CHILDREN'S HEALTH INSURANCE PROGRAM PERINATAL PROGRAM HEALTH BENEFIT PLAN

FOR UNBORN CHILDREN

EVIDENCE OF COVERAGE

HEALTH MAINTENANCE ORGANIZATION

NON-FEDERALLY QUALIFIED PLAN

THIS EVIDENCE OF COVERAGE (CONTRACT) IS ISSUED TO YOU, WHOSE CHILD HAS ENROLLED IN **COMMUNITY HEALTH CHOICE TEXAS** HEALTH BENEFIT PLAN THROUGH THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP). YOU AGREE TO ADHERE TO THESE PROVISIONS FOR COVERED HEALTH SERVICES BY COMPLETING THE ENROLLMENT FORM, PAYING THE APPLICABLE PREMIUM AND ACCEPTING THIS EVIDENCE OF COVERAGE. THIS DOCUMENT DESCRIBES YOUR RIGHTS AND RESPONSIBILITIES IN RELATION TO YOUR CHILD RECEIVING COVERED HEALTH SERVICES AND BENEFITS FROM **COMMUNITY HEALTH CHOICE TEXAS** THROUGH THE CHIP PROGRAM.

Issued by:
Community Health Choice, Inc.
2636 South Loop West, Suite 125
Houston, TX 77054
713.295.2294
1.888.760.2600

In association with:
Children's Health Insurance Program
P.O. Box 149276
Austin, TX 78714-9983
1.800.647.6558

CHIP–UB EOC

IMPORTANT NOTICE

To obtain information or make a complaint:

YOU may contact YOUR Member Services Representative at 713.295.2294.

COMMUNITY HEALTH CHOICE, INC.

YOU may call Community Health Choice Texas' toll-free telephone number for information or to make a complaint at **1.888.760.2600.**

YOU may also write to Community Health Choice Texas at:

2636 South Loop West, Suite 125
Complaints Coordinator
Houston, TX 77054

YOU may contact the Texas Department of Insurance to obtain information on companies, Coverages, rights or complaints at **1.800.252.3439**

YOU may write the Texas Department of Insurance.

Consumer Protection, MC 111-1A
Texas Department of Insurance
PO Box 149091
Austin, TX 78714-9101
Fax: 512.490.1007
Web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning YOUR fee or about a claim, you should contact Community Health Choice first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

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

Contents

I. INTRODUCTION 4

A. YOUR UNBORN CHILD'S Coverage under Community Health Choice 4

B. YOUR Contract with CHIP 4

II. DEFINITIONS. 4

III. WHEN DOES AN ENROLLED UNBORN CHILD BECOME COVERED? 8

IV. COST-SHARING 8

V. TERMINATION OF CHILD'S COVERAGE. 8

A. Disenrollment due to loss of CHIP Perinatal Program Eligibility 8

B. Disenrollment by Community Health Choice 8

VI. YOUR UNBORN CHILD'S HEALTH COVERAGE. 9

A. Selecting YOUR UNBORN CHILD'S Perinatal Program Provider. 9

B. Changing YOUR UNBORN CHILD'S Perinatal Program Provider 9

C. Emergency Services 9

D. Out-of-Network Services 9

E. Continuity of Treatment 9

F. Notice of Claims 10

G. Coordination of Benefits 10

H. Subrogation 10

VII. HOW DO I MAKE A COMPLAINT? 11

A. Complaint Process 11

B. Appeals to COMMUNITY HEALTH CHOICE 11

C. Internal Appeal of Adverse Determination 12

D. External Review by Independent Review Organization 12

E. Filing Complaints with the Texas Department of Insurance 12

F. Retaliation Prohibited 13

VIII. GENERAL PROVISIONS 14

A. Entire Agreement, Amendments 14

B. Release and Confidentiality of Medical Records 14

C. Clerical Error 14

D. Notice 14

E. Validity 14

F. Conformity with State Law. 14

IX. SCHEDULE OF BENEFITS, EXCLUDED SERVICES, AND COVERED HEALTH SERVICES. 15

CHIP PERINATAL PROGRAM EXCLUSIONS FROM COVERED SERVICES FOR CHIP PERINATES 22

I. INTRODUCTION

A. YOUR UNBORN CHILD'S Coverage under Community Health Choice

Community Health Choice provides benefits to YOUR UNBORN CHILD for Covered Health Services under CHIP Perinatal Program and determines whether particular health services are Covered Health Services, as described in Section IX, SCHEDULE OF BENEFITS, EXCLUDED SERVICES, AND COVERED HEALTH SERVICES, below. If properly enrolled, YOUR UNBORN CHILD is eligible for the benefits described in Section IX. All services must be provided by participating Physicians and Providers except for Emergency Services and for out-of-network services that are authorized by Community Health Choice. YOU have a Contract with Community Health Choice regarding matters stated in this Section I.A, as more fully described in this Contract.

B. YOUR Contract with CHIP

CHIP Perinatal Program has determined that YOUR UNBORN CHILD is eligible to receive Coverage and under what circumstances the Coverage will end. CHIP Perinatal Program also has determined YOUR UNBORN CHILD'S eligibility for other benefits under the CHIP Perinatal Program.

II. DEFINITIONS

ADMINISTRATOR: The contractor with the state that administers enrollment functions for CHIP health plans.

Adverse Determination: A decision that is made by US or OUR Utilization Review Agent that the health care services furnished or proposed to be furnished to a CHILD are not medically necessary or are experimental or investigational.

CHIP Perinatal Program: The Children's Health Insurance Program (CHIP) Perinatal Program that provides Coverage to each UNBORN CHILD in accordance with an agreement between Community Health Choice and the Health and Human Services Commission of the State of Texas.

Covered Health Services or Covered Services or Coverage: Those Medically Necessary Services that are listed in Section IX, SCHEDULE OF BENEFITS, EXCLUDED SERVICES, AND COVERED HEALTH SERVICES, of this Health Benefit Plan. Covered Services also include any additional services offered by Community Health Choice as Value Added Services (VAS) in Section IX, SCHEDULE OF BENEFITS, EXCLUDED SERVICES, AND COVERED HEALTH SERVICES, of this Health Benefit Plan.

Disability: A physical or mental impairment that substantially limits one or more of an individual's major life activities, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and/or working.

Emergency Behavioral Health Condition: Any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing an average knowledge of health and medicine:

1. requires immediate intervention and/or medical attention without which a UNBORN CHILD would present an immediate danger to themselves or others, or
2. that renders a UNBORN CHILD incapable of controlling, knowing or understanding the consequences of their actions.

Emergency Condition: Means an Emergency Medical Condition or an Emergency Behavioral Health Condition.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical care could result in:

1. placing the UNBORN CHILD'S health in serious jeopardy;
2. serious impairment to bodily functions to the UNBORN CHILD;

3. serious dysfunction of any bodily organ or part that would affect the UNBORN CHILD;
4. serious disfigurement to the UNBORN CHILD; or
5. in the case of a pregnant woman, serious jeopardy to the health of a woman or her UNBORN CHILD

Emergency Services and Emergency Care: Covered inpatient and outpatient services furnished by a Provider that is qualified to furnish such services and that are needed to evaluate or stabilize an Emergency Medical Condition and/or an Emergency Behavioral Health Condition, including post-stabilization care services related to labor and delivery of the UNBORN CHILD.

Experimental and/or Investigational: A service or supply is Experimental and/or Investigational if WE determine that one or more of the following is true:

1. The service or supply is under study or in a clinical trial to evaluate its toxicity, safety or efficacy for a particular diagnosis or set of indications. Clinical trials include, but are not limited to, Phase I, II, and III clinical trials.
2. The prevailing opinion within the appropriate specialty of the U.S. medical profession is that the service or supply needs further evaluation for the particular diagnosis or set of indications before it is used outside clinical trials or other research settings.

   WE will determine if this item 2 is true based on:

   a. Published reports in authoritative medical literature; and

   b. Regulations, reports, publications, and evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health, and the FDA.
3. In the case of a drug, a device or other supply that is subject to FDA approval:

   a. It does not have FDA approval; or

   b. It has FDA approval only under its Treatment Investigational New Drug regulation or a similar regulation;

   c. It has FDA approval, but it is being used for an indication or at a dosage that is not an accepted off-label use. Unlabeled uses of FDA-approved drugs are not considered Experimental or Investigational if they are determined to be:

      (i) included in one or more of the following medical compendia: The American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, The United States Pharmacopeia Information, and other authoritative compendia as identified from time to time by the Secretary of Health and Human Services; or

      (ii) in addition, the medical appropriateness of unlabeled uses not included in the compendia can be established based on supportive clinical evidence in peer-reviewed medical publications.
4. The Physician's or Provider's institutional review board acknowledges that the use of the service or supply is Experimental or Investigational and subject to that board's approval.
5. Research protocols indicate that the service or supply is Experimental or Investigational. This item applies protocols used by the UNBORN CHILD'S Physician or Provider, as well as for protocols used by other Physicians or Providers studying substantially the same service or supply.

Health Benefit Plan or Plan: The Coverage provided to UNBORN CHILD issued by COMMUNITY providing Covered Health Services.

HEALTH PLAN: Community Health Choice, Texas otherwise referred to as COMMUNITY, US, WE or OUR.

Home Health Services: Health services provided at a Member's home by health care personnel, as prescribed by the responsible Physician or other authority designated by Community Health Choice.

Hospital: A licensed public or private institution as defined by Chapter 241, Texas Health and Safety Code or in Subtitle C, Title 7, Texas Health and Safety Code.

Illness: A physical or mental sickness or disease.

Independent Review Organization: An entity that is certified by the Commissioner of Insurance under Chapter 4202 to conduct independent review of Adverse Determinations.

Initial Admission: Hospitalization from birth including ICU; includes transfers from another hospital to a hospital with an NICU and any readmission that is less than 24 hours post-discharge from the initial admission.

Injury or Accidental Injury: Accidental trauma or damage sustained by the UNBORN CHILD or the mother of the UNBORN CHILD to a body part or system that is not the result of a disease, bodily infirmity or any other cause and could cause harm to the UNBORN CHILD.

Life-threatening: A disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Medically Necessary Services: Health services that are:

Physical:

- reasonable and necessary to prevent Illness or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical malformation or limitations in function, threaten to cause or worsen a Disability, cause Illness or infirmity of a, UNBORN CHILD or endanger life;
- provided at appropriate facilities and at the appropriate levels of care for the treatment of UNBORN CHILD'S medical conditions;
- consistent with healthcare practice guidelines and standards that are issued by professionally recognized health care organizations or governmental agencies;
- consistent with diagnoses of the conditions;
- no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
- are not Experimental or Investigative; and
- are not primarily for the convenience of the UNBORN CHILD or health care provider.

Behavioral:

- reasonable and necessary for the diagnosis or treatment of a mental health or Chemical Dependency disorder to improve, maintain or prevent deterioration of function resulting from the disorder;
- provided in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
- are not Experimental or Investigative; and
- are not primarily for the convenience of the UNBORN CHILD or health care provider.

Medically Necessary Services must be furnished in the most appropriate and least restrictive setting in which services can be safely provided and must be provided at the most appropriate level or supply of service which can safely be provided and which could not be omitted without adversely affecting the CHILD'S physical and/or mental health or the quality of care provided.

Member: Any covered UNBORN CHILD who is eligible for benefits and who is enrolled in the Texas CHIP Perinatal Program.

Out-of-Area: Any location outside Community Health Choice's CHIP Perinatal Program Service Area.

Pediatrician: A Physician who is board eligible/board certified in pediatrics by the American Board of Pediatrics.

Physician: Anyone licensed to practice medicine in the State of Texas.

Perinatal Program Provider: A Physician, Physician Assistant or Advanced Practice Nurse or other qualified healthcare Provider who is contracted with Community Health Choice to provide Covered Health Services to an UNBORN CHILD and who is responsible for providing initial and primary care, maintaining the continuity of care, and initiating referrals for care.

Provider: Any institution, organization or person, other than a Physician, that is licensed to, or otherwise authorized to provide, a healthcare service in this State. The term includes, but is not limited to a hospital, doctor of chiropractic, pharmacist, registered nurse, optometrist, registered optician, pharmacy, clinic, skilled nursing facility or home health agency.

Service Area: CHIP Perinatal Provider Service Area as defined by the Texas Health and Human Services Commission.

Specialist Physician: A participating Physician, other than a Primary Care Physician, under Contract with COMMUNITY to provide Covered Health Services upon referral by the Primary Care Physician or Primary Care Provider.

UNBORN CHILD (CHIP Perinate): Any child from conception to birth whom the CHIP Perinatal Program has determined to be eligible for Coverage and who is enrolled under this Plan.

Urgent Behavioral Health Care: A behavioral health condition that requires attention and assessment within twenty-four (24) hours but that does not place the mother of the UNBORN CHILD in immediate danger to the UNBORN CHILD or others and the mother of the UNBORN CHILD is able to cooperate with treatment.

Urgent Care: A health condition, including Urgent Behavioral Health Care that is not an emergency but is severe or painful enough to cause a prudent layperson possessing the average knowledge of medicine to believe that her condition as it relates to the UNBORN CHILD requires medical treatment evaluation or treatment within twenty-four (24) hours by the Perinatal Program Provider or the Perinatal Program Provider's designee to prevent serious deterioration of the UNBORN CHILD's condition or health.

Usual and Customary Charge: The usual charge made by a group, entity or person who renders or furnishes covered services, treatments or supplies, provided the charge is not in excess of the general level of charges made by others who render or furnish the same or similar services, treatments or supplies.

Utilization Review: The system for retrospective, concurrent or prospective review of the medical necessity and appropriateness of Covered Health Services provided, being provided or proposed to be provided to an UNBORN CHILD. The term does not include elective requests for clarification of coverage.

Utilization Review Agent: An entity that is certified by the Commissioner of Insurance to conduct Utilization Review.

YOU and YOUR: Mother of the UNBORN CHILD.

III. WHEN DOES AN ENROLLED UNBORN CHILD BECOME COVERED?

Coverage of the UNBORN CHILD begins on the first day of the month in which the UNBORN CHILD is determined eligible for the CHIP Perinatal Program.

IV. COST-SHARING

No enrollment fees or cost-sharing (such as copays) are required for CHIP Perinatal covered services.

V. TERMINATION OF CHILD'S COVERAGE

A. Disenrollment due to loss of CHIP Perinatal Program Eligibility

Disenrollment may occur if your UNBORN CHILD loses CHIP Perinatal Program eligibility. Your UNBORN CHILD may lose CHIP Perinatal Program eligibility for the following reasons:

1. Change in health insurance status, e.g., a parent of an UNBORN CHILD enrolls in an employer-sponsored health plan;
2. Death of an UNBORN CHILD;
3. Mother of UNBORN CHILD permanently moves out of the state;
4. UNBORN CHILD'S parent or authorized representative requests (in writing) the voluntary disenrollment of an UNBORN CHILD;
5. Mother of UNBORN CHILD is enrolled in Medicaid or Medicare.

B. Disenrollment by Community Health Choice

Your UNBORN CHILD may be disenrolled by US, subject to approval by the Health and Human Services Commission, for the following reasons:

1. Fraud or intentional material misrepresentation made by YOU after 15 days written notice;
2. Fraud in the use of services or facilities after 15 days written notice;
3. Misconduct that is detrimental to safe Plan operations and the delivery of services;
4. Mother of the UNBORN CHILD no longer lives or resides in the Service Area;
5. Mother of UNBORN CHILD is disruptive, unruly, threatening or uncooperative to the extent that UNBORN CHILD's Membership seriously impairs Community Health Choice's or Provider's ability to provide services to the UNBORN CHILD or to obtain a member, and the mother of the UNBORN CHILD's behavior is not caused by a physical or behavioral health condition;
6. Mother of the UNBORN CHILD steadfastly refuses to comply with Community Health Choice restrictions (e.g., repeatedly using emergency room in combination with refusing to allow Community Health Choice to treat the underlying medical condition).

We will not disenroll an UNBORN CHILD based on a change in the UNBORN CHILD'S health status, diminished mental capacity of the mother of the UNBORN CHILD or because of the amount of Medically Necessary Services that are used to treat the UNBORN CHILD'S condition. WE will also not disenroll an UNBORN CHILD because of uncooperative or disruptive behavior resulting from the mother of the UNBORN CHILD's special needs, unless this behavior seriously impairs OUR ability to furnish services to the UNBORN CHILD or other enrollees.

VI. YOUR UNBORN CHILD'S HEALTH COVERAGE

A. Selecting YOUR UNBORN CHILD'S Perinatal Program Provider

YOU shall, at time of enrollment in Community Health Choice, select YOUR UNBORN CHILD'S Perinatal Program Provider. You may select an Obstetrician/Gynecologist (OB/GYN) to provide Covered Health Services within the scope of the professional specialty practice of the OB/GYN. The selection shall be made from those Physicians and Providers listed in Community Health Choice's published list of Physicians and Providers. YOU have the option to choose a Family Practice Physician with experience in prenatal care or other qualified health care Providers as a Perinatal Program Provider.

YOU shall look to the selected Perinatal Program Provider to direct and coordinate your UNBORN CHILD'S care and recommend procedures and/or treatment.

B. Changing YOUR UNBORN CHILD'S Perinatal Program Provider

YOU may request a change in YOUR UNBORN CHILD'S Perinatal Program Provider. When YOU call US to change YOUR CHILD'S Primary Care Provider, WE will make the change in OUR computer system while YOU are on the phone. The effective date of the change will be the first of the next month. WE will also send YOU YOUR CHILD's new Member ID Card right away.

C. Emergency Services

When YOU are taken to a Hospital emergency department, free-standing emergency medical facility or to a comparable emergency facility for care directly related to the labor or delivery of your covered UNBORN CHILD, the treating Physician/Provider will perform a medical screening examination to determine whether a medical Emergency directly related to the labor with delivery of the covered UNBORN CHILD exists and will provide the treatment and stabilization of an Emergency Condition.

If additional care directly related to the labor and delivery of the covered UNBORN CHILD is required after the UNBORN CHILD is stabilized, the treating Physician/Provider must contact Community Health Choice. Community Health Choice must respond within one hour of receiving the call to approve or deny Coverage of the additional care requested by the treating Physician/Provider.

If Community Health Choice agrees to the care as proposed by the treating Physician/Provider, or if Community Health Choice fails to approve or deny the proposed care within one hour of receiving the call, the treating Physician/Provider may proceed with the proposed care. Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinatal newborn are not a covered benefit.

YOU should notify Community Health Choice within twenty-four (24) hours of any out-of-network Emergency Services, or as soon as reasonably possible.

D. Out-of-Network Services

If Covered Health Services are not available to YOUR UNBORN CHILD through network Physicians or Providers, Community Health Choice, upon the request of a network Physician or Provider, shall allow referral to an out-of-network Physician or Provider and shall fully reimburse the out-of-network Physician or Provider at the Usual and Customary Charge or at an agreed upon rate. Community Health Choice further must provide for a review by a specialist of the same or similar specialty as the type of Physician or Provider to whom a referral is requested before Community Health Choice may deny a referral.

E. Continuity of Treatment

The contract between Community Health Choice and a Physician or Provider must provide that reasonable advance notice be given to YOU of the impending termination from the Plan of a Physician or Provider who is currently

treating YOUR UNBORN CHILD. The contract must also provide that the termination of the Physician or Provider contract, except for reasons of medical competence or professional behavior, does not release Community Health Choice from its obligation to reimburse the Physician or Provider who is treating YOUR UNBORN CHILD of special circumstance, such as an UNBORN CHILD who has a Disability, an acute condition or a life-threatening Illness or is past the twenty-fourth (24th) week of gestation, for YOUR UNBORN CHILD'S care in exchange for continuity of ongoing treatment for YOUR UNBORN CHILD then receiving medically necessary treatment in accordance with the dictates of medical prudence.

"Special circumstance" means a condition such that the treating Physician or Provider reasonably believes that discontinuing care by the treating Physician or Provider could cause harm to YOUR UNBORN CHILD. Special circumstance shall be identified by the treating Physician or Provider who must request that YOUR UNBORN CHILD be permitted to continue treatment under the Physician's or Provider's care and agree not to seek payment from YOU for any amount for which YOU would not be responsible if the Physician or Provider were still in Community Health Choice's network. Community Health Choice shall reimburse the terminated Physician or Provider for YOUR UNBORN CHILD'S ongoing treatment. For an UNBORN CHILD who at the time of termination is past the twenty-fourth (24th) week of gestation, Community Health Choice shall reimburse the terminated Physician or Provider for treatment extending through delivery, immediate postpartum care, and follow-up checkups within sixty days of delivery.

F. Notice of Claims

YOU should not have to pay any amount for Covered Health Services. If YOU receive a bill from a Physician or Provider, contact Community Health Choice.

G. Coordination of Benefits

Your UNBORN CHILD'S coverage under the CHIP Perinatal Program is secondary when coordinating benefits with any other insurance coverage. This means that the coverage provided under the CHIP Perinatal Program will pay benefits for covered services that remain unpaid after any other insurance coverage has paid.

H. Subrogation

Community Health Choice receives all rights of recovery acquired by YOU or YOUR UNBORN CHILD against any person or organization for negligence or any willful act resulting in Illness or Injury covered by Community Health Choice, but only to the extent of such benefits. Upon receiving such benefits from Community Health Choice, YOU and YOUR UNBORN CHILD are considered to have assigned such rights of recovery to Community Health Choice, and YOU agree to give Community Health Choice any reasonable help required to secure the recovery.

VII. HOW DO I MAKE A COMPLAINT?

A. Complaint Process

"Complaint" means any dissatisfaction expressed by YOU orally or in writing to US with any aspect of OUR operation, including but not limited to, dissatisfaction with plan administration; procedures related to review or appeal of an Adverse Determination; the denial, reduction or termination of a service for reasons not related to medical necessity; the way a service is provided; or disenrollment decisions.

If YOU notify US orally or in writing of a Complaint, WE will, not later than the fifth (5th) business day after the date of the receipt of the Complaint, send to YOU a letter acknowledging the date WE received YOUR Complaint. If the Complaint was received orally, WE will enclose a one-page Complaint form clearly stating that the Complaint form must be returned to US for prompt resolution.

After receipt of the written Complaint or one-page Complaint form from YOU, WE will investigate and send YOU a letter with OUR resolution. The total time for acknowledging, investigating, and resolving your Complaint will not exceed thirty (30) calendar days after the date WE receive YOUR Complaint.

YOUR Complaint concerning an Emergency or denial of continued stay for hospitalization will be resolved in one (1) business day of receipt of YOUR Complaint. The investigation and resolution shall be concluded in accordance with the medical immediacy of the case.

YOU may use the appeals process to resolve a dispute regarding the resolution of YOUR Complaint.

B. Appeals to COMMUNITY HEALTH CHOICE

1. If the Complaint is not resolved to YOUR satisfaction, YOU have the right either to appear in person before a Complaint appeal panel where YOU normally receive healthcare services, unless another site is agreed to by YOU, or to address a written appeal to the Complaint appeal panel. WE shall complete the appeals process not later than the thirtieth (30th) calendar day after the date of the receipt of the request for appeal.
2. WE shall send an acknowledgment letter to YOU not later the fifth (5th) day after the date of receipt of the request of the appeal.
3. WE shall appoint Members to the Complaint appeal panel, which shall advise US on the resolution of the dispute. The Complaint appeal panel shall be composed of an equal number of OUR staff, Physicians or other Providers, and enrollees. A Member of the appeal panel may not have been previously involved in the disputed decision.
4. Not later than the fifth (5th) business day before the scheduled meeting of the panel, unless YOU agree otherwise, WE shall provide to YOU or YOUR designated representative:
   a. any documentation to be presented to the panel by OUR staff;
   b. the specialization of any Physicians or Providers consulted during the investigation; and
   c. the name and affiliation of each of OUR representatives on the panel.
5. YOU, or YOUR designated representative if YOU are a minor or disabled, are entitled to:
   a. appear in person before the Complaint appeal panel;
   b. present alternative expert testimony; and
   c. request the presence of and question any person responsible for making the prior determination that resulted in the appeal.
6. Investigation and resolution of appeals relating to ongoing emergencies or denial of continued stays for hospitalization shall be concluded in accordance with the medical immediacy of the case but in no event to exceed one (1) business day after YOUR request for appeal. Due to the ongoing Emergency or continued Hospital stay, and at YOUR request, WE shall provide, in lieu of a Complaint appeal panel, a review by a Physician or Provider who has not previously reviewed the case and is of the same or similar specialty as typically manages the medical condition, procedure or treatment under discussion for review of the appeal.

7. Notice of OUR final decision on the appeal must include a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision.

C. Internal Appeal of Adverse Determination

An "Adverse Determination" is a decision that is made by US or OUR Utilization Review Agent that the healthcare services furnished or proposed to be furnished to a CHILD are not medically necessary or appropriate.

If YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider of record disagree with the Adverse Determination, YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider may appeal the Adverse Determination orally or in writing.

Within five (5) business days after receiving a written appeal of the Adverse Determination, WE or OUR Utilization Review Agent will send YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider, a letter acknowledging the date of receipt of the appeal. The letter will also include a list of documents that YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider should send to US or to OUR Utilization Review Agent for the appeal.

If YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider orally appeal the Adverse Determination, WE or OUR Utilization Review Agent will send YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider a one-page Appeal form. YOU are not required to return the completed form, but WE encourage YOU to because it will help US resolve YOUR appeal.

Appeals of Adverse Determinations involving ongoing emergencies or denials of continued stays in a Hospital will be resolved no later than one (1) business day from the date all information necessary to complete the appeal is received. All other appeals will be resolved no later than thirty (30) calendar days after the date WE or OUR Utilization Review Agent receives the appeal.

D. External Review by Independent Review Organization

If the appeal of the Adverse Determination is denied, YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider of record have the right to request a review of that decision by an Independent Review Organization (IRO). When WE or OUR Utilization Review Agent deny the appeal, YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider will receive information on how to request an IRO review of the denial and the forms that must be completed and returned to begin the independent review process.

In circumstances involving a Life-threatening condition, YOUR CHILD is entitled to an immediate review by an IRO without having to comply with the procedures for internal appeals of Adverse Determinations. In Life-threatening situations, YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider of record may contact US or OUR Utilization Review Agent by telephone to request the review by the IRO, and WE or OUR utilization review agent will provide the required information.

When the IRO completes its review and issues its decision, WE will abide by the IRO's decision. WE will pay for the IRO review.

The appeal procedures described above do not prohibit YOU from pursuing other appropriate remedies, including injunctive relief, declaratory judgment or other relief available under law, if YOU believe that the requirement of completing the appeal and review process places YOUR CHILD'S health in serious jeopardy.

E. Filing Complaints with the Texas Department of Insurance

Any person, including persons who have attempted to resolve complaints through OUR complaint system process and who are dissatisfied with the resolution, may report an alleged violation to the Texas Department of Insurance, P.O. Box 149091, Austin, Texas 78714-9101. Complaints to the Texas Department of Insurance may also be filed electronically at www.tdi.texas.gov.

The Commissioner of Insurance shall investigate a complaint against US to determine compliance within sixty (60) days after the Texas Department of Insurance's receipt of the Complaint and all information necessary for the Department to determine compliance. The Commissioner may extend the time necessary to complete an investigation in the event any of the following circumstances occur:

1. Additional information is needed;
2. An on-site review is necessary;
3. WE, the Physician or Provider or YOU do not provide all documentation necessary to complete the investigation; or
4. Other circumstances beyond the control of the Department occur.

F. Retaliation Prohibited

1. WE will not take any retaliatory action, including refusal to renew coverage, against an UNBORN CHILD because the UNBORN CHILD or person acting on behalf of the UNBORN CHILD has filed a Complaint against US or appealed a decision made by US.
2. WE shall not engage in any retaliatory action, including terminating or refusal to renew a contract, against a Physician or Perinatal Program Provider, because the Physician or Perinatal Program Provider has, on behalf of an UNBORN CHILD, reasonably filed a Complaint against US or has appealed a decision made by US.

VIII. GENERAL PROVISIONS

A. Entire Agreement, Amendments

This Contract and any attachments or amendments are the Entire Agreement between YOU and COMMUNITY. To be valid, any changes to this Contract must be approved by an officer of COMMUNITY and attached to this Contract.

B. Release and Confidentiality of Medical Records

Community Health Choice agrees to maintain and preserve the confidentiality of any and all your medical records. However, by enrolling in Community Health Choice, YOU authorize the release of information, as permitted by law, and access to any and all of your medical records for purposes reasonably related to the provision of services under this Contract, to Community Health Choice, its agents and employees, YOUR UNBORN CHILD'S Perinatal Program Provider, participating Providers, outside Providers of Utilization Review Committee, CHIP Perinatal Program and appropriate governmental agencies. Community Health Choice's privacy protections are described in more detail in its Notice of Privacy Practices. The Notice of Privacy Practices is available at www.CommunityHealthChoice.org or you may request a copy by calling 713.295.2294 or 1.888.760.2600.

C. Clerical Error

Clerical error or delays in keeping your records for YOUR and YOUR UNBORN CHILD'S Evidence of Coverage with CHIP Perinatal Program:

1. Will not deny Coverage that otherwise would have been granted; and
2. Will not continue Coverage that otherwise would have terminated.

If any important facts given to CHIP Perinatal Program about YOU or your UNBORN CHILD are not accurate and they affect Coverage:

1. The true facts will be used by CHIP Perinatal Program to decide whether Coverage is in force; and
2. Any necessary adjustments and/or recoupments will be made.

D. Notice

Benefits under Workers' Compensation are not affected.

E. Validity

The unenforceability or invalidity of any provision of this Evidence of Coverage shall not affect the enforceability or validity of the rest of this Contract.

F. Conformity with State Law

Any provision of this Contract that is not in conformity with the Texas HMO Act, and state or federal laws or regulations governing CHIP or other applicable laws or regulations shall not be rendered invalid but shall be construed and applied as if it were in full compliance with the Texas HMO Act, state and federal laws or regulations governing CHIP, and other applicable laws or regulations.

[CHIP Perinatal Unborn EOC BENEFIT SCHEDULE]

IX. SCHEDULE OF BENEFITS, EXCLUDED SERVICES, AND COVERED HEALTH SERVICES

These health services when medically necessary must be furnished in the most appropriate and least restrictive setting in which services can be safely provided and must be provided at the most appropriate level or supply of service that can safely be provided and that could not be omitted without adversely affecting the Member's physical health or the quality of life.

Emergency Care is a covered CHIP Perinatal Program service limited to those emergency services that directly relate to the delivery of the covered UNBORN CHILD until birth and must be provided in accordance with **Section VI. C. Emergency Services**. Please refer to **Section II Definition**s, for the definition of "Emergency and Emergency Condition" and the definition of "Emergency Services and Emergency Care" to determine if an Emergency Condition exists.

<table>
<tr><th>Covered Benefit</th><th>Limitations</th><th>Copayments</th></tr>
<tr><td>Inpatient General Acute
Services include:
Covered medically necessary Hospital provided services
• Operating, recovery, and other treatment rooms
• Anesthesia and administration (facility technical component)
• Medically necessary surgical services are limited to services that directly relate to the delivery of the UNBORN CHILD and services related to miscarriage or non-viable pregnancy (molar pregnancy, ectopic pregnancy or a fetus that expired in utero).
• Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:
• dilation and curettage (D&C) procedures,
• appropriate provider-administered medications,
• ultrasounds, and
• histological examination of tissue samples.</td><td>For CHIP Perinates in families with incomes at or below 198% of the Federal Poverty Level, the facility charges are not a covered benefit; however, professional services charges associated with labor with delivery are a covered benefit.
For CHIP Perinates in families with incomes above 198% up to and including 202% of the Federal Poverty Level, benefits are limited to professional service charges and facility charges associated with labor with delivery until birth.</td><td>None</td></tr>
<tr><td>Comprehensive Outpatient Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center
Services include the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital based emergency department or an ambulatory health care setting:
• X-ray, imaging, and radiological tests (technical component)
• Laboratory and pathology services (technical component)
• Machine diagnostic tests
• Drugs, medications, and biologicals that are medically necessary prescription and injection drugs
• Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy</td><td>Requires prior authorization and physician prescription
Laboratory and radiological services are limited to services that directly relate to antepartum care and/or the delivery of the covered CHIP Perinate until birth.
Ultrasound of the pregnant uterus is a covered benefit of the CHIP Perinatal Program when medically indicated.
Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, gestational age conformation or miscarriage or non-viable pregnancy.
Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT), and Ultrasonic Guidance for Cordocentesis:</td><td>None</td></tr>
</table>

Covered Benefit	Limitations	Copayments
(molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: • dilation and curettage (D&C) procedures, • appropriate provider-administered medications, • ultrasounds, and • histological examination of tissue samples.	FIUT are covered benefits of the CHIP Perinatal Program with an appropriate diagnosis. Laboratory tests for the CHIP Perinatal Program are limited to: non-stress testing, contraction stress testing, hemoglobin or hematocrit repeated once a trimester and at 32 to 36 weeks of pregnancy; or complete blood count (CBC), urinalysis for protein and glucose every visit, blood type and Rh antibody screen; repeat antibody screen for Rh negative women at 28 weeks followed by RHo immune globulin administration if indicated; rubella antibody titer, serology for syphilis, hepatitis B surface antigen, cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV) antibody screen, Chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple marker screens for neural tube defects (if the client initiates care between 16 and 20 weeks); screen for gestational diabetes at 24 to 28 weeks of pregnancy; other lab tests as indicated by medical condition of client. Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy or a fetus that expired in utero) are a covered benefit.	

Covered Benefit	Limitations	Copayments
Physician/Physician Extender Professional Services Services include, but are not limited to: • Medically necessary physician services are limited to prenatal and postpartum care and/or the delivery of the covered UNBORN CHILD until birth. • Physician office visits, in-patient, and outpatient services • Laboratory, x-rays, imaging, and pathology services, including technical component and/or professional interpretation • Medically necessary medications, biologicals, and materials administered in Physician's office • Professional component (in/outpatient) of surgical services, including: - Surgeons and assistant surgeons for surgical procedures directly related to the labor with delivery of the covered UNBORN CHILD until birth. - Administration of anesthesia by Physician (other than surgeon) or CRNA - Invasive diagnostic procedures directly related to the labor with delivery of the UNBORN CHILD. - Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy or a fetus that expired in utero). • Hospital-based Physician services (including Physician-performed technical and interpretive components) • Professional component associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Professional services associated with miscarriage or non-viable pregnancy include, but are not limited to: dilation and curettage (D&C) procedures, appropriate provideradministered medications, ultrasounds, and histological examination of tissue samples.	**Does not require authorization for specialty services** Professional component of the ultrasound of the pregnant uterus when medically indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation or gestational age conformation. Professional component of Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Amniocentesis, Cordocentrsis, and FIUT.	None

Covered Benefit	Limitations	Copayments
Birthing Center Services	Covers birthing services provided by a licensed birthing center. Limited to facility services (e.g., labor and delivery) Applies only to CHIP Perinate Members (UNBORN CHILD) with incomes at 198% FPL to 202% FPL.	None
Services Rendered by a Certified Nurse Midwife or Physician in a Licensed Birthing Center	Covers prenatal, birthing, and postpartum services rendered in a licensed birthing center. Prenatal services subject to the following limitations: Services are limited to an initial visit and subsequent prenatal (antepartum) care visits that include: (1) One (1) visit every four (4) weeks for the first 28 weeks of pregnancy; (2) One (1) visit every two (2) to three (3) weeks from 28 to 36 weeks of pregnancy; and (3) One (1) visit per week from 36 weeks to delivery. More frequent visits are allowed as Medically Necessary. Benefits are limited to: Limit of 20 prenatal visits and two (2) postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained and is subject to retrospective review. Visits after the initial visit must include: • interim history (problems, marital status, fetal status); • physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities); and • laboratory tests (urinalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32 to 36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16 to 20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client).	None

Covered Benefit	Limitations	Copayments
Prenatal Care and Pre-pregnancy Family Services and Supplies Covered services are limited to an initial visit and subsequent prenatal (antepartum) care visits that include: One (1) visit every four (4) weeks for the first 28 weeks or pregnancy; one visit every two (2) to three (3) weeks from 28 to 36 weeks of pregnancy; and one (1) visit per week from 36 weeks to delivery. More frequent visits are allowed as medically necessary.	**Does not require prior authorization** Limit of 20 prenatal visits and two (2) postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained in the Physician's files and is subject to retrospective review. Visits after the initial visit must include: interim history (problems, maternal status, fetal status), physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities), and laboratory tests (urinalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32 to 36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16 to 20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24 to 28 weeks of pregnancy; and other lab tests as indicated by medical condition of client).	None
Emergency Services, Including Emergency Hospitals, Physicians, and Ambulance Services Community Health Choice cannot require authorization as a condition for payment for emergency conditions related to labor and delivery. Covered services are limited to those emergency services that are directly related to the delivery of the covered UNBORN CHILD until birth. • Emergency services based on prudent lay person definition of emergency health condition	Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.	None

Covered Benefit	Limitations	Copayments
• Medical screening examination to determine emergency when directly related to the delivery of the covered UNBORN CHILD. • Stabilization services related to the labor and delivery of the covered UNBORN CHILD. • Emergency ground, air, and water transportation for labor and threatened labor is a covered benefit. • Emergency services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy or a fetus that expired in utero).		
Case Management Services Case Management Services are a covered benefit for the UNBORN CHILD.	These covered services include outreach informing, case management, care coordination, and community referral.	None
Care Coordination Services Care Coordination Services are a covered benefit for the UNBORN CHILD.		None
Drug Benefits Services include, but are not limited to: • Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals; and • Drugs and biologicals provided in an inpatient setting.	Services must be medically necessary for the UNBORN CHILD.	None
Value-Added Services		None

CHIP PERINATAL PROGRAM EXCLUSIONS FROM COVERED SERVICES FOR CHIP PERINATES

- For CHIP Perinates in families with incomes at or below 198% of the Federal Poverty Level, inpatient facility charges are not a covered benefit if associated with the initial Perinatal Newborn admission. "Initial Perinatal Newborn admission" means the hospitalization associated with the birth.
- Inpatient and outpatient treatments other than prenatal care, labor with delivery, and postpartum care related to the covered UNBORN CHILD until birth. Services related to preterm, false or other labor not resulting in delivery are excluded services.
- Inpatient mental health services
- Outpatient mental health services
- Durable medical equipment or other medically related remedial devices
- Disposable medical supplies
- Home and community-based health care services
- Nursing care services
- Dental services
- Inpatient substance abuse treatment services and residential substance abuse treatment services
- Outpatient substance abuse treatment services
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
- Hospice care
- Skilled nursing facility and rehabilitation hospital services
- Emergency services other than those directly related to the delivery of the covered UNBORN CHILD
- Transplant services
- Tobacco Cessation programs
- Chiropractic services
- Medical transportation not directly related to the labor or threatened labor and/or delivery of the covered UNBORN CHILD
- Personal comfort items including but not limited to, personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles that are not required for the specific treatment related to labor and delivery or post partum care
- Experimental and/or investigational medical, surgical or other health care procedures or services that are not generally employed or recognized within the medical community. This exclusion is an adverse determination and is eligible for review by an Independent Review Organization (as described in D, "External Review by Independent Review Organization")
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court other than a court of competent jurisdiction pursuant to the Texas Health and Safety Code Chapters 573, Subchapters B and C, 574, Subchapter D or 462, Subchapter D and Texas Family Code Chapter 55, Subchapter D
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to, artificial heart.
- Hospital services and supplies when confinement is solely for diagnostic testing purposes and not a part of labor and delivery.
- Prostate and mammography screening.

- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Dental devices solely for cosmetic purposes
- Out-of-network services not authorized by Community Health Choice except for emergency care related to the labor and delivery of the covered UNBORN CHILD
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity
- Medications prescribed for weight loss or gain
- Acupuncture services, naturopathy, and hypnotherapy
- Immunizations solely for foreign travel
- Routine foot care such as hygienic care. Routine foot care does not include treatment of injury or complications of diabetes
- Diagnosis and treatment of weak, strained or flat feet and the cutting or removal of corns, calluses, and toenails. This does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails.
- Corrective orthopedic shoes
- Convenience items
- Over-the-counter medications
- Orthotics primarily used for athletic or recreational purposes
- Custodial care. Care that assists with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a caregiver. This care does not require the continuing attention of trained medical or paramedical personnel.
- Housekeeping
- Public facility services and care for conditions that federal, state or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse that do not require the skill and training of a nurse
- Vision training, vision therapy or vision services
- Reimbursement for school-based physical therapy, occupational therapy or speech therapy services are not covered.
- Donor non-medical expenses
- Charges incurred as a donor of an organ
- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa)