Evry Health
A Globe Life Company

Your Benefits Information

Health Plan Details Enclosed

EPO & PPO

2026

MEMBER HANDBOOK

The Evry Health Premier EPO & PPO 2026

Evry Health offers exclusive provider organization (EPO) health plans and preferred provider organization (PPO) health plans.

EPO plans are built around networks that combine the flexibility of a PPO with the cost savings of an HMO. With an EPO plan, enrollees do not need to choose a primary care doctor or ask for referrals. Care is covered by doctors and facilities only in-network (except in emergencies).

PPO plans include out-of-network benefits and a wider range of in-network providers and services. With a PPO plan, enrollees do not need to choose a primary care doctor or ask for referrals.

This Member Handbook is NOT the legal document that defines the relationship between Members and Evry Health.

It exists to serve as a reference guide that provides a high-level description of benefits, limitations, conditions, exclusions, and other important information relevant to Members enrolled in this health plan.

Please reference the Plan Provisions – Certificate Holder Document

Hello!

It's a pleasure to welcome you to Evry Health. Thank you for your new membership. We're delighted to have the opportunity to offer you high-quality coverage, care, and service.

This handbook is meant to serve as an initial guide in understanding your coverage. Please note that your member ID card and Evry Rewards card will be arriving separately by mail.

We're here to help

Health insurance isn't always easy to understand, so if you have any questions at all about your Evry membership, coverage, or anything else you read about in these materials, please do not hesitate to contact our member services department. Our team is standing by to offer you whatever assistance and support possible.

Get Connected – Evry Mobile App and Member Portal

If you have not already done so, please visit www.evryhealth.com/members and select "Register your account" to get started. Android and iOS versions of the Evry App can be downloaded at https://www.evryhealth.com/mobileapp.

You will need your member ID number and the last four digits of your social security number in order to confirm your membership and sign-in for the first time. The App and Portal are the primary ways of accessing information and services related to your health coverage. Here are just a few of the things you can do with your secure account:

- Speak with a physician or therapist online 24/7.
- Access your Evry Care Plan and its personalized wellness solutions, rewards program, and more.
- See curated, personalized, trusted, and relevant health-related educational content.
- Look up your benefits information, claims history, in-network physicians, and Rx formulary.
- View plan documents and order new member ID cards.

We look forward to serving you.

Sincerely,

Christopher Gay, Chief Executive Officer

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PHONE NUMBERS AND INFORMATION

Questions? Call our toll-free numbers

1-855-579-3879 *Monday-Friday* *9am-5pm CST*	Customer Service and Member Services (Including language support for non-English speakers)

1-833-605-0625 *24/7*	Prime Theraputics Pharmacy Solutions (Drug Authorizations & Rx Customer Service)

Fax

1-325-603-0541	Evry Clinical Fax (Medical Prior Authorizations and Notifications)
1-866-291-3727	Prime Theraputics Pharmacy Solutions Fax (All pharmacy related services)

Email

support@evryhealth.com	Support email for customer service issues
fraud@evryhealth.com	Address to report fraud, waste, or abuse to Evry's special investigations unit (SIU)

Mail

PO Box 571208 Dallas, TX 75357	Evry Health Mailing Address
Prime Theraputics Attention: Claims Department 11013 W. Broad St. Suite 500 Glen Allen, VA 2306	Prescription & Specialty Pharmacy Services

Other Important Phone Numbers

2-1-1 Texas	2-1-1
Department of Aging and Disability Services (DADS)	1-800-458-9858
Department of Assistive and Rehabilitation Services (DARS)	1-800-628-5115
National Poison Control Center **(Calls are routed to the office nearest you)**	1-800-222-1222
Texas Health and Human Services Commission	1-866-566-8989
Texas Department of State Health Services (DSHS)	
Family and Community Health Services Help Line	1-800-422-2956
Texas Immunizations Registry Help Desk	1-800-348-9158
Immunizations Division	1-800-252-9152
7-1-1 (Texas Relay Service)	7-1-1
Women, Infants and Children (WIC) Program	1-800-942-3678

INTERPRETATION AND TRANSLATION SERVICES

Evry Health is committed to meeting our plan members' needs. Evry Health contracts with an interpreter service, Telelanguage, which supports over 240 languages 24/7/365. If you need an interpreter let Member Services know. Evry Health contracts with certified translation services at no cost to our plan members. If you need plan materials translated, contract Member Services at 855-579-3879. Evry Health also offers interpreter services through TDD 711.

LANGUAGE ACCESS SERVICES

(Spanish) Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Evry Health . tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-855-579-3879.

(Vietnamese) Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Evry Health . quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-855-579- 3879.

(Chinese) 如果您或您正在幫助的人有關於Evry Health . 方面的問題您有權利免費以您的母語得到幫助和訊息想要跟 一位翻譯員通話請致電 1-855-579-3879.

(Korean) 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이Evry Health . 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는1-855-579- 3879로 전화하십시오.

(Russian) Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Evry Health то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-855-579-3879.

(Amharic) እርስዎ፣ ወይምእርስዎየሚያግዙትግለሰብ፣ ስለEvry Health . ጥያቄካላችሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ 1-855-579-3879 ይደውሉ።

(Arabic) لديك أسئلة حول Evry Health. إذا كنت أنت أو أي شخص تساعده ، اتصل على 1-855-579-3879 للتحدث مع مترجم فوري ، تكلفة. لديك الحق في تلقي المساعدة والمعلومات بلغتك دون أي

(German) Falls Sie oder jemand, dem Sie helfen, Fragen zum Evry Health . haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-855-579-3879 an.

(French) Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Evry Health . vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-855- 579-3879.

(Tagalog) Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Evry Health . may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-855-579-3879.

(Japanese) ご本人様、またはお客様の身の回りの方でもEvry Health . についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料 金はかかりませ ん。通訳とお話される場合 、1-855-579-3879 までお電話ください。

(Cushite) Isin yookan namni biraa isin deeggartan Evry Health . irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-855-579-3879 tiin bilbilaa.

(Persian) 1-855-579-3879 د ددمایییین للصحا سستما یهه تتعاالاطط وو ککم کهه ددااررییدد ررا اایینن قح ییددباش ررگاهتشددا شما ,, ایي یکس کهه شما یهه اووو ککم ددکنییمیي ,, لوس رووددرا ل ددمایییین تتررییافدد ننگارراایي طوررور یهه ررا ووددخ ننبازز I رn وc. Health, Evry دوم ر

(Kru) I bale we, tole mut u ye hola, a gwee mbarga inyu Evry Health . U gwee Kunde I kosna mahola ni biniiguene i hop wong nni nsaa wogui wo. I Nyu ipot ni mut a nla koblene we hop, sebel 1-855-579-3879

EVRY'S CURRENT PRODUCTS

A new kind of health plan

Evry Health currently offers four distinct insurance products, and benefit details for each are included in the next section of this handbook.

All four options provide world-class coverage, 24/7 free telehealth, personalized care and attention, free digital wellness programs, and up to $1,000 in cash back rewards.

EPO: Our premium plan has no deductible and almost no copays. It's designed to give you and your family truly expanded access to the health care you need.

EPO HDHP: A more traditional but still benefit rich plan with a deductible and limited copays. This is a great option for families who use Health Savings Accounts (HSAs).

The EPO plans utilize a medical network that Evry Health has built ourselves. Our team has aggressively vetted participating medical providers and facilities in an earnest attempt to only work with high quality, world-class providers. We expect the highest standards of medical care and service from these providers, and our contracts with them often put a considerable amount of their reimbursements at risk based on how well they take care of you. EPO plans do not offer out of network coverage except in the case of urgent/emergent situations.

PPO: The same benefit design as the EPO but with a larger provider network, more participating hospital systems, and out-of-network benefits.

PPO HDHP: The same benefit design as the EPO HDHP but with a larger provider network, more participating hospital systems, and out-of-network benefits. The out of network coverage may have a higher cost share or meet a separate out-of-network deductible.

The PPO plans add a rented medical network on top of Evry's own medical network. This makes thousands of additional providers and facilities, including many major health systems throughout Texas, available to you and your family for a slightly increased premium.

INTRODUCTION

Welcome to Evry!

Evry Health is not your standard health plan.

We're on a mission to help make health insurance more affordable and to improve patient outcomes. We do this through the use of the latest technologies, with more efficient business practices, more innovative insurance products, and unparalleled customer service. Part of this mission means being the best possible partner with physicians and working together to help protect the health and wellbeing of our members.

This document serves as a guide on how to work with Evry Health.

What Evry Health Does

Evry Health is a commercial health insurer and managed care plan that contracts with physicians, hospitals, and other healthcare providers to deliver care and related services to Evry's members. Evry further promotes the health and wellbeing of its members through high quality care-based programs, such as clinically designed and focused care plans, various care management initiatives, and focused chronic condition management.

Our Beliefs

We created Evry Health to help change healthcare for the better, including providing expanded coverage and reduced premiums for our members. We want you to achieve your highest state of health, and in the circumstance that you need care, get the best care and attention. We are here to support you with education, guidance, and assistance coordinating things across what could otherwise be a very confusing and stressful situation.

IMPORTANT THINGS TO DO

- **Register online at www.evryhealth.com/members.** This is a critical step so that Evry is able to deliver you world-class service and that your eligibility requirements are met for all covered services.
- **Keep your Evry Health member identification card (Member ID Card) with you at all times.** Show it every time you need healthcare services. You should not let anyone else use your card.
- **Speak with a physician or therapist via the Evry App anytime at no additional cost with telehealth.** As part of Evry's continuing mission to make care convenient and affordable, doctors, and behavioral health professionals are available 24/7 with no copay.
- **Choose your primary care physician (PCP) on the member portal.** This is listed under the Account Settings section of Member Portal/Evry Mobile App. A PCP is your primary doctor. If you do not see your current PCP as an option in the Evry Premier Network and would like them as part of the network, please contact member services and we will investigate adding them.
- **Seek help immediately if it's an emergency.** Call 9-1-1 or go to the nearest emergency room (ER) for care. You can go to any qualified emergency facility - you never need an approval from us or your PCP for emergency care regardless of whether you are in our service area. You will be covered for emergency services in the U.S. even if the service provider is not part of the Evry Premier Network.
- **Give your Evry Care Guide a call.** They are here to serve as your personal health coach and can answer a wide range of healthcare related questions or can refer you to an appropriate resource. You also have a variety of additional services and resources, separate from the health plan's benefits, available to you. Your Care Guide will be happy to discuss them with you and help you get started.
- **Find your Explanation of Benefits (EOB) online.** Your EOBs are available through your member portal or mobile app. If we do not have a valid email address for you, your EOBs will be grouped and mailed standard every twenty-one days.

UNDERSTAND HOW YOUR PLAN WORKS

Evry Health offers EPO and PPO health plans.

With an EPO (Exclusive Provider Organization), your health insurance only works with in-network doctors. If you get care from doctors outside the network, the care won't be covered except in emergencies or if there are no in-network options.

EPOs can be great! You won't need a referral to see a specialist. You can make an appointment to see an in-network specialist like a dermatologist or cardiologist directly. Since no referral is needed, you can get the care you need without any delay or games.

EPO vs HMO vs PPO.

There are pros and cons for each, but we think you'll appreciate the benefits of having an EPO.

EPO:

- Full access to network
- No out-of-network benefits
- No referrals required for specialists
- Lower premiums

HMO:

- Limited access to network
- No out-of-network benefits
- Referrals required for specialists

PPO:

- Full access to network
- Out-of-network benefits available at a higher cost
- No referrals required for specialists

KNOW YOUR NETWORK

We provide high quality care in Texas with partners like HCA Medical City, Methodist, TIOPA, Magellan Health, Encompass Health, Patient Physician Network (PPN), Apria, Physician Surgical Network Affiliates (PSN), U.S. Dermatology, U.S. Renal Care, and many more great partners.

Evry Health's Texas primary service area include the following counties.

North Texas:

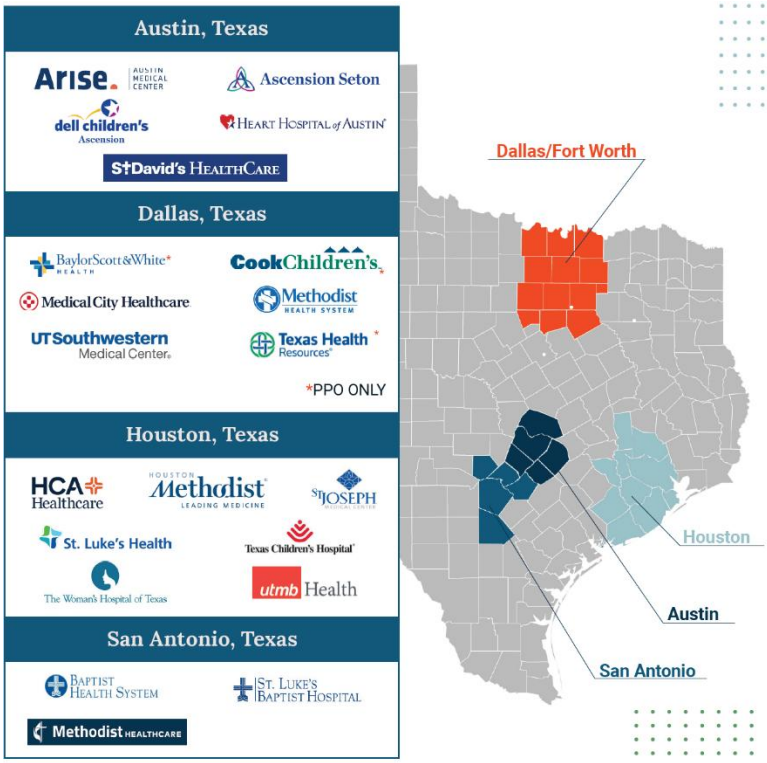
Dallas, Denton, Tarrant, Rockwall, Collin, Grayson, Cooke, Montague, Wise, Parker, Hood, Johnson, Ellis.

Central Texas:

Williamson, Hays, Travis, Bastrop, Caldwell, Guadalupe, Comal, Kendall, Bexas, Atascosa

South Texas:

Montgomery, Harris, Galveston, Grimes, Waller, Austin, Fort Bend, Wharton, Brazoria, Matagorda.

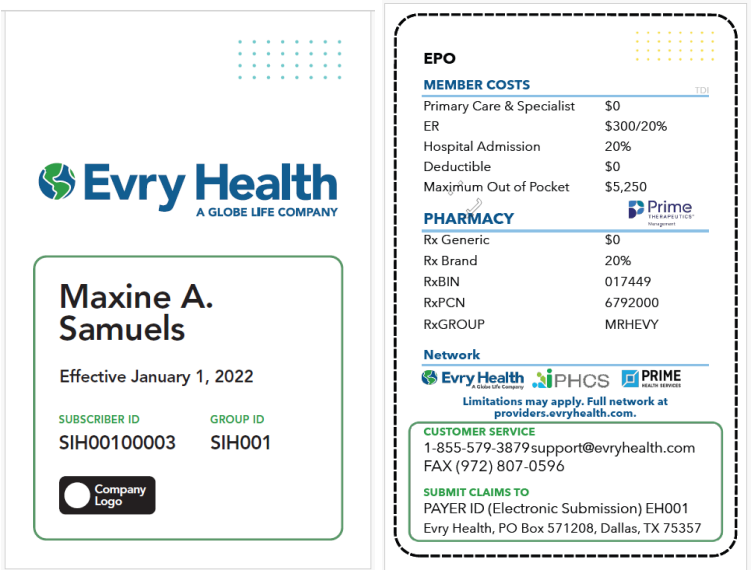


We proudly work with all high quality care providers from large health systems and physician associations to independent hospitals and private physician practices.

HOW TO USE YOUR HEALTH PLAN

Your Evry Health ID Card

Example Card



How to Use It

Present the card to your doctor, hospital, or other provider when you go for healthcare related services.

Your Evry Health ID Card has these important details:

- Full legal name
- Effective date of coverage
- Your Subscriber ID number
- Your Group ID
- Product Type (EPO/PPO)
- Plan Type (EPO/HDHP)
- Summary of member costs for primary care, specialists, ER, and hospital admissions
- Pharmacy BIN and PCN numbers
- Customer service contact number and email
- Evry's Fax number
- Evry's payer ID for electronic claims submission
- Evry's contact mailing address

Your Member ID Number

This number is unique to you and very important! In addition to helping you receive services from doctors and facilities, this number will be necessary for you to access the Evry Mobile App/Member Portal for the first time at registration, and for accessing certain care plan wellness programs.

While similar, the subscriber ID is shared with all the members of your household who have coverage with Evry Health on the same policy.

Replacing Your Card

You will get a new card if:

- You lose your ID card
- Your change your coverage
- Evry changes plan, cost, or contact information

How to replace your Evry ID Card

If your card is lost or stolen, call Member Services at 1-855-579-3879. You can also order a replacement card through the Member Portal. Please let us know if you suspect the card was stolen or may be used fraudulently.

Provider Directory

At Evry we believe in working with the best. We have assembled a care delivery team that delivers tremendous quality of care. Our network includes select physicians and facilities, and many of them are being paid for the quality of care they deliver to you. As a result, we believe we have assembled a network of care givers that are very interested in your well-being.

An up-to-date version of the Provider Directory can be found online at https://providers.evryhealth.com/, in the Member Portal, or through the Evry Mobile App. A printed Provider Directory will be provided if requested. This directory is searchable and filterable in a number of ways including by name, specialty, physical address, national provider identifier (NPI), distance, and more. You can also schedule a visit for some providers directly through the Provider Directory. We encourage you to leave feedback on doctors and facilities in the Provider Directory.

If you would like to learn even more about a PCP or specialist, such as medical school, residency training, or board certification, visit these websites:

- **American Medical Association**
  www.ama-assn.org
- **The Texas Medical Board**
  www.tmb.state.tx.us/
- **The Texas Nursing Board**
  www.bon.texas.gov

Our team will be happy to help you find an appropriate PCP, specialist, or facility. Please contact your Evry Care Guide or Member Services at 1-855-579-3879.

Cost Estimator

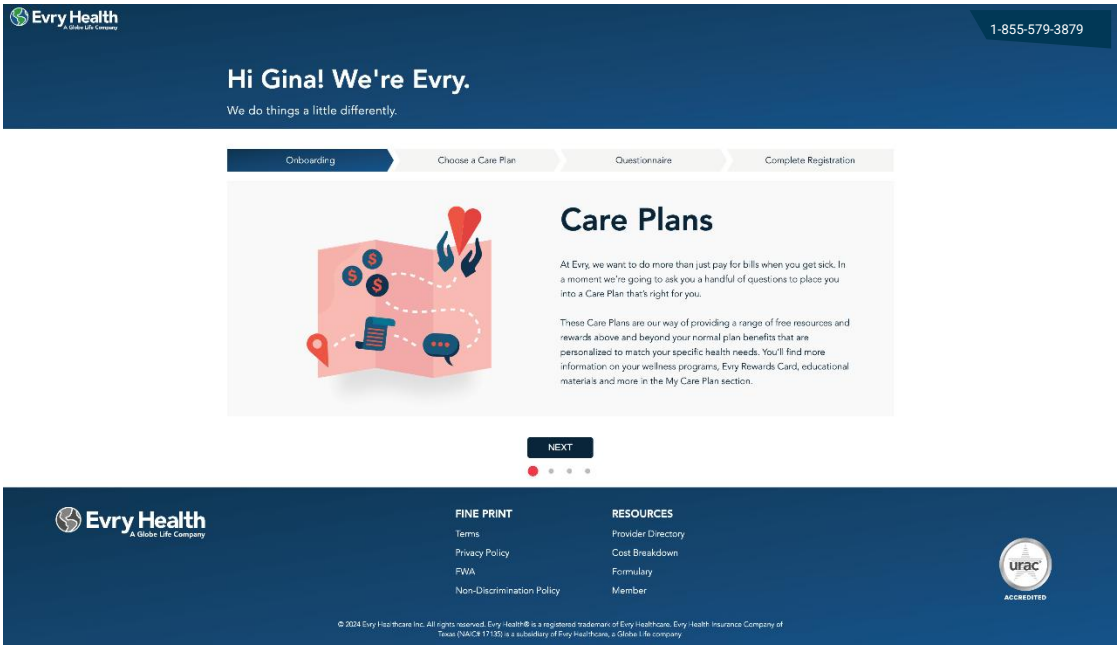
Evry's provider directory includes a useful tool that helps you and your family estimate and understand the cost of the most common medical services. You can search by procedure, medical code, or provider to see an estimate of the cost of a specific service by medical provider and location.

Member Portal and Mobile App

Please visit www.evryhealth.com/members at your earliest convenience. This site was created to simplify the way you engage with your health plan and make managing your coverage as easy as a few clicks. Use your mobile phone or desktop computer – the portal is accessible on both. We have built a single site experience that is personalized for you, where you can access information about your health, your claims, referrals, telehealth and other care needs.

Evry's beautiful and easy to use mobile application is available for iOS and Android. Please refer to https://www.evryhealth.com/mobileapp for links to each app store.

Evry's mobile app is the official recommended way of interacting with your health benefits Give it a try!



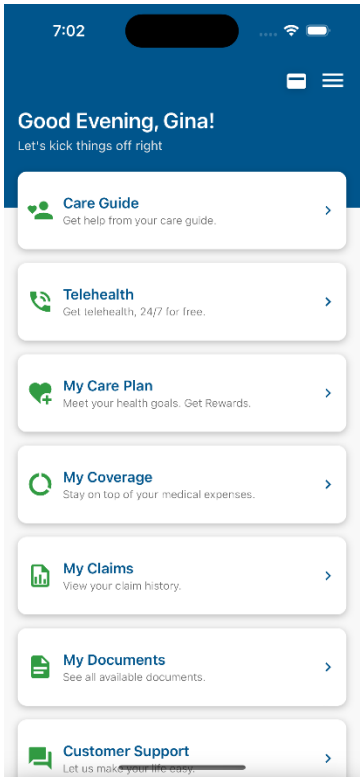
On the website or through the app you can:

- Talk to a doctor
- Access programs to help manage your health (mental health, diabetes, nutrition, and much more)
- Manage your rewards
- Review benefits
- Manage your family/dependents
- View claims
- View care plan
- Find a doctor
- Look up drug coverage (formulary)
- Access Evry Knowledge Center and FAQs
- View various plan documents
- Talk to customer support

Minors

Many legal requirements regarding health-related issues apply to minors. In Texas, the legal definition of a minor is a person under 18 years of age who has never been married and never been declared an adult by a court (emancipated).

Virtual Visit



Why wait for a doctor to have an appointment? Why not demand the same type of access to healthcare as we have for anything else we buy? Why not make it as simple as possible, and coordinate all the pieces so the experience is understandable and easy?

These are the questions we asked ourselves. At Evry, we believe access should be easy, simple, and coordinated. To accomplish these goals, we provide you with an immediate point of access through your phone. Once you log into the Evry portal or member app, we've put a doctor at your fingertips. You can speak or video chat with a board-certified doctor through the Evry Portal/App in minutes. These providers are available on-demand or by appointment 24 hours a day, 7 days a week.

There are no copays for your virtual visits. These providers can write prescriptions, make referrals to in-network providers, and treat a wide range of conditions. This service costs less than a retail clinic, urgent care or emergency room visit. Visit your Evry App for more information about virtual visits.

Your Evry Care Plan

At Evry, your health and peace of mind is our top priority. We want to do more for you than just pay your bills when you get sick. That's why we created Care Plans that can be tailored and adjusted for each member. When accessing the Member Portal for the first time, you will be asked a handful of short questions that help us to automatically place you into a care plan. These Care Plans provide free access to digital wellness solutions, online health tools, personalized educational content, lifestyle recommendations, and rewards that are different from your normal benefit plan benefits. You'll always have your normal benefits, but these Care Plans change over time to continually match your own health needs.

The Evry Reward Program

These Care Plans and your normal benefits are supported by a powerful reward program. In addition to your Evry Member ID card, you will receive an Evry-branded directed spend card in the mail. You will need to activate this card by SMS or online through your Member Portal and Mobile App. All Evry insured members of your household over the age of 16 will receive their own card. Balances are not shared across cards, but the cards can be shared by household and will help pay for select healthy foods, groceries, and items that support and sustain your health and well-being. This card works everywhere MasterCard is accepted. A complete list of covered items can be found on your Member Portal and Mobile App.

You can immediately earn $100.00 in Evry rewards for filling out your complete health assessment questionnaire! Once this is complete reach out to your Care Guide to discuss ways you can earn additional rewards up to $1,000.00 per plan year. It can be as simple as completing your first telehealth visit, trying out a nutritionist, prevention program, or following up with your provider.

Your Own Care Guide

In addition to your Care Plan, you are assigned your very own Care Guide at enrollment. This Care Guide is typically an experienced nurse or other medical professional and it's their job to help you navigate the healthcare system, get the support and care you need, and provide recommendations.

Things your Care Guide can do for you include:

- Help you schedule a doctor's appointment
- Solve issues ranging from an unexplained bill to filling out paperwork
- Explain your Care Plan and personalized benefits
- Give health and wellness advice
- Find ways to help you save time and money
- Help you prepare for procedures
- Help with admissions, discharges, and follow-up care
- Match you with the right doctor for your condition
- Assist you with locating an in-network doctor
- Answer questions about your benefit plan and coverage
- Guide you in exploring the Member Portal and Mobile App

Choosing a Primary Care Provider (PCP)

It is important to check the Evry Provider Directory to see if your current PCP is in the Evry Premier network. If not, you should select a new one or contact Member Services to request that your existing PCP is added to the network.

What is a PCP?

A primary care provider (PCP) is your main healthcare provider. They are your partner in health. PCPs are trained to provide care for a wide variety of health-related problems. They can be doctors, nurse practitioners or physician assistants. This can be a specialist in Family Medicine, Internal Medicine, Pediatrics, Geriatrics but it may also be an obstetrician/gynecologist (OBGYN). You will find a list of in-network primary care providers in our online provider directory.

Are referrals to specialists required? What is the role of my PCP?

Unlike many health plans, Evry does not require a referral to see any provider within the Evry Premier network or any provider made available through Evry App virtual visit service.

Member Services can also help you find physicians and provide details about their services and professional qualifications.

While you are not required to select a primary care provider, these practitioners can assist you in maintaining and monitoring your health as well as access the wide range of medical services from our network specialists and facilities.

What if my PCP and/or specialist cannot be added to the Evry Premier Network?

It will be important to choose a new PCP and/or specialist. Evry will make a commercially reasonable, best-efforts attempt to add qualified healthcare providers to the network, if requested, but we cannot guarantee success. There are a multitude of reasons for why it may not make sense for a particular provider and insurer to work together. We have put a tremendous amount of effort into assembling not just a network but a world-class network. Our network consists of vetted, high-quality physicians, facilities, and service providers and is regularly expanding over time. We have every confidence that you will be able to find an excellent PCP in-network.

Can I change my PCP?

Of course, you should be happy with your chosen healthcare professionals. Most of the time it is best to keep the same PCP so that he or she can get to know your needs and personal history. If you do change providers, please let us know by updating your selection on the Member Portal or by contacting Member Services.

Making an Appointment with your Doctor

Simply call your PCP or specialist and request an appointment. You can also call your care guide or check our app to help assist you. When you call, let them know you are an Evry Health member and have your Member ID card with you as you may be asked for the ID numbers on the card. Your Evry Care Guide or the Member Services department staff will also be happy to attempt to schedule an appointment on your behalf.

Please remember to bring your Evry ID card with you for your appointment. Be on time or early for your appointment. Contact your Evry Care Guide if you need assistance with transportation to make your appointment. You should call your doctor if you will be late or otherwise cannot keep your appointment. This will help shorten everyone's waiting time.

Choosing or Changing Doctors

Choosing or Changing Doctors: Whether you're looking for a primary care provider (PCP) or specialist, follow these steps to find what you need:

What's the difference between an in-network and out-of-network provider?

In-network provider: To help you save money, most plans provide access to a network of doctors and facilities. These doctors and facilities must meet certain requirements and agree to accept a specified rate for covered services under your plan. These health care professionals are considered "in-network."

Out-of-network provider: If a doctor or facility is not contracted with your health plan, they are considered "out-of-network" and can charge you full price for their services.

How to search for an in-network provider:

- Log into the Evry Health website to search for an in-network provider. The searchable directory at http://www.evryhealth.com/providerdirectory shows you

results based on your health plan network, the specialty chosen, and your location.

- Know before you go. Before you visit any provider or facility, we recommend you call ahead to be sure they are in your plan's network, as well as confirm their address, office hours, and that they are accepting new patients.

Transition of Care and Continuity of Care

Evry Health seeks to ensure that when members transition from one plan to another, one service provider to another, or one service delivery system to another, their covered services continue seamlessly throughout their transition.

1. Transition of Care: Applies to a member who is new to the Evry Health plan.
2. Continuity of Care: Applies to an Evry Health member receiving services from an in-network provider who is leaving the Evry Health Plan network, at the time of contract termination or network disruption, the Evry Health member may be able to keep getting services from them for a specified period of time.

This means you may qualify to continue to receive services for specified medical and behavioral conditions with health care providers who are not in the Evry Health network. This care is for a defined period of time until the safe transfer of care to an in-network provider or facility can be arranged. This process acts as a "bridge to coverage" for those in the middle of an "active course of treatment" as you transition from your old plan to your new Evry Health plan. This applies to covered services/benefits only.

What is a Transition of Care:

When changing plans you may be able to continue to receive services for specified medical and behavioral conditions with health care providers who are not in your plan's network at in-network coverage levels. This care is for a defined period of time until the safe transfer of care to an in-network doctor or facility can be arranged. You must apply for Transition of Care at enrollment but no later than 30 days after the effective date of your coverage.

What is Continuity of Care:

With Continuity of Care, you may be able to receive services at in-network coverage levels for specified medical and behavioral conditions when your health care provider

leaves your plan's network. There must be solid clinical reasons preventing immediate transfer of care to another health care provider. This care is for a defined period of time. You must apply for Continuity of Care within 30 days of your health care provider's termination date. This is the date that they are leaving the Evry network.

See member portal for more information on the Continuity and Transitions of Care. You may also view and download the form at www.evryhealth.com/forms.

Disabled Adult Dependent

For information on eligibility requirements to see if your dependent child meets the eligibility requirements for continued coverage after reaching the age limit (26 years), please visit the member resources section on our website. You will find a form at https://www.evryhealth.com/forms with more information. This form needs to be completed and returned to Evry Health for approval to allow for coverage for a disabled adult dependent.

Types of Medical Care

Routine Medical Care

Routine care is the regular care you get from your PCP to help you stay healthy, such as checkups, or to manage an existing chronic condition like diabetes. You should be able to see your PCP within 14 days from the date you call to make your appointment.

If you are not able to get an appointment as quickly as you would like, please consider a virtual visit through the telehealth service in your Evry Mobile App or Member Portal.

After Hours Care

Medical care after hours is covered. If you have an urgent medical need, you may visit the Evry App member portal for a virtual visit that is convenient for you, 24 hours/day, seven days/week. If you have a life or limb-threatening emergency, go to the closest emergency room or dial 9-1-1. No authorization is necessary for emergency care.

Virtual Visit

Virtual care, also known as telemedicine, is fully covered if received through Evry's telehealth partner Doctor on Demand.

You can speak or video chat with a board-certified doctor, psychologist, or psychiatrist within minutes. These providers are available on-demand or by appointment 24 hours a day, 7 days a week. In addition to on-demand appointments, you are able to schedule a visit to see a doctor of your choosing through this platform.

There are no copays for your virtual visits – virtual care is entirely free to you. These doctors can write prescriptions, make referrals to in-network providers, and treat a wide range of conditions. Visit your Evry App for more information about virtual visits.

Urgent Medical Care

There are some illnesses and injuries that need prompt attention but not typically serious enough to require emergency services. Some examples include:

- sore throat
- pink eye
- minor cuts and burns
- muscle sprains/strains
- earache
- cold, cough, runny nose
- vomiting and diarrhea
- urinary tract infections
- cellulitis and skin conditions

If you think you or your child needs urgent care, access your Evry Health app for access to speak with a doctor through Evry's 24/7 telehealth service as soon as possible or call your doctor's office, even on nights and weekends. These services may cost less than an in-person retail clinic visit, urgent care visit, or emergency room visit. See above for more information or visit your health plan summary of benefits and coverage.

The telehealth virtual visit is a high-quality video first option for on-demand medical care with a board-certified provider in 5 minutes or less for an urgent care visit. A doctor will tell you what to do. In some cases, the doctor may tell you to go to an urgent care clinic. If this happens, please refer to your Evry Health Provider Network directory for urgent care centers.

Emergency Care

Health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson to believe that the individual's condition if left untreated could place their health in serious jeopardy, impair bodily functions, or result in serious disfigurement, and for a pregnant woman, result in serious jeopardy to the health of the fetus. Emergency care also pertains to behavioral health services. If you or a family member needs emergency care, go to the closest emergency room or dial 9-1-1. There is no need for prior authorization.

Emergency and Non-Emergency Services Disclosure

Surprise Billing – Know your rights

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn’t in Evry's network. “Out-of-network” describes providers and facilities that haven’t signed a contract with Evry. Out-of-network providers may be permitted to bill you for the difference between what we agreed to pay and the full amount charged for a service. This is called “balance billing.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit. “Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for Emergency services.

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan’s in-network cost-sharing amount (such as copayments and coinsurance). You can’t be balance billed for these emergency services. This includes services you may get after you’re in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center:

- When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most

those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, air ambulance, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

Additional Protections

- Evry Health Plan will pay out-of-network providers and facilities directly. Again, you are only responsible for paying your in-network cost-sharing for covered services.
- Evry Health Plan will count any amount you pay for emergency services or certain out-of-network services (described above) towards your in-network deductible and out-of-pocket limit.
- Your provider, hospital, or facility must refund any amount you overpay within 60 days of you reporting the overpayment to them.
- A provider, hospital or other type of facility cannot ask you to limit or give up these rights.

If you receive services from an out-of-network provider, hospital or facility in any OTHER situation, you may still bebalance billed, or you may be responsible for the entire bill.

If you voluntarily receive non-emergency services from an out-of-network provider or facility, you may also be balance billed.

Out-of-Network Care

Out-of-network care for non-emergency situations is only available for PPO products and is not a covered benefit for the Evry Premier EPBP or Evry Choice HDHP. Non-emergent care outside of the Evry Health network may be covered for the EPO plans if:

- The type of care is not provided within the Evry Health network, and
- You receive a referral from your primary care provider or specialist and
- You receive authorization, in advance, from Evry Health.

If you choose to see a provider who is not a participating network provider without prior authorization from Evry Health Plan, you will be responsible for all the charges for all services. Evry Health Plan has no obligation to pay these charges.

When you are out of town

Services outside of the country are not covered for EPO or PPO members. When you are traveling within the U.S., you may go to any hospital emergency room or urgent care center that is convenient for you. Routine care received out-of-network is covered only for the PPO products. If you need emergency care, go to the nearest hospital or call 9-1-1. Following an emergency or urgent care visit out-of-network, one follow-up visit is covered if you cannot reasonably travel back to your service area.

Travel expenses back to the Evry Health Plan network are not a covered benefit. If you plan to be outside the Evry Health Plan service area and need your prescription filled, we have many network pharmacies across the country that you may use. Evry Health Plan members are NOT covered anywhere outside of the U.S.

Dependents Residing Outside Service Area

If you are a dependent residing or attending school outside of the Evry Health Medical Plan service area, you have access to digital on demand visits through the Evry App and Portal. In addition, prescriptions are covered when filled at an in-network pharmacy. Evry Health has a national prescription network. Non-emergent/non-urgent care is not covered out of area or out-of-network for the EPO plans.

Emergent/Urgent out-of-network services or out of area care is a covered benefit. When urgent care or emergency services are needed, visit the closest facility or call 9-1-1.

Dependents of dependents (grandchildren)

Children of a dependent are not covered for any period of time, including the first 61 days of life, unless court- ordered parental responsibility is awarded to the Evry Health subscriber. You must provide a copy of the court order to your Benefits Department, along with the enrollment form.

Pregnancy Care

Evry supports you in planning for your family and finding the necessary care for you. Your Care Guide can help you with resources and guidance to assist with all your care needs related to your pregnancy. Additionally, the member portal has suggestions to help you. Evry's maternity care plan may be of specific interest to you, with targeted and individualized content, incentives to earn on your Rewards Card, and identifying other services such as lactation coaching, questions on delivery or postpartum, and more.

You should make an appointment with your OB/GYN for your first prenatal care visit as soon as you believe you are pregnant but no later than the end of the first trimester.

Please note that newborns will be covered for 61 days from their date of birth after which time they will need to be enrolled as a dependent for benefits to continue.

Behavioral Health

Services related to mental wellness including psychology, psychiatry, substance abuse, addiction treatment, and more are a core part of the health plan. There are many important things to consider when choosing the right provider for you or your child, and we encourage you to speak with your primary care provider. If you need assistance finding someone to talk with, your Care Guide can refer you to a resource to help you make this decision. Because we know that your mental health is a priority for your overall health, there are several options available including specialists in your area, virtual visits (speaking/video with a mental health provider via your phone or device) as well as specialized programs (phone/device) that specialize on mental health conditions such as depression and anxiety.

Initial Coverage Determination Process

There are several types of initial coverage requests, and each has a different procedure described below:

- Pre-service coverage determination request (urgent and non-urgent)
- Concurrent care coverage determination request (urgent and non-urgent)

Pre-Service Initial Coverage Determination Request (Urgent and Non-Urgent)

Pre-service requests are services that you have not yet received. Failure to receive authorization before receiving a service that must be authorized or pre-certified in order to be a covered benefit may be the basis for our denial of your pre-service request or post-service claim for payment. If you receive any of the services you are requesting before we make our decision, your pre-service request will become a post-service appeal with respect to those services. Tell us, in writing, that you want to make a request for us to pay for a service you have not yet received. You must call us at 1-855-579-3879 or write us at:

Evry Health Insurance Company of Texas
Service Request
PO Box 571208
Dallas, TX 75357

If you want us to consider your pre-service initial coverage request on an urgent basis, your request should tell us that. We will decide whether your request is urgent or non-urgent unless your attending health care provider tells us your request is urgent. If we determine that your request is not urgent, we will treat your request as non-urgent. Generally, a request is urgent only if using the procedure for non-urgent requests (a) could seriously jeopardize your life, health or ability to regain maximum function or if you are already disabled, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the services you are requesting.

We will review your request and, if we have all the information we need, we will make a decision within a reasonable period of time but not later than 15 calendar days after we receive your request. We may extend the time for making a decision for an additional 15 calendar days if circumstances beyond our control delay our decision, if we notify you prior to the expiration of the initial 15 calendar day period and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information within the initial 15-day decision period, and we will give you 45 days to send the information. We will make a decision within 15 calendar days after we receive the requested information (including documents) we requested.

We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the

requested information (including documents) within 45 days after we send our request, we will make a decision based on the Information we have within 15 days following the end of the 45-day period.

We will send written notice of our decision to you and, if applicable to your provider.

If your pre-service appeal request was considered on an urgent basis, we will notify you of our decision (whether adverse or not) orally, or in writing, within a timeframe appropriate to your clinical condition but not later than 72 hours after we receive your request. Within 24 hours after we receive your request, we may ask you for more information. We will notify you of our decision within 48 hours of receiving the first piece of requested information. If we do not receive any of the requested information, then we will notify you of our decision within 48 hours after making our request. If we notify you of our decision orally, we will send you written confirmation within 3 days after that. If we deny your request (if we do not agree to provide or pay for all the services you requested), our adverse benefit determination notice will tell you why we denied your request and how you can appeal.

Concurrent Care Coverage Determination Request (Urgent and Non-Urgent)

Concurrent care coverage requests are requests that the health plan continues to provide, or pay for, an ongoing course of covered treatment to be provided over a period of time or number of treatments, when the course of treatment already being received is scheduled to end. We may either (a) deny your request to extend your current authorized ongoing care (your concurrent care request) or (b) inform you that authorized care that you are currently receiving is going to end early and you can appeal our adverse benefit determination at least 24 hours before your ongoing course of covered treatment will end, then during the time that we are considering your appeal, you may continue to receive the authorized services. If you continue to receive these services while we consider your appeal and your appeal does not result in our approval of your concurrent care coverage request, then we will only pay for the continuation of services until we notify you of our appeal decision.

Tell us, in writing, that you want to make a concurrent care request for an ongoing course of covered treatment. Inform us in detail of the reasons that your authorized ongoing care should be continued or extended. Your request and any related documents you give us constitute your request.

If you want us to consider your request on an urgent basis and you contact us at least 24 hours before your care ends, you may request that we review your concurrent care request on an urgent basis. We will decide whether your request is urgent or non-urgent unless your attending health care provider tells us your request is urgent. If we determine that your concurrent review request is not urgent, we will treat your request as non-urgent. Generally, a request is urgent only if delaying the review (a) could seriously jeopardize your life, health or ability to regain maximum function or if you are already disabled, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment; or (c) your attending provider requests that your request be treated as urgent.

We will review your concurrent review request and if we have all the information we need, we will make a decision within a reasonable period of time. If you submitted your request 24 hours or more before your care is ending, we will make our decision before your authorized care actually ends. If your authorized care ended before you submitted your request, we will make our decision but no later than 15 days after we receive your request. We may extend the time for making a decision for an additional 15 calendar days if circumstances beyond our control delay our decision, if we send you notice before the initial 15 calendar day decision period ends and explain the circumstances for which we need the extra time and when we expect to make a decision.

If we tell you we need more information, we will ask you for the information before the initial decision period ends and we will give you until your care is ending or, if your care has ended, 45 calendar days to send us the information. We will make our decision as soon as possible if your care has not ended or within 15 calendar days after we first receive any information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within the stated timeframe after we send our request, we will make a decision based on the information we have within the appropriate timeframe, not to exceed 15 calendar days following the end of the timeframe we gave you for sending the additional information.

We will send written notice of our decision to you and, if applicable to your provider, upon request. If we consider your concurrent request on an urgent basis, we will notify you of our decision orally or in writing as soon as your clinical condition requires, but not later than 24 hours after we received your appeal. If we notify you of our decision orally, we will send you written confirmation within 3 calendar days after receiving your request. If we deny your request (if we do not agree to provide or pay for extending the

ongoing course of treatment), our adverse benefit determination notice will tell you why we denied your request and how you can appeal.

Appeal Process

- If your service request was denied, you have the right to appeal the decision.
- Within 180 days after you receive our adverse benefit determination notice, you must tell us, verbally or in writing that you want to appeal our denial of your initial coverage determination. Please include the following: (1) your name and Member I.D. Number, (2) your medical condition or relevant symptoms, (3) the specific service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit determination and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may either mail or fax your written appeal to the Grievance and Appeal Department.
- For first level appeal reviews, Evry Health Plan will conduct a written appeal review. You have the right to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your request for benefits. You may not be present for the written appeal review.
- For standard appeal requests that do not involve emergency or urgent care needs, we will make a decision and notify you in writing within 30 calendar days of receipt of your appeal for a pre-service appeal or within 60 calendar days of receipt of your appeal for a post-service appeal.
- For emergency and urgent care appeal requests, you will be notified of the decision, in writing, as expeditiously as your medical condition requires, but no later than seventy-two (72) hours from the date the appeal request was filed. You may also begin an external review at the same time as the internal appeals process if the matter involves an urgent care situation, or if you are in an ongoing course of treatment.
- If you do not agree with the outcome of the first level appeal decision, you may request another review, in writing, called a second-level review, within sixty (60) calendar days of the first level review decision.
- Evry Health Plan will provide you, upon request, sufficient information relating to the review to help you to make an informed judgement about whether to submit the adverse determination to a review. Your decision to go forward with or not go forward with a review will have no effect on your rights to any other benefits under

your health insurance plan, the process for selecting the decision maker or the impartiality of the decision maker.

- A committee will conduct this review. All committee members will not have been involved in any prior decision of your issue, nor will they be subordinates of previous decision makers. You have the right to participate in the review in person or by telephone conference but are not required to. You will be notified in writing in advance as to when the committee meeting will occur, and if you wish to participate you or your appointed representative can present your position to the committee.
- You have the right to receive, upon request, a copy of the materials that Evry Health Plan intends to present at the review committee at least five (5) calendar days prior to the date of the review meeting. Any new material developed after the five (5) day deadline shall be provided by Evry Health Plan, when practicable. You have the right to ask questions of the review committee.

The review committee will hold a meeting to review the appeal request. For standard appeal requests that do not involve emergency or urgent care needs, you will be notified of the review committee's decision, in writing, within seven (7) calendar days after the review committee meeting. For emergency and urgent care second level appeal requests, you will be notified of the committee's decision, in writing, as expeditiously as your medical condition requires, but no later than seventy-two (72) hours after the review committee meeting.

Urgent Appeal

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent; we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health or ability to regain maximum function or if you are already disabled, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the services you are requesting; or (c) your attending provider requests that your appeal be treated as urgent.

External Appeal

Following receipt of an adverse benefit determination, you may have a right to request an external review. You have the right to request an independent external review of our decision if our decision involves an adverse benefit determination involving a denial of a claim, in whole or in part, that is (1) a denial of a preauthorization for a service; a denial of a request for services on the ground that the service is not medically necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; and/or (3) a denial of a request for services on the ground that the service is experimental or investigational.

You may request an external review for denial of a request for an alternate standard or a waiver of a standard that would otherwise be applicable to an individual under a wellness and prevention program that offers incentives or rewards for satisfaction of a standard related to a health risk factor (this is not subject to the internal appeal process). These review requests are not eligible for the expedited external review process.

Prior Authorization

Some services require your doctor to receive approval from Evry Health for those services to be covered and paid by Evry. This means your doctor (whether a PCP or specialist) and Evry must agree that the requested services are medically necessary. Medically necessary services or supplies are ones that are needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and generally refers to services that protect life, keep you from getting seriously ill or disabled, and reduce severe pain.

Getting authorization for most procedures should take no more than 5 business days and can be expedited in special situations. Authorizations for organ transplant services and clinical trials may require a minimum of 30 days.

Your doctor will be able to tell you more about this process and answer most questions you might have. We may need to ask your doctor why you need special care. We may not approve the service after reviewing the relevant clinical guidelines. In such a case we will send you and your doctor a letter stating the decision and reasons why authorization was not granted. The letter will also tell you how to appeal the decision.

If you or your provider have questions you should call us at 1-855-579-3879 or write us at:

Evry Health Insurance Company of Texas
Complaints and Appeals
PO Box 571208
Dallas, TX 75357

With an EPO plan, care is covered by doctors and facilities only in-network (except in emergencies). Non-emergent out-of-network services or out of area services are not a covered benefit.

Please note that emergency services never need prior authorization, but some post-stabilization services and types of medical transportation do. A 50% penalty may apply if services that require prior authorization are received without that prior authorization.

What services need prior authorizations?

Please note that the services listed within each category may not be exhaustive and can be plan specific. The intent is to provide an example of items which may require prior authorization. You should encourage your provider to contact Evry Health for more details or call to check your benefit coverage to see if prior authorization is required before a planned health service.

EPO members:

- require prior authorization for *all* out-of-network non emergent care services;
- and for certain services rendered by in-network providers.

PPO members:

- *may* require prior authorization, for some out-of-network non emergent care services which depend on the service being rendered;
- and for certain services rendered by in-network providers.

The services listed below are services which may be governed by your specific health plan coverage which may impact coverage decisions. Prior authorization is not a guarantee of benefits or payment. The terms of your plan control the available benefits. All planned admissions and any planned inpatient procedure require preauthorization, all unplanned admissions require notification unless otherwise specified below. Preauthorization is required before the service is provided in non-emergent situations. All EPO non-emergent out-of-network services or out of area services require prior authorization. Most non-emergent out-of-network services or out of area services are

not a covered benefit under the EPO plans. Retroactive requests will be denied unless there are extenuating circumstances.

Prior Authorization List

Please note that the services listed below within each category may not be exhaustive and apply to both EPO and PPO members. Note: Any services not listed and are non emergent out-of-network or out-of-area services require prior authorization for EPO members Please call or check the website if you are uncertain whether a prior authorization is needed or to see if a provider is in-network.

- **Admissions**:
    - All **planned** or **scheduled** inpatient medical, inpatient behavioral, or inpatient chemical dependency and surgical admissions, including acute, rehab, skilled nursing facilities require prior approval. *Exception: Notification is required within 24 hours or one business day* for maternity admission for vaginal delivery or C-section. An inpatient stay longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery will require prior authorization.
    - All **unplanned** admissions require *notification* within 72 hours or three calendar days of the admission.
    - All **Inpatient hospital/facility stays**: the length of stay must have prior approval.
        - The provider may request additional days to be authorized, if needed.
    - All **transfers** to another hospital or to or from a specialty unit in a hospital require prior approval.
- **Advanced imaging**: CT, CTA, MRI, MRA, PET Scan, Angiogram, Arteriogram, etc.
- **Behavioral Health**: All inpatient services for substance use disorder, developmental/cognitive screening and testing, neuropsych/psych testing, transcranial magnetic stimulation, intensive outpatient program (IOP) services, partial hospitalization program (PHP) services, residential treatment center (RTC) services.

- **Clinical Trials**: All clinical trials including cancer and clinical innovation.
- **Dental services**: All services for inpatient oral maxillofacial/craniofacial services, such as orthognathic surgery, TMJ surgery. Medical plan generally does not cover dental related services.
- **Dialysis**: All services
- **Durable Medical Equipment (DME) & Supplies** items may include implants, new technologies, and replacement of hearing aid devices every 36 months.
    - This can include:
        - Braces, orthotics, prosthetics
        - Bone growth stimulators
        - Cranial molding helmets
        - Cochlear implants
        - Diabetic supplies: implantable continous glucose monitors, therapeutic continuous glucose monitors
        - Hearing devices: Hearing aids
        - Hospital beds and accessory equipment
        - Implantable DME: including ocular/corneal implants
        - Mobility devices: wheelchairs, power operated vehicles, gait trainers and lifts
        - Pneumatic Compressors
        - Wound care devices
- **Gene therapy and molecular diagnostics**: Genetic testing, biomarker, genomic, pharmacogenetic, pharmacogenomics, and pharmacodynamic testing.
- **Habilitative services:** Physical therapy (PT), occupational therapy (OT), speech therapy (ST).
- **Hematology and Oncology:** Cancer treatment including chemo, radiation, and surgery.

- **Home Services**: (This is an optional benefit – verify with your employer to see if this is a covered benefit).
    - Home care: skilled nursing, non skilled nursing, extended home care, hemodialysis, home medical visits, ST/OT/OT services
    - Home Infusion therapy services: hydration, nutrition, medications including antibiotics
    - Hospice services (inpatient and home services after first 6 months)
    - Medical foods or enteral nutrition: oral foods generally not a covered benefit
- **In-Office Procedures**: may include services greater than $1000.00.
- **Non-Emergency Transportation/Transfer**: Land transportation or transfer (ambulance, taxi, car service) and air ambulance, generally not covered.
- **Ophthalmology**: All medical eye condition treatments except for cataracts and Yag laser are covered without authorization.
- **Other Services (see provider directory for in-network providers)**:
    - For wound care including, but not limited to hyperbaric oxygen, negative pressure wound therapy, wound care specialty supplies
    - Photodynamic therapy
- **Out-of-Network Services/Out-of-Area Care**: Members in an EPO plan do not have coverage for out-of-network non-emergent care services. Members in the PPO and PPO HDHP have out-of-network benefits for emergent and non emergent care.
- **Rehabilitative Services**: Chiropractic care, acupuncture, physical therapy (PT), speech therapy (ST), occupational therapy (OT), cardiac rehab, pulmonary rehab.
- **Surgical Procedures and services**: All non-emergent surgical procedures and services.
- **Pathology and Laboratory Services**: Drug testing, genetic testing and molecular diagnostics, miscellaneous and unlisted codes. Check website or call to check specific code.

- **Pharmacy** and specialty pharmacy, medications, devices and/or new technologies.
- **Physician administered medications**:
    - Examples may include: Biologicals and certain biosimilars, botulinum toxins, chemotherapy and supportive care drugs, gene therapy, injectable medications with miscellaneous billing codes, intravenous immunoglobulins, intravitreal injectable medications for ophthalmology use, viscosupplementation
    - Refer to Evry's website for specific requirements and/or exclusions
- **Experimental and investigational** services are not covered per plan design.

Generally Excluded Services

The items below are items that the plan generally does not cover. Members should check their policy or plan document for more information and a list of any other excluded services. This list is provided solely to help provide transparency into Evry's process: Please note that some employers may elect to include these optional benefits.

- Abortion (except for a pregnancy, that as certified by a physician, places a woman in danger of death or serious risk of substantial impairment of a major bodily function unless an abortion is performed).
- Cosmetic surgery or procedures only to improve appearance (except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or disease when medically necessary). See definitions section for more information.
- Infertility and erectile dysfunction treatments.
- Experimental and investigational treatments.
- Gene therapy.
- Long-term care.
- Care when traveling outside the United States.
- Private duty nursing.

- Routine eye or dental care for children and adults.
- Routine foot care (except in connection with diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency.
- Transgender services including hormone therapy.
- Weight loss surgery.

Other Covered Services

The items below are plan specific covered services where limitations may apply. This is not an inclusive list.

- Acupuncture and chiropractic care up to 5 visits per plan year.
- Home health care up to a 60 visits per plan year.
- Rehabilitative & Habilitative services up to 35 per plan year combined modalities (speech therapy, occupational therapy, physical therapy services).
- Skilled nursing care up to 25 days per plan year.
- Weight loss programs through Care Plan or up to 5 visits per plan year with registered dietician.

Getting a second medical opinion

If you have questions about care you have received or care your doctor says you need, you may want a second opinion to diagnose an illness or make sure the recommended treatment is right for you.

You should discuss this with your PCP, Care Guide, or another provider through Evry's telehealth service. They will send you to another doctor who works with Evry and is the same kind of doctor you first visited. You may receive an OK from Evry to see a doctor who does not have a contract with Evry Health if we have no other doctors in the network who see patients with your health issue.

Applicable Government Programs

Texas Women's Health Program

The Texas Women's Health Program provides family planning exams, related health screenings and birth control to women ages 18 to 44 whose household income is at or below the program's income limits (185 percent of the federal poverty level). You must submit an application to find out if you can get services through this program. To learn more about services available through the Texas Women's Health Program, write, call, or visit the program's website:

Texas Women's Health Program
P.O. Box 14000
Midland, TX 79711-9902
Phone: 1-800-335-8957
Fax: (toll-free) 1-866-993-9971
Website: www.texaswomenshealth.org/

DSHS Primary Health Care Program

The DSHS Primary Health Care Program serves women, children, and men who are unable to access the same care through insurance or other programs. To get services through this program, a person's income must be at or below the program's income limits (200 percent of the federal poverty level). A person approved for services may have to pay a co-payment, but no one is turned down for services because of a lack of money.

Primary Health Care focuses on prevention of disease, early detection and early intervention of health problems.

The main services provided are:

- Diagnosis and treatment
- Emergency services
- Family planning
- Preventive health services, including vaccines (shots) and health education, as well as laboratory, x-ray, nuclear medicine or other appropriate diagnostic services.

Secondary services that may be provided are nutrition services, health screening, home health care, dental care, rides to medical visits, medicines your doctor orders

(prescription drugs), durable medical supplies, environmental health services, treatment of damaged feet (podiatry services), and social services.

You will be able to apply for Primary Health Care services at certain clinics in your area. To find a clinic where you can apply, visit the DSHS Family and Community Health Services Clinic Locator at http://txclinics.com/.

To learn more about services you can get through the Primary Health Care program, email, call, or visit the program's website:

Website: www.dshs.state.tx.us/phc/
Phone: (512) 776-7796
Email: PPCU@dshs.state.tx.us

DSHS Expanded Primary Health Care Program

The Expanded Primary Health Care program provides primary, preventive, and screening services to women age 18 and above whose income is at or below the program's income limits (200 percent of the federal poverty level). Outreach and direct services are provided through community clinics under contract with DSHS. Community health workers will help make sure women get the preventive and screening services they need. Some clinics may offer help with breast feeding.

You can apply for these services at certain clinics in your area. To find a clinic where you can apply, visit the DSHS Family and Community Health Services Clinic Locator at http://txclinics.com/.

To learn more about services you can get through the DSHS Expanded Primary Health Care program, visit the program's website, call, or email:

Website: www.dshs.state.tx.us/ephc/Expanded-PrimaryHealth-Care.aspx
Phone: (512) 776-7796
Fax: (512)-776-7203
Email: PPCU@dshs.state.tx.us

DSHS Family Planning Program

The Family Planning Program has clinic sites across the state that provide quality, low-cost, and easy-to-use birth control for women and men. To find a clinic in your area visit the DSHS Family and Community Health Services Clinic Locator at http://txclinics.com/.

To learn more about services you can get through the Family Planning program, visit the program's website, call, or email:

Website: www.dshs.state.tx.us/famplan/
Phone: (512) 776-7796
Fax: (512)-776-7203
Email: PPCU@dshs.state.tx.us

Claim Submission

Your Evry provider will submit claims directly to Evry Health for reimbursement. In the event that you receive services for emergent out of area care, and are required to pay for services up front, you can submit a Direct Member Reimbursement request. Please submit all necessary documentation, including proof of payment. The claim form is located in the member portal and online at www.evryhealth.com/forms.

Notice Regarding Inclusion of New Technology

Evry Health has a formal mechanism to evaluate and address new developments in technology and new applications of existing technology for inclusion in its benefits plan to keep pace with changes and to ensure that members have equitable access to safe and effective care. Evry Health reviews at least annually or as needed, to conduct assessments pertaining to our existing technology as well as potential new technology that may be deemed beneficial to assist Evry Health in assisting throughout their healthcare journey.

COVERED SERVICES

Doctor services

Covered services include:

- Visits to PCPs, specialists, and other providers
- Routine physicals for children through 18 years of age
- Adult wellness/physical exams
- Telehealth visits available through the Evry Health App/Portal

Ambulances

For emergency care, professional local ground ambulance transportation or air ambulance transportation to the nearest appropriate hospital or facility.

Emergency ground ambulance transportation from one acute care hospital to another acute care hospital for diagnostic or therapeutic services (e.g., MRI, CT scans, acute interventional cardiology, intensive care unit services, etc.) may be considered medically necessary when specific criteria are met. For example, when trained ambulance attendants are required to monitor your status, such as vital signs or oxygen intake, or provide treatment such as fluids or medications. Non-emergency ground ambulance transportation services provided primarily for convenience is not considered medically necessary and is therefore, not covered. Non-emergency air ambulance transportation services may be medically necessary but require pre-authorization.

Audiology screenings

Covered services include screening tests for hearing loss and related diagnostic follow-up care.

Audiology services

Physician services and supplies needed to restore loss of or correct impaired speech or impaired hearing is covered for medically necessary conditions with prior authorization, under the benefit plan. Treatment related to hearing aids and speech processors are subject to limitations and coinsurance factors for surgeries, implants and durable medical equipment. Ages 19 and older, check with your employer to see if this is a covered benefit.

Cancer screenings

Covered services include preventive services such as mammograms, bone density tests, and screening for prostate cancer and colorectal cancer. Mammograms are limited to one each plan year. Please see your plan documents for more information.

Benefits are also available for certain tests for the detection of human papillomavirus and cervical cancer, for each woman enrolled in the Plan who is 18 years of age or older.

Dental

Some types of dental services are covered under the Evry Medical Insurance policy. These include certain Oral Surgeries, addressing a congenital defect, or the result of an accidental Injury, or injury resulting from domestic violence. Injuries resulting from biting or chewing are not an Accidental Injury for Medical insurance.

Dental care provided by a dentist in a hospital may result in Medically Necessary, non-dental related services ancillary to the dental treatment (such as anesthesia). Routine dental care is not covered.

Diagnostic and Therapeutic Services

Diagnostic radiology (such as x-rays) and certain laboratory procedures are covered as Medical-Surgical expenses. The coinsurance requirements differ depending on place of service. Advanced Diagnostic Imaging (CT/CTA Scans, MRI/MRAs, PET or SPECT, angiogram, arteriogram), may require prior authorization. Medically necessary sleep studies, radiation therapy, infusion therapy, injections and renal dialysis are covered medical expenses.

Durable medical equipment (DME) and supplies

Durable medical equipment includes items like devices, therapeutic devices, including support garments and other non-medicinal items, and artificial appliances. Items must be medically necessary and some may require prior authorization; examples may include but are not limited to, implantable DME, braces – orthoses, cranial molding helmets, hearing aids/devices/cochlear implants, hospital beds, including mattresses or overlays, powered wheelchairs/scooter/accessories, ocular/corneal implants, bone growth stimulators, limb prosthesis, mechanical pumps for venous insufficiency or lymphedema.

Emergency services

In case of Emergency, call 911 immediately. Emergency services are covered as in-network regardless of where care is actually received, meaning the cost share for in-network or out-of-network emergency care is the same. Emergency services can be rendered at an Emergency Room, Urgent Care Center or Retail Clinic. In addition, urgent care telehealth services are available through the Evry App/Portal via Included Health's Doctor on Demand. Board certified physicians are available 24/7, accessible within minutes for urgent situations. These services are available at no cost to you.

For EPO members, following an emergency or urgent care visit out-of-network, one follow-up visit is covered if you cannot reasonably travel back to your service area. Services outside of the country are not covered.

Family planning

Well-baby and pregnancy support benefits are considered part of the sustaining and preventative coverage of your medical insurance. Depending on your plan, prescriptive contraceptives may be covered as part of your pharmacy benefits. Prescriptive contraceptives are typically covered as a pharmacy benefit unless your employer has a Religious Employer Exemption in place that modifies this coverage. Prenatal visits are treated as preventive well-woman visits and are 100% covered. Cost sharing will apply to services such as ultrasounds or bloodwork, etc., that are not listed as preventive with either the U.S. Preventive Services Task Force A and B list of the HRSA Women's Preventive Services Guidelines. There are digital options available to help with family planning and maternity care. Contact your care guide to discuss eligibility.

Delivery (Vaginal or Cesarean)

All hospital, physician, laboratory and other expenses related to a vaginal or medically necessary cesarean delivery are covered when done at an accredited facility within the Evry Health network. Only emergency deliveries are covered outside of the Evry Health network. Any sickness or disease that is a complication of pregnancy or childbirthwill be covered in the same manner and with the same limitations as any other sickness or disease.

Mother and child may have a minimum hospital stay of 48 hours following a vaginal delivery or 96 hours following a cesarean delivery, unless mother and attending physicianmutually agree to a shorter stay. If 48 hours or 96 hours following delivery falls after 8 p.m., the hospital stay will continue and be covered until at least 8 a.m. the followingmorning.

> **Note:** If mother and baby are discharged together, one cost share is applied. If discharged separately, cost share may apply twice.
>
> **Limitations:** Home deliveries are not covered.

Please note that newborns will be covered for 61 days from their date of birth after which time they will need to be enrolled as a dependent for benefits to continue.

Postpartum

Breastfeeding support and equipment are covered benefits for Evry Health mothers of newborns. A breast pump can be ordered, please call 855-579-3879 for more information. Coverage is limited to the standard equipment provided by a contracted DME provider.

Fertility

Infertility treatments are generally not a covered benefit. Sometimes medically necessary infertility treatment with in-vitro fertilization may be a covered benefit with limitations – coverage differs from employer. Check with your employer to see if this is a covered benefit. Applicable coinsurance would apply.

Evry Health provides coverage for fertility preservation services to members who receive a medically necessary treatment for cancer, including surgery, chemotherapy, or radiation, that the American Society of Clinical Oncology or the American Society for Reproductive Medicine has established may directly or indirectly cause impaired fertility. The fertility preservation services must be consistent with established medical

practices or professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine and must be prior authorized.

Home Healthcare

Home based healthcare services are plan specific and have limits per plan year and prior approval review for medical necessity may be required. Check with your employer to see if this is a covered benefit.

Benefit maximum: Home Health services are limited to 60 days per plan year.

Hospice Care

Inpatient and home hospice services for a terminally ill member are covered when provided by an approved network hospice program. Each hospice benefit period has a duration of three months. Hospice services may require prior authorization. Hospice benefits are allowed only for individuals who are terminally ill and have a life expectancy of six months or less. Any member qualifying for hospice care is allowed two 3-month hospice benefit periods Should the member continue to live beyond the prognosis of life expectancy and require an additional period of hospice, prior authorization is required.

Inpatient hospital

All non-urgent inpatient admissions, including acute, non-acute, behavioral health/psychiatric, and rehabilitation, must be pre-authorized before admission. Failure to obtain prior authorization may result in a 50% penalty.

In the case of an elective inpatient admission, the call for preauthorization should be made at least five working days before you are admitted unless it would delay Emergency Care. In an emergency, notification should take place within two working days after admission, or as soon thereafter as reasonably possible.

To satisfy preauthorization requirements, you, your physician, provider of services, or a family member may call during business hours one of the toll-free numbers shown on the back of your Identification Card. Your provider may also contact us to request verification that proposed medical or health care services will be covered under your

Plan. Calls made after these hours will be recorded and returned not later than 24 hours after the call is received. We will follow up with your provider's office.

If care is not available from Network Providers as determined by Evry Health, and Evry Health authorizes your visit to an Out-of-Network Provider to be covered at the In-Network Benefit level prior to the visit, In-Network Benefits will be paid; otherwise, for EPO members, out-of-network or out of area services are not a covered benefit. ***Preauthorization is required before the service is provided in non-emergent situations. Non-emergent out-of-network services or out of area services are not a covered benefit with the EPO plans.***

When an inpatient admission is preauthorized, a length-of-stay is assigned. If you require a longer stay than was first preauthorized, your provider may seek an extension for the additional days. Benefits will not be available for room and board charges for medically unnecessary days.

Outpatient hospital

Certain specialized care may need to be delivered in an outpatient setting, that is not intense or serious enough to be admitted into the hospital, but something more than primary care. Examples of outpatient care include, but is not limited to, orthopedic services, cardiology, speech or respiratory therapy, outpatient surgery, sleep studies, radiation therapy for cancer patients, treatment for chemical or similar substance-based dependencies, and mental health-based services.

Lab services

All medically necessary laboratory testing and pathology services ordered by your primary care provider or specialist, or resulting from emergency or urgent care are covered.

Certain genetic tests are covered and may require prior authorization. Prenatal diagnosis and screening during pregnancy using chorionic villus sampling (CVS), amniocentesis or ultrasound are covered to identify conditions or specific diseases/ disorders for which a child and/or the pregnancy may be at risk.

Serious Mental Illness, Chemical Dependency, Mental Health and, Behavioral Health Services (Inpatient and Outpatient behavioral health services may be plan specific)

Inpatient Psychiatric/Mental/Behavioral Health Services:

- Inpatient psychiatric care is covered at an in-network facility.
- Prior authorization is required for non-emergency admissions. Failure to obtain prior authorization may result in a 50% penalty. Notification to the plan should be made as soon as reasonably possible, preferably within one business day of an emergency admission.

Partial Hospitalization/Day Treatment:

- "Partial hospitalization" is defined as continuous treatment at a network facility of at least three hours per day but not exceeding 12 hours per day.
- Prior authorization may be required.

Outpatient Psychiatric/Mental/Behavioral Health Services:

- Individual and group psychotherapy sessions are covered. Marital and couples counseling, family therapy and counseling are covered. You may obtain mental health services from any mental health professional in the Evry Health provider network, no referral is necessary.

Biologically Based Mental Illnesses and Mental Disorders:

- Evry Health will provide coverage for the treatment of biologically based mental illnesses and mental disorders that is no less extensive than for any other physical illness. No benefit maximum. Prior authorization is required for inpatient services.

Orthotics and prosthetics

Generally, prosthetic appliances and orthopedic items such as braces, crutches, casts, etc. are covered and included as part of the medical-surgical benefits, specifically Durable Medical Equipment (DME). Newer technologies may need to be pre-authorized.

Rehabilitative and Habilitative Physical therapy, occupational therapy, and speech therapy

In general, “therapy” is intended to imply the need for intense and direct interaction with a care professional to provide treatment and relief from a medical condition, such as a brain injury, stroke, joint or bone injuries, etc. Physical, speech, and occupational therapy services must be provided by specifically licensed therapists. It is possible to have these services provided in home, but this is subject to review and pre-authorization. There are options for digital physical therapy, call your care coordinator to see if you are eligible for this program.

Benefit maximum: 35 visits per plan year, combined.

Podiatry

Podiatry and other similar specialist are covered as providing care within the scope of their license and are appropriately certified.

Pregnancy care – See Family Planning

Prostate and rectal care – See Cancer Screening

Temporary detention order (TDO) services

A temporary detention order directs a law enforcement officer to take a person into custody and transport him or her to a specified facility for further treatment. The person may be detained for 24 hours to permit necessary medical treatment. A medical temporary detention order cannot be issued for a person under the age of 18.

Transplants

Benefits for covered services and supplies related to an organ or tissue transplant must meet the following conditions:

(1) The transplant procedure is not Experimental/Investigational in nature; and

(2) Donated human organs or tissue or an FDA-approved artificial device are used; and

(3) The recipient is a Participant under the Plan; and

(4) The transplant procedure is preauthorized as required under the Plan; and

(5) The Participant meets all the criteria established by Evry Health in pertinent written medical policies; and

(6) The Participant meets all the protocols established by the Hospital in which the transplant is performed.

Covered services and supplies "related to" an organ or tissue transplant include, but are not limited to, x-rays, laboratory testing, chemotherapy, radiation therapy, prescription drugs, procurement of organs or tissues from a living or deceased donor, and complications arising from such transplant.

Benefits are available and will be determined on the same basis as any other sickness when the transplant procedure is considered Medically Necessary and meets all of the conditions cited above.

Benefits will be available for:

(1) A recipient who is covered under this Plan; and
(2) A donor who is a Participant under this Plan; or
(3) A donor who is not a Participant under this Plan.

Covered services and supplies include services and supplies provided for the:

(1) Donor search and acceptability testing of potential live donors; and
(2) Evaluation of organs or tissues including, but not limited to, the determination of tissue matches; and
(3) Removal of organs or tissues from living or deceased donors; and
(4) Transportation and short-term storage of donated organs or tissues.

No benefits are available for a Participant for the following services or supplies:

(1) Living and/or travel expenses of the recipient or a live donor;
(2) Expenses related to maintenance of life of a donor for purposes of organ or tissue donation;
(3) Purchase of the organ or tissue; or
(4) Organs or tissue (xenograft) obtained from another species.

Preauthorization is required for any organ or tissue transplant.

Vision

Some types of vision services are covered under the Evry Medical Insurance policy. These include certain Eye Surgeries, addressing a specific functioning defect, or the result of an Accidental Injury, or injury resulting from domestic violence.

Vision-related care provided by a specialist in a hospital may result in Medically Necessary, non-vision related services ancillary to the vision treatment (such as anesthesia, but not the Lasik surgery itself). Eye exams and eyewear are not covered services.

NON-COVERED SERVICES

There are some kinds of care that your coverage cannot help with:

- Any services or supplies that are not medically necessary
- Medical equipment and supplies that are:
  - Only useful for your comfort or hygiene
  - New or still being tested
  - Performs the function of already provided equipment
- Supplies for hygiene or appearance
- Care for health problems you received at work, if they are covered by your employer, Workers' Compensation, or by a disease law that relates to your job
- Procedures that are new or still being tested
- Cosmetic surgery
- Surgery done to reverse a sterilization

HELP IN OTHER LANGUAGES

Evry Health provides multilingual interpretation services for more than 240 languages through a 24/7 phone interpreter services. Some health education materials are available in both English and Spanish. Finally, many in-network providers speak more than one language.

Americans with Disabilities Act

We follow the rules of the Americans with Disabilities Act of 1990 (ADA). This act exists to protect you from being treated differently due to a disability. If at any time you feel you have been treated in a different way because of a disability, please call our Member Services department toll-free at 1-855-579-3879.

Evry offers certain services for members with special needs. Speak with your Care Guide for more information

COMPLAINTS

How to resolve an issue with Evry Health

We are here to listen and help. If you have a complaint regarding a person, a service, the quality of care, a rescission of coverage, or contractual benefits not related to Medical Necessity, you can call our toll-free number and explain your concern to one of our Customer Service representatives at 855-579-3879. The Customer Service Representative will provide you with a one-page form for completion.

A complaint does not include: a misunderstanding or problem of misinformation that can be promptly resolved by Evry by clearing up the misunderstanding or supplying the correct information to your satisfaction; or you or your provider's dissatisfaction or disagreement with an adverse determination.

You can use the complaint form to give us the details about what happened. Please provide complete information so that we can review your case in the best way possible.

Send to:

Evry Health Insurance Company of Texas
Complaints Department
PO Box 571208
Dallas, TX 75357
Fax: (325) 603-0541 or

Support@evryhealth.com

Evry's Complaint Process

Evry Health will never retaliate against the member because the member filed a complaint or appealed the decision. Similarly, Evry Health will never retaliate against a physician or provider because the provider has filed a complaint or appealed a decision on the member's behalf.

FRAUD, WASTE, AND ABUSE (FWA)

Fraud, Waste, and Abuse are improper actions that result in inappropriate and unnecessary spending.

> **Fraud** is distinct from waste and abuse in that it is committed when one party knowingly or willingly makes a material misrepresentation or omission with the intend to defraud and obtain a benefit.
>
> **Waste** is the overutilization, extravagant, careless, or unnecessary expenditure of healthcare benefits or services. This is often caused by disorganization or a misuse of resources.
>
> **Abuse** refers to practices that are inconsistent or outside of the bounds of generally accepted practices in the industry, which results in unnecessary services and payments.

Evry Health views all Fraud, Waste, and Abuse (FWA) related activities with special interest and maintains a comprehensive anti-fraud program. Evry's Special Investigations Unit (SIU) handles the detection, prevention, and investigation of FWA in the delivery of healthcare services. The SIU depends heavily upon reports from members, providers, and the public to identify incidents of FWA.

Reporting Fraud, Waste, and Abuse

If you or your family suspect that FWA has occurred which relates to Evry in any form, please report it to Evry Health immediately. Please contact Evry's SIU at the following:

Mail	Phone	Email
Evry Health Insurance Company of Texas. Special Investigations Unit P.O. Box 192527 Dallas, TX 75357	Compliance Hotline: **1-855-579-3879**	fraud@evryhealth.com

Please do not hesitate to call the Compliance Hotline with any questions regarding Evry's Compliance Program, to seek advice on how to handle compliance related

situations at work, or with general compliance related concerns, including reporting violations of the law, regulations, policies, or procedures.

All calls are treated confidentially and callers may remain anonymous if they so choose. Callers may be asked if they are willing to identify themselves for the purposes of Evry following-up on the issue with the caller.

All reports through the Compliance Hotline remain anonymous. Retaliation against anyone who raises a concern is prohibited.

KEY TERMS AND DEFINITIONS

See your member benefits documents for complete list of definitions.

Allowable expense means any health care expense that is covered in full or in part by any of the benefit plan. This includes any coinsurance or copayments in the plan, and without reduction for any applicable deductible.

Allowable Amount means the maximum amount determined by Evry Health to be eligible for consideration of payment for a particular service, supply, or procedure.

Behavioral Health Practitioner means a Physician or Professional Other Provider who renders services for Mental Health Care, Serious Mental Illness or Chemical Dependency.

Birthday refers only to the month and day in a plan year. This does not include the year in which the individual is born.

Calendar Year means the period commencing on a January 1 and ending on the next succeeding December 31.

Claim means a request that benefits be provided or paid. The benefits claimed may be in the form of services, including supplies; payment for all or a portion of the expenses incurred; or an indemnification.

Coinsurance Amount means the dollar amount expressed as a percentage of Eligible Expenses incurred by a Participant during a Plan year that exceeds benefits provided under the Plan.

Copayment Amount means the payment, as expressed in dollars, that must be made by or on behalf of a Participant for certain services at the time they are provided.

Cosmetic, Reconstructive, or Plastic Surgery means surgery that:
1. Can be expected or is intended to improve the physical appearance of a Participant; or 2. Is performed for psychological purposes; or 3. Restores form but does not correct or materially restore a bodily function.

Deductible means the dollar amount of Eligible Expenses that must be incurred by a Participant before benefits under the Plan will be available.

Effective date is the date your insurance coverage commences.

Eligible Expenses mean either, Inpatient Hospital Expenses, Medical-Surgical Expenses, Extended Care Expenses, or Special Provisions Expenses, as described in this Benefit Booklet.

Emergency Care means an emergency medical condition means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect, in the absence of immediate medical attention, to result in:

- Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

If you or a family member needs emergency care, go to the closest emergency room or dial 9-1-1. There is no need for prior authorization.

Explanation of Benefits (EOB) the EOB is not a bill. It will explain any charges that the patient still owes or may have already paid (in the form of a copay at the time the medical care was received, for example).

Experimental/Investigational means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as *standard medical treatment* of the condition being treated. It also means any items requiring Federal or other governmental agency approval that has not been granted at the time services were provided.

In-Network Benefits means the benefits available under the Plan for services and supplies that are provided by a Network Provider or an Out-of-Network Provider when acknowledged by Evry Health.

Life-Threatening Disease or Condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Medically Necessary or Medical Necessity means those services or supplies covered under the Plan which are:

1. Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, or bodily malfunction; and
2. Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States; and
3. Not primarily for the convenience of the Participant, their Physician, Behavioral Health Practitioner, the Hospital, or the Other Provider; and

4. The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the Participant. When applied to hospitalization, this further means that the Participant requires acute care as a bed patient due to the nature of the services provided or the Participant's condition, and the Participant cannot receive safe or adequate care as an outpatient.

The medical staff of Evry Health shall determine whether a service or supply is Medically Necessary under the Plan. Part of this consideration includes the views of the state and national medical communities and the guidelines and practices of Medicare, Medicaid, or other government-financed programs. It also considers peer reviewed literature. Although a Physician, Behavioral Health Practitioner or Professional Other Provider may have prescribed treatment, such treatment may not be Medically Necessary within this definition.

Network means identified Physicians, Behavioral Health Practitioners, Professional Other Providers, Hospitals, and other facilities that have entered into agreements with Evry Health for participation in a managed care arrangement.

Network Provider means a Hospital, Physician, Behavioral Health Practitioner or Other Provider who has entered into an agreement with Evry Health to participate as a managed care Provider.

Non-Contracting Facility means a Hospital, a Facility Other Provider, or any other facility or institution which has not executed a written contract with Evry Health for the provision of care, services, or supplies for which benefits are provided by the Plan. Any Hospital, Facility Other Provider, facility, or institution with a written contract with Evry Health which has expired or has been canceled is a Non-Contracting Facility.

Out-of-Network Provider means a Hospital, Physician, Behavioral Health Practitioner or Other Provider who has not entered into an agreement with Evry Health as a managed care Provider.

Out-of-Pocket Maximum means the cumulative dollar amount of Eligible Expenses, including the Plan year or Policy Year Deductible, incurred by a Participant during a Plan year.

Physician means a person licensed doctor of medicine or a doctor of osteopathy.

Plan Year means the period commencing on a member’s effective date and ending twelve months later.

Preauthorization means a determination by Evry Health that medical care or health care services proposed to be provided to a patient are medically necessary and appropriate.

Provider means a Hospital, Physician, Behavioral Health Practitioner, Other Provider, or any other person, company, or institution furnishing to a Participant an item of service or supply listed as Eligible Expenses.

Retail Health Clinic means a Provider that provides treatment for minor illnesses. Retail Health Clinics are typically located in retail stores and are typically staffed by Advanced Practice Nurses or Physician Assistants.

Routine Patient Care Costs means the costs of any Medically Necessary health care service for which benefits are provided under the Plan, without regard to whether the Participant is participating in a clinical trial.

Routine patient care costs do not include:

1. The investigational item, device, or service itself;
2. Items and services that are provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Serious Mental Illness means the following psychiatric illnesses defined by the American Psychiatric Association in the *Diagnostic and Statistical Manual (DSM)*:

1. Bipolar disorders (hypomanic, manic, depressive, and mixed);
2. Depression in childhood and adolescence;
3. Major depressive disorders (single episode or recurrent);
4. Obsessive-compulsive disorders;
5. Paranoid and other psychotic disorders;
6. Schizo-affective disorders (bipolar or depressive); and
7. Schizophrenia.

Skilled Nursing Facility means a facility primarily engaged in providing skilled nursing services and other therapeutic services and which is:

1. Licensed in accordance with state law (where the state law provides for licensing of such facility); or
2. Medicare or Medicaid eligible as a supplier of skilled inpatient nursing care.

Specialty Care Provider means a Physician or Professional Other Provider who has entered into an agreement with Evry Health to participate as a managed care Provider of specialty services.

Telehealth Service means a health service, other than a Telemedicine Medical Service, delivered by a health professional licensed, certified, or otherwise entitled to practice in Texas and acting within the scope of the health professional's license, certification, or

entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.

Telemedicine Medical Service means a health care service delivered by a Physician or Behavioral Health Practitioner licensed in Texas, or a health professional acting under the delegation and supervision of a Physician or Behavioral Health Practitioner licensed in Texas and acting within the scope of the Physician's or health professional's license to a patient at a different physical location than the Physician or health professional using telecommunications or information technology.

Utilization Review means a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services and a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services. This term does not include a review in response to an elective request for clarification of coverage.

Virtual Provider means a licensed Provider that has entered into a contractual agreement with Evry Health to provide diagnosis and treatment of injuries and illnesses through either (i) interactive audio communication (via telephone or other similar technology), or (ii) interactive audio/video examination and communication (via online portal, mobile application or similar technology).

Virtual Visits means services provided for the treatment of non-emergency medical and behavioral health conditions as described in Other Coverage Services provision.

Waiting Period means a period established by an Employer that must pass before an individual who is a potential enrollee in a Health Benefit Plan is eligible to be covered for benefits. No such Waiting Period may exceed 90 days unless permitted by applicable law. If our records show that your group has a Waiting Period that exceeds the time period permitted by applicable law, then we reserve the right to begin your coverage on a date that we believe is within the required period. Regardless of whether we exercise that right, your group is responsible for your Waiting Period. If you have questions about your Waiting Period, please contact your Employer.

RIGHTS AND RESPONSIBILITIES

Statement of Member Rights and Responsibilities:

Evry Health member has the right:

- To be treated with respect and recognition of their dignity and their right to privacy.
- To receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
- To participate with practitioners in making decisions about their health care.
- To a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- To voice complaints or appeals about the organization or the care it provides.
- To make recommendations regarding the organization's member rights and responsibilities policy.
- To obtain language assistance through the language assistance line.
- To have their treatment and other member information kept private. Only where permitted by law, member records may be released without member permission.
- To access timely care in an easy and efficient manner.
- To ask for and have access to your medical records easily despite any visual, hearing, or physical disability.
- To have all forms of PHI as secure as possible against unauthorized access and use across the organization.
- To be notified when private health information (PHI) pertaining to work-related medical monitoring, surveillance, or work-related injuries or illnesses are requested/sent to their employer.
- To invoke your rights and not have it affect the way the organization and its providers treat you.

Evry Health member has the responsibility:

- To supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.

- To follow plans and instructions for care that they have agreed to with their practitioners.
- To understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- To share any worries or concerns pertaining to the quality of care received.

Tell someone if you suspect abuse and fraud using one of the following:

- Call 855-579-3879 and request “Compliance”
- Email fraud@evryhealth.com
- Mail us at:
    - Evry Healthcare, Inc.
    - Special Investigations Unit
    - P.O. Box 571208
    - Dallas, TX 75357

A copy of the Members’ Right and Responsibilities is available at any time at www.evryhealth.com. It is also available on request by calling general customer service number at 1-855-579-EVRY during regular business hours M-F 9am-5pm CST.

Regulatory Notices

Appendix A – Forms

Please visit http://www.evryhealth.com/forms/ for member resources