severance of a foot through or above the ankle joint; or permanent loss of vision	100%
Hand and Sight of One Eye Complete severance of at least 4 fingers at or above the metacarpal phalangeal joint or at least 3 fingers and the thumb on the same hand; and permanent loss of vision of one eye	100%
Hand and Foot Complete severance of at least 4 fingers at or above the metacarpal phalangeal joint or at least 3 fingers and the thumb on the same hand; and complete severance of a foot through or above the ankle joint	100%
Foot and Sight of One Eye Complete severance of a foot through or above the ankle joint; and permanent loss of vision of one eye	100%
Quadriplegia Complete and irreversible loss of all motion and all practical use of both arms and legs that lasts longer than 365 days	100%

Accidental Loss of:	Benefit Amount
Paraplegia Complete and irreversible loss of all motion and all practical use of both legs that lasts longer than 365 days	75%
Hemiplegia Complete and irreversible loss of all motion and all practical use of one arm and one leg on the same side of the body that lasts longer than 365 days	50%
Sight of One Eye Permanent loss of vision of one eye	50%
Foot Complete severance of a foot through or above the ankle joint	50%
Hand Complete severance of at least 4 fingers at or above the metacarpal phalangeal joint or at least 3 fingers and the thumb on the same hand	50%
Speech Permanent, irrevocable and total loss of the capability to speak	50%
Hearing Permanent, irrevocable and total deafness	50%
Uniplegia Complete and irreversible loss of all motion and all practical use of one arm or one leg that lasts longer than 365 days	25%
Thumb and Index Finger of the Same Hand Complete severance, through the metacarpal phalangeal joints, of the thumb and index finger of the same hand	25%

The accident must result from an insured hazard and covered loss must occur within one year after the accident. If you sustain more than one loss as a result of the same accident, only one amount (the largest) will be paid.

Additional Benefits

This plan will pay additional benefits for the following:

Additional Benefits	Benefit Amount
Coma If an injury causes you to lapse into a coma, subject to the terms and conditions of this plan, within 30 days of the accident; remain in a coma for 30 consecutive days; and be confined to a hospital to receive Medically Necessary treatment for coma. This Benefit Amount is subject to Maximum Payment for Multiple losses and Multiple Benefits of this plan.	1% per month of Principal Sum up to 100% of the Principal Sum <i>(The monthly payment will be made until the earliest of the date on which you die; you are no longer in a coma; or total payments equal the Maximum Amount for coma.)</i>
Carjacking If you suffer a covered loss resulting from injury due to a Carjacking. This Benefit Amount is not subject to Maximum Payment for Multiple losses and Multiple Benefits of this plan.	10% of Principal Sum up to \$25,000.

Additional Benefits

Benefit Amount

Home Alteration or Vehicle Modification

If a covered loss due to an injury requires you to incur expenses, within 18 months after injury, for Home Alteration or Vehicle Modification. This Benefit Amount is payable if: (1) a physician certifies that it is needed to accommodate your physical disability; (2) it is made by people experienced in such Home Alterations/Vehicle Modifications; (3) it is in compliance with any applicable laws or requirements for approval by the appropriate governmental authority in the jurisdiction where the services are rendered; and; (4) the expenses do not exceed the usual level of charges for similar alterations and modifications in the jurisdiction where the expenses are incurred. This Benefit Amount is not subject to Maximum Payment for Multiple losses and Multiple Benefits of this plan.

10% of Principal Sum for each (home or vehicle) up to \$50,000

Medical Evacuation & Repatriation

If your injury occurs while under a hazard and requires Medical Evacuation or Repatriation, which is ordered by a physician who certifies it is necessary to prevent death or serious deterioration of your medical condition, while you are on a covered trip which is more than 100 miles from your primary residence and lasts no more than 365 days. If your injury occurs while under a hazard and requires Emergency Medical Treatment while on a covered trip, this plan will guarantee payment of the hospital Admission Guaranty incurred for such Emergency Medical Treatment. If you are required to stay in the hospital for more than five days, due to such injury, this plan will pay the Benefit Amount for Family Travel Expenses if: you are confined to the hospital and the hospital is at least 75 miles away from your permanent residence; and all transportation arrangements for immediate family members are made by this plan's Assistance Services Administrator and are by the most direct and economical route. This Benefit Amount is not subject to Maximum Payment for Multiple losses and Multiple Benefits of this plan.

Unlimited Maximum Benefit with a Benefit Amount of \$5,000 for Hospital Admission Guaranty and a maximum of \$100 per day up to 5 days for Family Travel Expense

(The Medical Evacuation or Repatriation must be approved and arranged by this plan's Assistance Services Administrator. The Benefit Amounts for Hospital Admission Guaranty and Family Travel Expense are part of, and not in addition to, the Maximum Benefit Amount for Medical Evacuation or Repatriation shown above.)

Psychological Therapy Expense

If an injury causes you to suffer a covered Loss resulting in a physician's determination that psychological therapy is required for either you or your dependent. The Benefit Amount for this expense is payable on an excess basis to any other amounts paid or are payable by any other insurance or payment source for Medical Services or disability. This Benefit Amount is not subject to the Maximum Payment for Multiple losses and Multiple Benefits of this plan.

5% of Principal Sum up to \$25,000 or when 2 years have elapsed from the date of a covered Loss, whichever is earliest

Rehabilitation Expense

If an injury causes you to suffer a covered Loss which prevents you from performing all the duties of your regular occupation; and requires you to obtain rehabilitation, as determined by a physician and approved by this plan. The Benefit Amount for this expense is payable on an excess basis to any other amounts paid or are payable by any other insurance or payment source for Medical Services or disability. This Benefit Amount is not subject to the Maximum Payment for Multiple Losses and Multiple Benefits of this plan.

5% of Principal Sum up to \$25,000 or when 2 years have elapsed from the date of a covered Loss, whichever is earliest

Burn

If an injury causes you to be burned (third degree) by a source that is thermal, chemical, electrical or nuclear. This Benefit Amount is not subject to the Maximum Payment for Multiple losses and Multiple Benefits of this plan.

10% of Principal Sum up to a maximum of \$20,000

(This Benefit Amount is determined by multiplying the percentage of body surface actually burned by the maximum Benefit Amount shown above.)

Additional Benefits	Benefit Amount
<p>Child Care Expense If an injury causes your death and child care expenses are incurred within 365 days of your death for your Dependent Child, under the age of 13 years, or Incapacitated Dependent Child. This Benefit Amount is not subject to the Maximum Payment for Multiple losses and Multiple Benefits of this plan.</p>	5% of Principal Sum up to \$5,000 annually for each Dependent Child, with a Maximum Benefit Amount of \$25,000
<p>Education Expense If an injury causes your death and your Dependent Child is enrolled full time, or subsequently enrolls full time within 365 days of your death, at an institution of higher learning and incurs an Educational Expense. This Benefit Amount is not subject to the Maximum Payment for Multiple losses and Multiple Benefits of this plan.</p>	5% of Principal Sum up to \$5,000 annually for each Dependent Child, with a Maximum Benefit Amount of \$25,000 <i>(The Education Expense payment is limited to four consecutive years for each Dependent Child.)</i>
<p>Seat Belt and Occupant Protection Device (Air Bag) Benefit If you are injured, resulting in a covered loss, while you are operating or riding in a private passenger automobile accident; and were wearing a properly fastened, original, factory-installed seat belt; or were in a seat protected by a properly deployed Occupant Protection Device. Verification of the actual use of the seat belt and proper operation of the occupant protection device at the time of the accident must be a part of an official report of the accident or be certified, in writing, by the investigating officer(s). This Benefit Amount is not subject to Maximum Payment for Multiple losses and Multiple Benefits of this plan.</p>	10% of Principal Sum for seat belt and an additional 10% for Occupant Protection Device, with a maximum benefit of \$50,000 for both coverages <i>(If it cannot be determined whether you were using a seat belt, then an Alternate Benefit amount of \$2,000 will be paid. The Benefit Amount for the Occupant Protection Device will only be paid if the seat belt Benefit Amount is paid.)</i>
<p>Temporary Total Disability (Class I only) If you are injured, resulting in a covered loss, and if Accidental Bodily injury causes you to suffer Temporary Total Disability.</p>	\$250 per week up to a maximum of 52 weeks

Accident Medical Expense for Full-Time Employees

If you are a full-time employee and suffer an injury that requires you to first incur medical expenses for care and treatment within 30 calendar days after the accident that caused the injury, this plan will pay the reasonable and customary charges incurred for medical services received due to the injury. The reasonable and customary charges must be incurred within 365 days after the date of the accident that caused the injury. The Benefit Amount for Accident Medical Expense is payable in addition to any other applicable Benefit Amount under this plan. Payment of the Maximum Benefit Amount of \$5,000 for Accident Medical Expense is also subject to the following:

Additional Benefits	Benefit Amount
<p>Dental If, due to Accident Bodily Injury, you require dental care and treatment due to an injury as set forth above.</p>	\$5,000
<p>Physical Therapy (PT) If, due to Accidental Bodily Injury, you are not hospital confined and require diathermy, ultrasonic, whirlpool or heat treatment, adjustment, manipulation massage or any form of physical therapy and the office visit associated with such therapy due to an injury as set forth above.</p>	\$2,500
<p>Orthopedic Appliance If, due to Accidental Bodily Injury, you are not hospital confined and require orthopedic appliances or braces due to an injury as set forth above.</p>	\$1,000
<p>Transportation If, due to Accidental Bodily Injury, you require transportation to the nearest location where appropriate medical care and treatment can be provided due to an injury as set forth above.</p>	\$500

The Benefit Amounts shown above for Dental, PT, Orthopedic Appliance and Transportation are part of, and not in addition to, the Maximum Benefit Amount for Accident Medical Expense.

Medical Services (if medically necessary)

- Medical care and treatment by a physician
- Hospital room and board and hospital care, both inpatient and outpatient
- Drugs and medicines required and prescribed by a physician
- Diagnostic tests and X-rays prescribed by a physician
- Transportation, in an emergency transportation vehicle, from the location where you become injured to the nearest hospital where appropriate medical treatment can be obtained
- Dental care and treatment due to injury
- Physical therapy, including diathermy, ultrasonic, whirlpool or heat treatment, adjustment, manipulation, massage and the office visit associated with such therapy
- Treatment performed by a licensed medical professional when prescribed by a physician, if hospitalization would have been otherwise required
- Rental of durable medical equipment
- Artificial limbs and other prosthetic devices
- Orthopedic appliances or braces
- Eyeglasses, contact lenses and other vision or hearing aids

Accident Medical Expense does not apply to charges and services for:

- Which you have no obligation to pay
- Any injury where workers' compensation benefits or occupational injury benefits are payable
- Any injury occurring while fighting, except in self-defense
- Treatment that is educational, experimental or investigational in nature or that does not constitute accepted medical practice
- Treatment by a person employed or retained by Baylor Scott & White Health, or
- Treatment involving conditions caused by repetitive motion injuries or cumulative trauma and not as the result of an injury.

Temporary Total Disability Benefits for Full-Time Employees

If you are a full-time employee and suffer Temporary Total Disability as a result of an injury within 30 calendar days of the accident that caused the injury, this plan will pay a benefit after 30 calendar days of Temporary Total Disability due to that injury in any one period of disability.

The amount of the weekly benefit is \$250. The amount of the weekly benefit is accrued and payable on a monthly basis as long as you remain temporarily totally disabled due to that

injury in that period of disability. The weekly Benefit Amount for Temporary Total Disability will be paid until the earliest of the date on which: (1) you die; (2) you fail to provide this plan with satisfactory evidence of a continuing Temporary Total Disability; (3) you no longer have a Temporary Total Disability; or (4) the Maximum Benefit Period of 52 weeks has ended.

Periods of disability separated by less than 14 consecutive days of returning to work will be considered one period of disability, unless due to separate and unrelated causes. No weekly Benefit Amount for Temporary Total Disability shall be paid for any period of time for which you were not under the continuous care of a physician.

Exposure and Disappearance

If you are unavoidably exposed to the elements by reason of an accident and as a result of that exposure you suffer a loss for which a benefit is otherwise payable, the loss will be covered under the terms of this plan.

If your body has not been found within one year of a disappearance, stranding, sinking or wrecking of a Conveyance in which you were an occupant while covered by this plan, then you will be deemed to have suffered accidental death within the meaning of this plan, subject to all other terms and provisions of this plan.

Arbitration

In the event of a dispute under this plan, either the insurance carrier of this plan, you or, in the event of Loss of Life, your beneficiary, may make a written demand for arbitration. In that case, the insurance carrier of this plan and you, or, in the event of Loss of Life, your beneficiary, will each select an arbitrator. The two arbitrators will select a third. If they cannot agree within fifteen days, then either the insurance carrier of this plan or you, or, in the event of Loss of Life, your beneficiary, may request that the choice of arbitrator be submitted to the American Arbitration Association. The arbitration will be held in the State of your principal residence. Each participant shall bear the cost for arbitration and shall share equally in the cost of the umpire and the proceedings.

Claim Notice and Claim Forms

Written notice of a claim must be given to the insurance carrier of this plan within twenty days after your loss or commencement of any loss, or as soon thereafter as reasonably possible. The notice should include the Insured Person's name, this plan's name and the policy number 9906-65-60. Failure to give claim notice within twenty days will not invalidate or reduce any otherwise valid claim if notice is given as soon as reasonably possible.

You may also request claim forms, to submit to the insurance carrier of this plan, from the Risk Management Department. See the [Administrative & General Information](#) section for contact information.

Upon receipt of a written notice of a claim, the insurance carrier of this plan will send you or your designee, within fifteen days, forms for giving Proof of Loss to this plan. If such forms are not received, then you or your designee should send the insurance carrier of this plan a written description of the loss. This written description should include information detailing the occurrence, type and extent of the loss for which the claim is made.

Claim Proof of Loss

For claims involving disability, complete Proof of Loss must be given to the insurance carrier of this plan within thirty calendar days after commencement of the period for which this plan is liable. If the loss is one for which this plan requires continuing eligibility for periodic benefit payments, subsequent written proof of eligibility must be furnished at such intervals as this plan may reasonably require. Failure to furnish proof within the time required neither invalidates nor reduces any claim if notice was furnished as soon as reasonably possible and in no event later than one year after the deadline to submit complete Proof of Loss, except in the absence of your legal capacity. For all claims except those involving disability, complete Proof of Loss must be given to this plan within ninety days after the date of loss, or as soon as reasonably possible.

Claim Payment

Upon receipt of due written proof of death, Benefit Amount for your Loss of Life will be paid to the beneficiary designated by you. If you have not chosen a beneficiary or if there is no beneficiary alive when you die, then this plan will pay the Benefit Amount for Loss of Life to the first surviving party in the following order: (1) your spouse; (2) in equal shares to your surviving children; (3) in equal shares to your surviving parents; or (4) in equal shares to your surviving brothers and sisters. If none of these survive, your beneficiary will be your estate.

Upon receipt of due written Proof of Loss, payments for all losses, except loss of life, will be made to you, unless otherwise directed by you or your designee, or unless otherwise noted in this plan. If any beneficiary has not reached legal age of the majority, then this plan will pay such beneficiary's legal guardian.

Benefits payable under this plan involving disability, this plan will pay you the applicable Benefit Amount no less frequently than monthly during the period for which this plan is liable. All payments by this plan are subject to receipt of complete Proof of Loss. For all benefits payable under this plan except those for disability, this plan will pay you or your beneficiary the applicable Benefit Amount within sixty calendar days from the receipt of Proof of Loss.

Claim and Suit Cooperation

In the event of a claim under this plan, Baylor Scott & White Health, you or your beneficiary, if applicable, must fully cooperate with the insurance carrier of this plan in

their handling of the claim, including, but not limited to, the timely submission of all medical and other reports and full cooperation with all physical examinations and autopsies that they may require. If the insurance carrier of this plan is sued in connection with a claim under this plan, then Baylor Scott & White Health, you or your beneficiary must fully cooperate with them in the handling of the suit. Baylor Scott & White Health, you or your beneficiary must not, except at your own expense, voluntarily make any payment or assume any obligation in connection with any suit without their prior written consent.

Legal Action Against the Insurance Carrier of This Plan

No legal action may be brought against this plan until sixty days after the insurance carrier of this plan has been given complete Proof of Loss. No such action may be brought after three years from the time complete Proof of Loss is required to be given. No such action may be brought unless there has been full compliance with all terms of this plan. In no case will the insurance carrier of this plan be liable for benefits that are not payable under the terms of this plan or that exceed the applicable Benefit Amounts or limits of insurance of this plan.

Physical Examination and Autopsy

The insured carrier of this plan has the right and opportunity to examine by a physician approved by this plan, at its own expense, the person of any individual whose loss is the basis of a claim under this plan when and as often as it may reasonably require during the pendency of the claim, and to make an autopsy in case of death where it is not forbidden by law.

Workers' Compensation or Occupational Injury

This plan is not in lieu of and does not affect any requirements for coverage by any Workers' Compensation Act or similar law.

Plan Limitations

Maximum Payment for Multiple Losses and Multiple Benefits

For any Benefit Amount identified as subject to this provision, payment of such Benefit Amount will reduce the Principal Sum. If you are entitled to receive payment for multiple Benefit Amounts as the result of one accident, then the maximum this plan will pay for all benefits shall not exceed the Principal Sum. For any Benefit Amount identified as not subject to this provision, payment of such Benefit Amount will be in addition to any Principal Sum payable under this plan. If you suffer multiple covered losses as the result of one accident, then this plan will only pay the single largest Benefit Amount applicable to all such covered losses.

Aggregate Limits of Insurance

If more than one Insured Person suffers covered loss in the same accident, then this plan will not pay more than the following Aggregate Limits:

- \$15,000,000 per accident
- \$10,000,000 per Felonious Assault hazard
- \$10,000,000 per Bomb hazard
- \$3,000,000 per Aircraft accident
- \$10,000,000 per War Risk accident

The Aggregate Limit per Aircraft accident and hazard is a sublimit. It is part of, and not in addition to, the Aggregate Limit per accident. It reduces and does not increase the Aggregate Limit per accident.

If an accident results in Benefit Amounts becoming payable, which, when totaled, exceed the applicable Aggregate Limit, then the Aggregate Limit will be divided proportionally among the Insured Persons, based on each applicable Benefit Amount.

General Exclusions

Aircraft Pilot or Crew — Travel or flight in or on (including entering or exiting) any aircraft while acting or training as a pilot or crew member; however, this exclusion does not apply to passengers who temporarily perform pilot or crew functions in a life-threatening emergency.

Disease or Illness — Emotional trauma, mental or physical illness, disease, pregnancy, childbirth or miscarriage, bacterial or viral infection, bodily malfunctions, or medical or surgical treatment thereof; however, this exclusion does not apply to a bacterial infection caused by an accident or by accidental consumption of a substance contaminated by bacteria.

Incarceration — While the Insured Person is incarcerated after conviction.

Owned, Leased, or Operated Aircraft — Travel or flight in or on (including entering or exiting) any owned, leased or operated aircraft, unless otherwise provided by this plan.

Services in the Armed Forces — Full-time active duty in the armed forces of any country or international authority; however, this exclusion does not apply to the first 60 consecutive days of active military service with the armed forces of any country or established international authority.

Suicide or Intentional Injury — Suicide or any attempt at suicide; intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury.

Trade Sanctions — When the United States of America has imposed any trade or economic sanctions prohibiting insurance of any accident, accidental bodily injury or loss; or there is any other legal prohibition against providing insurance of any accident, accidental bodily injury or loss.

War — Declared or undeclared war in the following jurisdictions: (1) your jurisdiction of permanent residence; and (2) Afghanistan, Iraq, Canada and United States. This plan may change the jurisdiction in (2) at any time upon seven days prior written notice to Baylor Scott & White Health.

GLOSSARY

Assistance Services Administrator — The organization that contracts with the insurance company of this plan to provide Medical Evacuation and Repatriation services to the Insured Person.

Benefit Amount — The amount stated in this plan which applies: (1) at the time of an accident; (2) to an Insured Person; and (3) for the applicable hazard.

Bomb — Any real or dummy explosive device designed and constructed as such, placed on Baylor Scott & White Health's premises with intent to cause injury, damage or fright.

Carjacking — The unlawful forced removal or detention of an Insured Person while operating or riding as a passenger in, boarding or alighting from, a private passenger automobile during theft or attempted theft of such private passenger automobile. The Carjacking must be confirmed in writing by a police report in the jurisdiction where the loss occurs.

Conveyance — Any motorized craft, vehicle or mode of transportation licensed or registered by a governmental authority with competent jurisdiction.

Dependent Child — Insured Person's unmarried child from the moment of birth, including a natural child, grandchild, stepchild and adopted child from the date of placement with the Insured Person. The Dependent Child must be primarily dependent upon such Insured Person for maintenance and support, and must be: (1) under the age of 25; or (2) classified as an Incapacitated Dependent Child.

Family Travel Expense — Actual costs incurred by an immediate family member for temporary lodging, transportation and meals while traveling to and from visits with an Insured Person.

Felonious Assault — Any willful and unlawful use of force by an individual against an Insured Person in connection with the commission of, or attempted commission of robbery, theft, kidnapping, hostage taking, Hijacking/Skyjacking, assault, murder, manslaughter, riot or insurrection. Such use of force must be a felony or the equivalent of a felony under any country, state, territory, or local statutory or common law applicable in the jurisdiction where accident, injury or loss occurs.

Hijacking/Skyjacking — The unlawful seizure or wrongful exercise of control of an aircraft or Conveyance and its crew, in which an Insured Person is traveling.

Home Alteration — Changes to an Insured Person's primary residence that are necessary to make the residence accessible and habitable of such Insured Person.

Hospital — A public or private institution which: (1) is licensed in accordance with the laws of the jurisdiction where it is located; (2) is accredited by the Joint Commission on Accreditation of Hospitals; (3) operates for the reception, care, and treatment of sick, ailing or injured persons as inpatients; (4) provides organized facilities for diagnosis and medical or surgical treatment; (5) provides 24-hour nursing care; (6) has a physician

or staff of physicians; and (7) is not primarily a day clinic, rest or convalescent home, assisted living facility or similar establishment, and is not, other than incidentally, a place for the treatment of alcoholics or drug addicts.

Hospital Admission Guaranty — Any charge or expense made by a Hospital prior to and as a condition of an Insured Person's admission.

Incapacitated Dependent Child — A child who, as a result of being mentally or physically challenged, is permanently incapable of self-support and permanently dependent on an Insured Person for support and maintenance; and the incapacity must have occurred while the child was under the age of 25.

Medical Evacuation — The emergency transportation of an Insured Person from the location where such Insured Person is injured or becomes ill to the nearest Hospital where appropriate medical care and treatment can be provided.

Medically Necessary — A medical or dental service, supply or course of treatment which: (1) is ordered or prescribed by a physician; (2) is appropriate and consistent with the patient's diagnosis; (3) is in accord with current accepted medical or dental practice; and (4) could not be eliminated without adversely affecting the patient's condition.

Reasonable and Customary Charge — The lesser of: (1) the usual charge made by physicians or other healthcare providers for a given service or supply; or (2) the charge this plan reasonably determined to be the prevailing charge made by physicians or other healthcare providers for a given service or supply in the geographical area where it is furnished.

Rehabilitation — Treatment other than psychological therapy intended to prepare the Insured Person for work in any gainful occupation, including an Insured Person's regular occupation that is: (1) provided by a therapist licensed, registered or certified to perform such treatment; or (2) provided in a Hospital or other facility, which is licensed to provide such treatment. The Rehabilitation must take place under the direction of a physician.

Relocation Travel — Travel by an Insured Person: (1) between the Insured Person's old and new regular places of employment or residence as part of a Relocation; and (2) at Baylor Scott & White Health's authorization, direction and expense.

Relocation — The transfer of an Insured Person by Baylor Scott & White Health from this person's current regular place of employment with Baylor Scott & White Health to a new regular place of employment with Baylor Scott & White Health that is more than 50 miles from such current place of employment.

Repatriation — (1) The transfer of an Insured Person from the local Hospital where Emergency Medical Treatment is initially given to another Hospital or to an Insured Person's domicile or permanent residence; and (2) the necessary arrangement for the returns of an Insured Person's remains to the Insured

Person's domicile or permanent residence in the event of an Insured Person's Loss of Life.

Salary — An Insured Person's basic annual earnings from Baylor Scott & White Health at the time of accident, excluding commissions, overtime and incentive payments.

Temporary Total Disability — As used in this plan, an injury that solely and directly: (1) prevents an Insured Person from performing all the substantial and material duties of such person's regular occupation, or, with respect to an Insured Person who is unemployed, prevents such person from engaging in the normal and customary activities of a person of like age and sex in good health; (2) causes a condition which is medically determined by a physician to be continuous; and (3) requires the continuous care of a physician.

Vehicle Modification — Changes, including but not limited to installation of equipment, to a private passenger automobile that are necessary to make such automobile accessible to or drivable by an Insured Person.

War — (1) Hostilities following a formal declaration of War by a governmental authority; (2) armed, open and continuous hostilities between two countries in the absence of a formal declaration of War by a governmental authority; or (3) armed, open and continuous hostilities between two factions, each in control of territory, or claiming jurisdiction over the geographic area of hostility.

LEGAL SERVICES PLAN

Introduction

This Legal Services Plan was established to provide personal legal services for eligible employees of Baylor Scott & White Health, their spouses and dependent children (unmarried up to the age of 21). This summary provides information about the benefits available under the Plan and how to obtain those benefits. Eligibility for this benefit is addressed in the *A Guide to Your Benefits* section.

Hyatt Legal Plans, Inc. has been selected to provide for legal plan benefits. The services will be provided through a panel of carefully selected Participating Law Firms. Lawyers in this network are called Plan Attorneys. These arrangements are described in detail in this summary. If you have any questions that are not answered in this summary, please contact Hyatt Legal Plans at 800-821-6400 or PeoplePlace.

How to Get Legal Services

Web Site

To use this Legal Service Plan, visit the Hyatt Legal Plans' web site at www.legalplans.com. Once there, click on the "Members Log in" icon at the top of the page. You will be taken to a secure page that will require you to enter the last four digits of your Social Security or Membership Number and Zip Code. After you enter the last four digits of your Social Security or Membership Number and Zip Code you will jump to a page that is specific for member services. On this page you can choose the following options:

- [How Do I Use the Plan?](#)
- [Covered Services](#)
- [Attorney Locator](#)
- [Obtain Case Number](#)
- [Life Guide](#)
- [Self-Help Documents/Forms](#)

Client Service Center

You may also use this Legal Service Plan by calling Hyatt Legal Plans' Client Service Center at 1-800-821-6400 Monday - Friday 8 a.m. to 8 p.m., Eastern Time. Be prepared to give the last four digits of your Social Security or Membership Number and Zip Code. If you are a spouse or an eligible dependent child of an eligible person, you will need the last four digits of the Social Security or Membership Number and Zip Code of the employee through whom you are eligible. The Client Service Representative who answers your call will:

- Verify your eligibility for services;
- Make an initial determination of whether and to what extent your case is covered (the Plan Attorney will make the final determination of coverage);
- Give you a Case Number, which is similar to a claim number (you will need a new Case Number for each new case you have);
- Give you the telephone number of the Plan Attorney most convenient to you; and
- Answer any questions you have about the Legal Plan.

You then call the Plan Attorney to schedule an appointment at a time convenient to you. Evening and Saturday appointments may be available.

If you choose, you may select your own attorney. Also, where there are no Participating Law Firms, you will be asked to select your own attorney. In both of these circumstances, Hyatt Legal Plans will reimburse you for these non-Plan attorneys' fees in accordance with a set fee schedule.

For services to be covered, you or your eligible dependents must have obtained a Case Number, retained an attorney and the attorney must begin work on the covered legal matter while you are an eligible member of the legal plan.

What Services Are Covered

You and your eligible dependents are entitled to receive certain personal legal services. The available benefits are very comprehensive, but there are limitations and other conditions that must be met. Please take time to read the description of benefits carefully. All benefits are available to you and your spouse and dependents, who are referred to below as Participant(s), unless otherwise noted or you are enrolled in a Single or Employee Only plan.

Advice and Consultation

Advice and Consultation may take place in the Plan Attorney's office or by telephone conference if both parties agree.

This service provides the opportunity to discuss with an attorney any personal legal problems that are not specifically excluded. The Plan Attorney will explain the Participant's rights, point out his or her options and recommend a course of action. The Plan Attorney will identify any further coverage available under the Plan, and will undertake representation if the Participant so requests. If representation is covered by the Plan, the Participant will not be charged for the Plan Attorney's services. If representation is recommended, but is not covered by the plan, the Plan Attorney will provide a written fee statement in advance. The Participant may choose whether to retain the Plan Attorney at his or her own expense, seek outside counsel, or do nothing. There are no restrictions on the number of times per year a Participant may use this service; however, for a noncovered matter, this service is not intended to provide the Participant with continuing access to a Plan Attorney in order to seek advice that would allow the Participant to undertake his or her own representation.

Consumer Protection

Consumer Protection Matters

This service covers the Participant as a plaintiff, for representation, including trial, in disputes over consumer goods and services where the amount being contested exceeds the small claims court limit in that jurisdiction and is documented in writing. This service does not include disputes over real estate, construction, insurance or collection activities after a judgment.

Small Claims Assistance

This service covers counseling the Participant on prosecuting a small claims action; helping the Participant prepare documents; advising the Participant on evidence, documentation and witnesses; and preparing the Participant for trial. The service does not include the Plan Attorney's attendance or representation at the small claims trial, collection activities after a judgment or any services relating to post-judgment actions.

Personal Property Protection

This service covers counseling the Participant over the phone or in the office on any personal property issue such as consumer credit reports, contracts for the purchase of personal property, consumer credit agreements or installment sales agreements.

Counseling on pursuing or defending small claims actions is also included. The service also includes reviewing any personal legal documents and preparing promissory notes, affidavits and demand letters.

Debt Matters

Debt Collection Defense

This benefit provides Participants with an attorney's services for negotiation with creditors for a repayment schedule and to limit creditor harassment, and representation in defense of any action for personal debt collection, tax agency debt collection, foreclosure, repossession or garnishment, up to and including trial if necessary. It includes a motion to vacate a default judgment. It does not include counter, cross or third party claims; bankruptcy, any action arising out of family law matters including support and post decree issues; or any matter where the creditor is affiliated with the sponsor or employer.

Identity Theft Defense

This service provides the Participant with consultations with an attorney regarding potential creditor actions resulting from identity theft and attorney services as needed to contact creditors, credit bureaus and financial institutions. It also provides defense services for specific creditor actions over disputed accounts. The defense services include limiting creditor harassment and representation in defense of any action that arises out of the identity theft such as foreclosure, repossession or garnishment, up to and including trial if necessary. The service also provides the Participant with online help and information about identity theft and prevention. It does not include counter claims, cross claims, bankruptcy, any action arising out of divorce or post decree matters, or any matter where the creditor is affiliated with the sponsor or employer.

Tax Audits

This service covers reviewing tax returns and answering questions the IRS or a state or local taxing authority has concerning the Participant's tax return; negotiating with the agency; advising the Participant on necessary documentation; and attending an IRS or a state or local taxing authority audit. The service does not include prosecuting a claim for the return of overpaid taxes or the preparation of any tax returns.

Defense of Civil Lawsuits

Administrative Hearing Representation

This service covers Participants in defense of civil proceedings before a municipal, county, state or federal administrative board, agency or commission. It includes the hearing before an administrative board or agency over an adverse governmental action. It does not apply where services are available or are being provided by virtue of an insurance policy. It does not include family law matters, post judgment matters or litigation of a job-related incident.

Civil Litigation Defense

This service covers the Participant in defense of an arbitration

proceeding or civil proceeding, including pet liability and school hearings before a municipal, county, state or federal administrative board, agency or commission, or in a trial court of general jurisdiction. It does not apply where services are available or are being provided by virtue of an insurance policy. It does not include family law matters, post judgment matters, matters with criminal penalties or litigation of a job-related incident. Services do not include bringing counterclaims, third party or cross claims.

Incompetency Defense

This service covers the Participant in the defense of any incompetency action, including court hearings when there is a proceeding to find the Participant incompetent.

Document Preparation

Affidavits

This service covers preparation of any affidavit in which the Participant is the person making the statement

Deeds

This service covers the preparation of any deed for which the Participant is either the grantor or grantee.

Demand Letters

This service covers the preparation of letters that demand money, property or some other property interest of the Participant, except an interest that is an excluded service. It also covers mailing them to the addressee and forwarding and explaining any response to the Participant. Negotiations and representation in litigation are not included.

Mortgages

This service covers the preparation of any mortgage or deed of trust for which the Participant is the mortgagor. This service does not include documents pertaining to business, commercial or rental property.

Promissory Notes

This service covers the preparation of any promissory note for which the Participant is the payor or payee.

Document Review

This service covers the review of any personal legal document of the Participant, such as letters, leases or purchase agreements.

Elder Law Matters

This service covers counseling the Participant over the phone or in the office on any personal issues relating to the Participant's parents as they affect the Participant. The service includes reviewing documents of the parents to advise the Participant on the effect on the Participant. The documents include Medicare or Medicaid materials, prescription plans, leases, nursing home agreement, powers of attorney, living wills and wills. The service also includes preparing deeds involving the parents when the Participant is either the grantor or grantee; and preparing promissory notes involving the parents when the Participant is the payor or payee.

Family Law

Divorce, Dissolution and Annulment (Contested and Uncontested) – Twenty Hour Maximum

This service is available to the Participant only, not to a spouse or dependents, for the first twenty hours of service. This service includes preparing and filing all necessary pleadings, motions and affidavits, drafting settlement agreements, and representation at the hearing or trial, whether the Participant is a plaintiff or a defendant. This service does not include disputes that arise after a decree is issued. It is the Participant's responsibility to pay fees beyond the first twenty hours.

Name Change

This service covers the Participant for all necessary pleadings and court hearings for a legal name change.

Prenuptial Agreement

This service covers representation of the Participant and includes the negotiation, preparation, review and execution of a Prenuptial Agreement between the Participant and his or her fiancé/partner prior to their marriage or legal union (where allowed by law), outlining how property is to be divided in the event of separation, divorce or death of a spouse. Representation is provided only to the Participant. The fiancé/partner must have separate counsel or must waive his or her right to representation. It does not include subsequent litigation arising out of a Prenuptial Agreement.

Protection from Domestic Violence

This service covers the Participant only, not the spouse or dependents, as the victim of domestic violence. It provides the Participant with representation to obtain a protective order, including all required paperwork and attendance at all court appearances. The service does not include representation in suits for damages, defense of any action, or representation for the offender.

Adoption and Legitimization (Contested and Uncontested)

This service covers all legal services and court work in a state or federal court for an adoption for the Participant and spouse. Legitimization of a child for the Participant and spouse, including reformation of a birth certificate, is also covered.

Guardianship or Conservatorship (Contested and Uncontested)

This service covers establishing a guardianship or conservatorship over a person and his or her estate when the Participant or spouse is appointed as guardian or conservator. It includes obtaining a permanent and/or temporary guardianship or conservatorship, gathering any necessary medical evidence, preparing the paperwork, attending the hearing and preparing the initial accounting. This service does not include representation of the person over whom guardianship or conservatorship is sought, or any annual accountings after the initial accounting or terminating the guardianship or conservatorship once it has been established.

Immigration

Immigration Assistance

This service covers advice and consultation, preparation of affidavits and powers of attorney, review of any immigration documents and helping the Participant prepare for hearings.

Personal Injury

Personal Injury (25% Network Maximum)

Subject to applicable law and court rules, Plan Attorneys will handle personal injury matters (where the Participant is the plaintiff) at a maximum fee of 25% of the gross award. It is the Participant's responsibility to pay this fee and all costs. If the Participant's suit is unsuccessful, no payment is due from the Participant.

Real Estate Matters

Boundary or Title Disputes (Primary Residence)

This service covers negotiations and litigation arising from boundary or title disputes involving a Participant's primary residence, where coverage is not available under the Participant's homeowner or title insurance policies. The service includes filing to remove a mechanic's lien.

Eviction and Tenant Problems (Primary Residence - Tenant Only)

This service covers the Participant as a tenant for matters involving leases, security deposits or disputes with a residential landlord. The service includes eviction defense, up to and including trial. It does not include representation in disputes with other tenants or as a plaintiff in a lawsuit against the landlord, including an action for return of a security deposit.

Security Deposit Assistance (Primary Residence - Tenant Only)

This service covers counseling the Participant as a tenant in recovering a security deposit from the Participant's residential landlord for the Participant's primary residence; reviewing the lease and other relevant documents; and preparing a demand letter to the landlord for the return of the deposit. It also covers assisting the Participant in prosecuting a small claims action; helping prepare documents; advising on evidence, documentation and witnesses; and preparing the Participant for the small claims trial. The service does not include the Plan Attorney's attendance or representation at small claims trial, collection activities after a judgment or any services relating to postjudgment actions.

Home Equity Loans (Primary Residence)

This service covers the review or preparation of a home equity loan on the Participant's primary residence.

Property Tax Assessment (Primary Residence)

This service covers the Participant for review and advice on a property tax assessment on the Participant's primary residence. It also includes filing the paperwork; gathering the evidence; negotiating a settlement; and attending the hearing necessary to seek a reduction of the assessment.

Refinancing of Home (Primary Residence)

This service covers the review or preparation, by an attorney representing the Participant, of all relevant documents (including the refinancing agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation) that are involved in refinancing of or in obtaining a home equity loan on a Participant's primary residence. The benefit also includes attendance of an attorney at closing. This benefit includes obtaining a permanent mortgage on a newly constructed home. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the refinancing of a second home, vacation property, rental property or property held for business or investment.

Sale or Purchase of Home (Primary Residence)

This service covers the review or preparation, by an attorney representing the Participant, of all relevant documents (including the construction documents for a new home, the purchase agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation) that are involved in the purchase or sale of a Participant's primary residence or of a vacant property to be used for building a primary residence. The benefit also includes attendance of an attorney at closing. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the sale or purchase of a second home, vacation property, rental property, property held for business or investment or leases with an option to buy.

Sale or Purchase of Home (Second or Vacation Home)

This service covers the review or preparation, by an attorney representing the Participant, of all relevant documents (including the construction documents for a new second home or vacation home, the purchase agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the purchase or sale of a Participant's second home, vacation home or of a vacant property to be used for building a second home or vacation home. The benefit also includes attendance of an attorney at closing. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the sale or purchase of a second home or vacation home held for rental purpose, business, investment or income or leases with an option to buy.

Zoning Applications

This service provides the Participant with the services of a lawyer to help get a zoning change or variance for the Participant's primary residence. Services include reviewing the law, reviewing the surveys, advising the Participant, preparing applications, and preparing for and attending the hearing to change zoning.

Traffic and Criminal Matters

Juvenile Court Defense

This service covers the defense of a Participant and a

Participant's dependent child in any juvenile court matter, provided there is no conflict of interest between the Participant and child. In that event the service provides an attorney for the Participant only including service for Parental Responsibility.

Traffic Ticket Defense (No DUI)

This service covers representation of the Participant in defense of any traffic ticket including traffic misdemeanor offenses, except driving under influence or vehicular homicide, including court hearings, negotiation with the prosecutor and trial.

Restoration of Driving Privileges

This service covers the Participant with representation in proceedings to restore the Participant's driving license.

Wills and Estate Planning

Living Wills

This service covers the preparation of a living will for the Participant.

Powers of Attorney

This service covers the preparation of any power of attorney or healthcare proxy when the Participant is granting the power.

Probate (10% Network Discount)

Subject to applicable law and court rules, Plan Attorneys will handle probate matters at a fee 10% less than the Plan Attorney's normal fee. It is the Participant's responsibility to pay this reduced fee and all costs.

Wills and Codicils

This service covers the preparation of a simple or complex will for the Participant. The creation of any testamentary trust is covered. The benefit includes the preparation of codicils and will amendments. It does not include tax planning.

Exclusions

Excluded services are those legal services that are not provided under the plan. No services, not even a consultation, can be provided for the following matters:

- Employment-related matters, including company or statutory benefits
- Matters involving the employer, MetLife® and affiliates, and plan attorneys
- Matters in which there is a conflict of interest between the employee and spouse or dependents in which case services are excluded for the spouse and dependents
- Appeals and class actions
- Farm and business matters, including rental issues when the Participant is the landlord
- Patent, trademark and copyright matters
- Costs or fines
- Frivolous or unethical matters
- Matters for which an attorney-client relationship exists prior to the Participant becoming eligible for plan benefits

Plan Confidentiality, Ethics and Independent Judgement

Your use of the Plan's legal services is confidential. The Plan Attorney will maintain strict confidentiality of the traditional lawyer-client relationship. Your employer will know nothing about your legal problems or the services you use under the Plan. The Plan Administrator will have access only to limited statistical information needed for orderly administration of the Plan.

No one will interfere with your Plan Attorney's independent exercise of professional judgment when representing you.

All attorneys' services provided under the Plan are subject to ethical rules established by the courts for lawyers. The attorney will adhere to the rules of the Plan and he or she will not receive any further instructions, direction or interference from anyone else connected with the Plan. The attorney's obligations are exclusively to you. The attorney's relationship is exclusively with you. Hyatt Legal Plans, Inc., or the law firm providing services under the Plan, is responsible for all services provided by their attorneys.

You should understand that the Plan has no liability for the conduct of any Plan Attorney. You have the right to file a complaint with the state bar concerning attorney conduct pursuant to the Plan. You have the right to retain at your own expense any attorney authorized to practice law in this state.

Plan attorneys will refuse to provide services if the matter is clearly without merit, frivolous or for the purpose of harassing another person. If you have a complaint about the legal services you have received or the conduct of an attorney, call Hyatt Legal Plans at 1-800-821-6400. Your complaint will be reviewed and you will receive a response within two business days of your call.

Other Special Rules

In addition to the coverages and exclusions listed, there are certain rules for special situations. Please read this section carefully.

What if other coverage is available to you? If you are entitled to receive legal representation provided by any other organization such as an insurance company or a government agency, or if you are entitled to legal services under any other legal plan, coverage will not be provided under this Plan. However, if you are eligible for legal aid or Public Defender services, you will still be eligible for benefits under this Plan, so long as you meet the eligibility requirements.

What if you are involved in a legal dispute with your dependents? You may need legal help with a problem involving your spouse or your children. In some cases, both you and your child may need an attorney. If it would be improper for one attorney to represent both you and your dependent, only you will be entitled to representation by the Plan Attorney. Your dependent will not be covered under the Plan.

What if you are involved in a legal dispute with another employee? If you or your dependents are involved in a dispute with another eligible employee or that employee's dependents, Hyatt Legal Plans will arrange for legal representation with independent and separate counsel for both parties.

What if the court awards attorneys' fees as part of a settlement? If you are awarded attorneys' fees as a part of a court settlement, the Plan must be repaid from this award to the extent that it paid the fee for your attorney.

Denials of Coverage

If you are denied coverage by Hyatt Legal Plans or by any Plan Attorney, you may appeal by sending a letter to:

Hyatt Legal Plans, Inc.
Director of Administration
Eaton Center 1111 Superior Avenue
Cleveland, Ohio 44114-2507

The Director will issue Hyatt Legal Plans' final determination within 60 days of receiving your letter. This determination will include the reasons for the denial with reference to the specific Plan provisions on which the denial is based and a description of any additional information that might cause Hyatt Legal Plans to reconsider the decision, an explanation of the review procedure and notice of the right to bring a civil action under Section 502(a) of ERISA.

ACCIDENTAL INJURY INSURANCE

Summary of Benefits

Accidental Injury coverage provides a benefit according to the schedule below when a Covered Person suffers Covered Injuries or undergoes a broad range of medical treatments or care resulting from a Covered Accident.

Who Can Elect Coverage

- **You:** Active Employees regularly working a minimum of 20 hours per week, who are United States citizens and permanent resident aliens, regularly working and residing in the United States and their U.S. citizen Spouse and Dependent Children who are residing in the United States.

You will be eligible for coverage immediately.

- **Your Spouse/Domestic Partner:** Up to age 99, as long as you apply for and are approved for coverage yourself. Your Child(ren): Birth to 26; 26+ if disabled, as long as you apply for and are approved for coverage yourself.

Available Coverage

This Accidental Injury plan provides off the job only coverage. The benefit amounts shown in this summary will be paid regardless of the actual expenses incurred. Benefits are only payable when all policy terms and conditions are met. Please read all the information in this summary to understand terms, conditions, state variations, exclusions and limitations applicable to these benefits. See your Certificate of Insurance for more information.

Initial & Emergency Care	Benefit Amount
Ground Ambulance/Air Ambulance*	\$400/\$1,600
Emergency Care Treatment	\$200
Diagnostic Exam (x-ray or lab)	\$50
Physician Office Visit	\$200
HOSPITALIZATION BENEFITS	
Hospital Admission	\$2,000
Hospital Stay (per day)	\$200
Intensive Care Unit Stay (per day)	\$400
FRACTURES AND DISLOCATIONS	
Per covered surgically-repaired fracture	\$200-\$8,000
Per covered non-surgically-repaired fracture	\$100-\$4,000
Chip Fracture (percent of fracture benefit)	25%
Per covered surgically-repaired dislocation	\$200-\$6,000
Per covered non-surgically-repaired dislocation	\$100-\$3,000
FOLLOW-UP CARE	
Follow-up visit to the doctor	\$100
Follow-up physical therapy visits	\$50
ENHANCED ACCIDENT BENEFITS	
Examples:	
Small Lacerations (Less than or equal to 6 inches long and requires 2 or more sutures)	\$100
Large Lacerations (more than 6 inches long and requires 2 or more sutures)	\$600
Coma (lasting 7 days with no response)	\$10,000
Concussion	\$150

NOTE: This insurance is NOT a substitute for comprehensive or major medical insurance coverage.

Portability Feature

You, your spouse, and child(ren) can continue 100% of your coverage at the time your coverage ends. You must be under the age of 99 in order to continue your coverage. Rates may change and all coverage ends at age 100. Applies to United States Citizens and Permanent Resident Aliens residing in the United States.

Important Definitions and Policy Provisions

Coverage Type: Benefits are paid when a covered injury results, directly and independently of all other causes, from a Covered Accident.

Covered Accident: A sudden, unforeseeable, external event that results, directly and independently of all other causes, in a Covered Injury or Covered Loss and occurs while the Covered Person is insured under this Policy; is not contributed to by disease, sickness, mental or bodily infirmity; and is not otherwise excluded under the terms of this Policy.

Covered Injury: Any bodily harm that results directly and independently of all other causes from a Covered Accident.

Covered Person: An eligible person who is enrolled for coverage under this Policy.

Covered Loss: A loss that is from a Covered Accident suffered by the Covered Person within the applicable time period described in the Policy.

Hospital: An institution that is licensed as a hospital pursuant to applicable law; primarily and continuously engaged in providing medical care and treatment to sick and injured persons; managed under the supervision of a staff of medical doctors; provides 24-hour nursing services by or under the supervision of a graduate registered Nurse (R.N.); and has medical, diagnostic and treatment facilities with major surgical facilities on its premises, or available to it on a prearranged basis, and charges for its services. The term Hospital does not include a clinic, facility, or unit of a Hospital for: rehabilitation, convalescent, custodial, educational, or nursing care; or the aged, drug addicts or alcoholics.

When your coverage begins: Coverage begins on the later of the program's effective date, the date you become eligible, or the first of the month following the date you completed enrollment form is received. Your coverage will not begin unless you are actively at work on the effective date. Coverage for all Covered Persons will not begin on the effective date if hospital, facility or home confined, disabled or receiving disability benefits or unable to perform activities of daily living.

When your coverage ends: Coverage ends on the earliest of the date you and your dependents are no longer eligible, the date the group policy is no longer in force, or the date for the last period for which required premiums are paid. Under certain circumstances, your coverage may be continued if you stop working. Be sure to read the Continuation of Insurance provisions in your Certificate.

30 Day Right To Examine Certificate: If a Covered Person is not satisfied with the Certificate for any reason, it may be returned within 30 days after receipt. Any premium that has been paid will be returned and the Certificate will be void as if it had never been issued.

Benefit Conditions and Limitations

This document provides only the highlights. All claims for a covered loss must meet specific Benefit Conditions and Limitations and are otherwise subject to all other terms set forth in the group policy.

Common Exclusions

In addition to any benefit specific exclusions, no payments will be made for losses caused directly or indirectly, in whole or in part, by:

- intentionally self-inflicted injury, including suicide or any attempted suicide;
- committing an assault or felony;
- bungee jumping; parachuting; skydiving; parasailing; hang-gliding;
- declared or undeclared war or act of war;
- aircraft or air travel, except as a commercial passenger or Aircraft used by the Air Mobility Command (unless owned, leased or controlled by Subscriber);
- sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment, except bacterial infection from an accidental external cut or wound or accidental ingestion of contaminated food;
- activities of active military duty, except Reserve or National Guard active duty training lasting 31 days or less;
- operating any vehicle under the influence of alcohol or any drug, narcotic or other intoxicant;
- voluntary use of drugs, unless taken as prescribed and under direction of a physician;
- services or treatment rendered by a Physician, Nurse or any other person who is: employed by the Subscriber, living with or immediate family of the Covered Person, or providing alternative medical treatments; and
- injuries that occur during the course of any employment for pay, benefit or profit. Actual policy terms may vary depending on your plan design and location.

Specific Benefit Exclusions & Limitations

- **Ground Ambulance/Air Ambulance:** Services must be provided from the scene of the Covered Accident or within 90 days of Covered Accident. *Limits:* payable once per Covered Accident, per Covered Person; limit 1 benefit per month; only one benefit will be paid ground/air, whichever is greater.

- **Emergency Care Treatment:** Treatment must occur within 30 days of the Covered Accident. *Limits:* payable once per Covered Accident, per Covered Person; limit 1 Covered Accidents per month. *Excludes:* treatment provided by an Immediate family member, clinic, or doctor's office.
- **Diagnostic Exam:** payable once per Covered Accident, per Covered Person; Treatment must occur within 90 days of the Covered Accident.
- **Physician Office Visit:** Must be diagnosed and treated by a Physician within 90 days of the Covered Accident. *Limits:* payable once per Covered Accident, per Covered Person; not payable if a Covered Person is eligible to receive a benefit under Emergency Treatment. *Excludes:* routine health examinations or immunizations for Covered Persons Age 60 and older, visits for Mental or Nervous Disorders, and visits by a surgeon while Confined to a Hospital.
- **Hospital Admission:** Inpatient admission must occur within 90 days of the Covered Accident due to such accident; *Limits:* payable once per Covered Accident; limit 1 benefit per month. *Excludes:* treatment in an emergency room, provided on an outpatient basis, or for re-admission for the same Covered Accident.
- **Hospital Stay per day:** Must be admitted for at least 23 hours or admitted inpatient and confined within 90 days of the Covered Accident. *Limits:* 365 days per Covered Accident; 1 benefit per month; not payable for hospital re-admission for same Covered Accident; if eligible for Hospital Stay Benefit and Initial Intensive Care Unit Benefit, only 1 benefit will be paid for the same Covered Accident, whichever is greater; Stays within 90 days for the same or a related Covered Accident are considered one Stay.
- **Intensive Care Unit Stay per day:** Must be admitted for at least 23 hours or admitted inpatient and confined within 90 days of the Covered Accident. *Limits:* 365 days per Covered Accident, 1 benefit per month; not payable for hospital re-admission for same Covered Accident; if eligible for Hospital Stay Benefit and Initial Intensive Care Unit Benefit, only 1 benefit will be paid for the same Covered Accident, whichever is greater; Stays within 90 days for the same or a related Covered Accident are considered one Stay.
- **Fracture/Dislocation:** If more than one fracture, only one benefit will be paid, whichever is the greater amount. Chip fracture not paid in addition to closed fracture. *Limits:* Both fractures and dislocations are limited to 1 per accident. Must be diagnosed and treated by a physician within 90 days of the Covered Accident.
- **Follow-up visit to the doctor/Follow-up physical therapy visits:** *Limits:* 10 benefits for each Covered Person per Covered Accident for both visits to the doctor and also physical therapy visits; limit 1 Covered Accident

per month for a Covered Person. Must be examined, treated or prescribed by physician. Examination or treatment must be provided within 90 days and treatment must be completed within 365 days of the Covered Accident.

- **Large Lacerations:** Treatment by physician must be received within 90 days of the Covered Accident. *Limits:* payable 1 time per Covered Person, Per Covered Accident; Multiple lacerations pay a maximum of 2 times the benefit.
- **Coma:** *Limits:* payable 1 time per Covered Accident. Must be unconscious for 7 days or more with no response to external stimuli and requiring artificial respiratory or life support. *Excludes:* medically induced coma.
- **Concussion:** Must be diagnosed by a physician within 90 days of the Covered Accident. *Limits:* payable 1 time per Covered Accident.

CRITICAL ILLNESS INSURANCE

Summary of Benefits

Critical Illness insurance provides a cash benefit when a Covered Person is diagnosed with a covered critical illness or event after coverage is in effect. See State Variations (marked by *) below.

Who Can Elect Coverage

- **You:** Active Employees regularly working a minimum of 20 hours per week, who are United States citizens and permanent resident aliens, regularly working and residing in the United States and their U.S. citizen Spouse and Dependent Children who are residing in the United States.
You will be eligible for coverage immediately.
- **Your Spouse/Domestic Partner:** Up to age 99, as long as you apply for and are approved for coverage yourself. Your Child(ren): Birth to 26; 26+ if disabled, as long as you apply for and are approved for coverage yourself.

Available Coverage

The benefit amounts shown will be paid regardless of the actual expenses incurred. The benefit descriptions are a summary only. There are terms, conditions, state variations, exclusions and limitations applicable to these benefits. Please read all of the information in this Summary and your Certificate of Insurance for more information. All Covered Critical Illness Conditions must be due to disease or sickness.

	Benefit Amount	Guaranteed Issue Amount
Employee	\$15,000, \$30,000	Up to \$30,000
Spouse	100% of employee amount	Up to \$30,000
Children	100% of employee amount	All guaranteed issue

See "Guaranteed Issue" section below for more information.

Covered Conditions	Benefit Amount
Cancer Conditions	
Skin Cancer*	\$250 1x per

Covered Conditions	Initial Benefit Amount %	Recurrence % of Initial Benefit Amount
Invasive Cancer	100%	100%
Carcinoma in Situ	25%	25%
VASCULAR CONDITIONS		
Heart Attack	100%	100%
Stroke	100%	100%
Coronary Artery Disease	25%	25%
NERVOUS SYSTEM CONDITIONS		
Advanced Alzheimer's Disease	25%	Not Available
Amyotrophic Lateral Sclerosis (ALS)	25%	Not Available
Parkinson's Disease	25%	Not Available
Multiple Sclerosis	25%	Not Available
INFECTIOUS CONDITIONS		
Bacterial Meningitis	25%	25%
Malaria	25%	25%
Tuberculosis	25%	25%

Covered Conditions	Initial Benefit Amount %	Recurrence % of Initial Benefit Amount
Necrotizing Fasciitis	25%	25%
Osteomyelitis	25%	25%
CHILDHOOD CONDITIONS*		
Cerebral Palsy	100%	Not Available
Cystic Fibrosis	100%	100%
Muscular Dystrophy	100%	100%
Poliomyelitis	100%	Not Available
OTHER SPECIFIED CONDITIONS		
Benign Brain Tumor	100%	100%
Blindness	100%	Not Available
Coma	25%	25%

Covered Conditions	Initial Benefit Amount %	Recurrence % of Initial Benefit Amount
End-Stage Renal (Kidney) Disease	100%	100%
Major Organ Failure	100%	100%
Paralysis	100%	100%
OCCUPATIONAL CONDITIONS		
Occupational Hepatitis B	100%	100%
Occupational Hepatitis C	100%	100%
Occupational HIV	100%	100%
Occupational Ebola	25%	25%

Wellness Treatment, Health Screening Test, or Preventive Care Benefit*	Benefit Amount
Examples includes (but are not limited to) routine gynecological exams, general health exams, mammography, and certain blood tests.	\$50 per day, limited to 1 per year

*For Childhood Conditions, the Initial Benefit Amount % listed above refers to the Employee's percentage amount. Please refer to the beginning of the Available Coverage section above for details on how much coverage is available for covered children.

Benefits	
Initial Critical Illness Benefit*	Benefit for a diagnosis made after the effective date of coverage for each Covered Condition shown above. The amount payable per Covered Condition is the Initial Benefit Amount multiplied by the applicable percentage shown. Each Covered Condition will be payable one time per Covered Person, subject to the Maximum Lifetime Limit. A 180 days separation period between the dates of diagnosis is required.*
Skin Cancer Benefit	Pays benefit stated above.
Maximum Lifetime Limit	The maximum benefit payable per Covered Person is the lesser of 5 times the elected Benefit Amount or \$150,000. The following benefits are not subject to this limit: Skin Cancer and Optional Benefits.

* Benefit for the diagnosis of a subsequent and same Covered Condition for which an Initial Critical Illness Benefit Recurrence Benefit has been paid, payable after a 12 month separation period from diagnosis of a previous Covered Condition, subject to the Maximum Lifetime Limit.

Portability Feature

You can continue 100% of coverage for all Covered Persons at the time your coverage ends. You must be covered under the policy and be under the age of 99 in order to continue your coverage. Rates may change and all coverage ends at age 100. Applies to United States Citizens and Permanent Resident Aliens residing in the United States.

Important Policy Provisions and Definitions

Covered Person: An eligible person who is enrolled for coverage under the Policy.

Covered Loss: A loss that is specified in the Policy in the Schedule of Benefits section and suffered by the Covered Person within the applicable time period described in the Policy.

When your coverage begins: Coverage begins on the later of the program's effective date, the date you become eligible, the first of the month following the date your completed enrollment form is received, or if evidence of insurability is required, the first of the month after we have approved you (or your dependent) for coverage in writing, unless otherwise agreed upon by Cigna. Your coverage will not begin unless you are actively at work on the effective date. Coverage for all Covered Persons will not begin on the effective date if the covered person is confined to a hospital, facility or at home, disabled or receiving disability benefits or unable to perform activities of daily living.

When your coverage ends: Coverage ends on the earliest of the date you and your dependents are no longer eligible, the date the group policy is no longer in force, or the date for the last period for which required premiums are paid. For your dependent, coverage also ends when your coverage ends, when their premiums are not paid or when they are no longer eligible. Under certain circumstances, your coverage may be continued. Be sure to read the provisions in your Certificate about when coverage may continue.

30 Day Right To Examine Certificate: If a Covered Person is not satisfied with the Certificate of Insurance for any reason, it may be returned within 30 days after receipt. Any premium that has been paid will be returned and the Certificate will be void as if it had never been issued.

Benefit Reductions, Common Exclusions and Limitations

Exclusions

In addition to any benefit-specific exclusions, benefits will not be paid for any Covered Loss that is caused directly or indirectly, in whole or in part by any of the following:

- intentionally self-inflicted injury, suicide or any attempt thereat while sane or insane;
- commission or attempt to commit a felony or an assault; • declared or undeclared war or act of war;
- a Covered Loss that results from active duty service in the military, naval or air force of any country or international organization (upon our receipt of proof of service, we will refund any premium paid for this time; Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days);
- voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;

- operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant ("Under the influence of alcohol", for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Loss occurred)
- a diagnosis not in accordance with generally accepted medical principles prevailing in the United States at the time of the diagnosis.

Specific Benefit Exclusions and Limitations

The date of diagnosis must occur while coverage is in force and the condition definition must be satisfied.

Only one Initial Benefit will be paid for each Covered Condition per person and benefits will be subject to separation periods and Maximum Lifetime Limits.

- Skin Cancer, basal cell/squamous cell carcinoma or certain forms of melanoma.
- Invasive Cancer, uncontrolled/abnormal growth or spread of invasive malignant cells. Excludes pre-malignant conditions or conditions with malignant potential, carcinoma in situ, basal cell carcinoma, squamous cell carcinoma of the skin, unless metastatic disease develops, melanoma that is diagnosed as Clark's Level I or II or Breslow less than 0.75mm, or melanoma in situ, or prostate tumor that is classified as T-1a, b, or c, N-0, and M-0 on a TNM classification scale. Also excludes the recurrence or metastasis of an original Cancer that was diagnosed prior to the coverage effective date if the Insured has undergone treatment for such cancer within 12 months of being diagnosed with cancer while under this coverage.
- Carcinoma in Situ, non-invasive malignant tumor. Excludes premalignant conditions or conditions with malignant potential, skin cancers (basal/squamous cell carcinoma or melanoma / melanoma in situ).
- Heart Attack, includes the following that confirms permanent loss of heart muscle function: 1) EKG changes; 2) elevation of cardia enzyme.
- Stroke, cerebrovascular event—for instance, cerebral hemorrhage—confirmed by neuroimaging studies or with neurological deficits lasting 96 hours or more. Excludes transient ischemic attack (TIAs), brain injury related to trauma or infection, brain injury associated with hypoxia or anoxia, vascular disease affecting eye or optic nerve or ischemic disorders of the vestibular system.
- Coronary Artery Disease, heart disease/angina requiring coronary artery bypass surgery, as prescribed by a Physician. Excludes angioplasty (percutaneous coronary intervention) and stent implantation.
- Advanced Alzheimer's Disease, progressive degenerative disorder that attacks the brain's nerve cells resulting in the inability to perform 3 or more of the Activities of Daily Living.
- Amyotrophic Lateral Sclerosis (ALS aka Lou Gehrig's Disease), motor neuron disease resulting in muscular

weakness and atrophy. Parkinson's Disease, progressive, degenerative neurologic disease with indicated signs of the disease.

- Multiple Sclerosis, disease involving damage to brain and spinal cord cells with signs of motor or sensory deficits confirmed by MRI. Bacterial Meningitis, bacterial infection in the brain and spinal cord. Excludes viral (aseptic) meningitis.
- Malaria, parasitic (mosquito-borne) disease resulting in infection. Excludes infection by the *P. malariae*, *P. vivax*, *P. ovale*. Tuberculosis, airborne infectious disease with indicated signs of the disease. Excludes latent or inactive Tuberculosis.
- Necrotizing Fasciitis (aka flesh-eating disease), bacterial infection in skin layers and tissue. Osteomyelitis, chronic bacterial infection that deteriorates bone/bone marrow.
- Cerebral Palsy, brain injury or abnormality occurring within 24 hours of birth resulting in developmental brain disorder. Cystic Fibrosis, progressive disorder that affects exocrine glands.
- Muscular Dystrophy, progressive disorder that interferes with formation of healthy muscles.
- Poliomyelitis, acute, infectious disease caused by the poliovirus with indicated signs of the disease. Excludes non-paralytic polio or post-polio syndrome.
- Benign Brain Tumor, non-cancerous abnormal cells in the brain.
- Blindness, irreversible sight reduction in both eyes; Best corrected single eye visual acuity less than 20/200 (E-Chart) or 6/60 (Metric) or with visual field reduction (both eyes) to 20 degrees or less.
- Coma, unconscious state lasting at least 96 continuous hours. Excludes any state of unconsciousness intentionally or medically induced from unconsciousness intentionally which the Covered Person is able to be aroused.
- End-Stage Renal (Kidney) Disease, chronic, irreversible function of both kidneys. Requires hemo or peritoneal dialysis.
- Major Organ Failure, includes: liver, lung, pancreas, kidney, heart or bone marrow. Happens when transplant is prescribed or recommended and placed on UNOS registry. If the Covered Person has a combination transplant (i.e. heart and lung), a single benefit amount will be payable. Recurrence Benefit not payable for same organ for which a benefit was previously paid.
- Paralysis, complete, permanent loss of use of two or more limbs due to a disease. Excludes loss due to Stroke, Multiple Sclerosis and Cerebral Palsy.

Guaranteed Issue

If you are a new hire, you are not required to provide evidence of good health if you enroll during your eligibility waiting period and you choose an amount of coverage up to and including the Guaranteed Issue Amount. If you apply for an amount of coverage greater than the Guaranteed Issue Amount, coverage in excess of the Guaranteed Issue Amount will not be issued until approval is issued for acceptable evidence of good health. Guaranteed Issue coverage may be available at other specified periods of time. BSWH will notify you when these periods of time are available. Your Spouse must be age 18 or older to apply if evidence of insurability is required.



Baylor Scott & White

HEALTH

Baylor Scott & White Health is legally required to provide you with an SPD that describes your benefits in everyday language. From time to time, Baylor Scott & White Health may update this SPD by giving you a “Summary of Material Modifications” (SMM). This SPD replaces your 2018 SPD. For complete information, each benefit section must be read along with the *A Guide to Your Benefits* and *Administrative and General Information* sections.

Effective January 1, 2019