

**Electronic Data Systems
Corporation**

**Group #014487
Retiree Plan**

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Blue Cross and Blue Shield of Texas provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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SCHEDULE OF COVERAGE

Plan Provisions	In–Network Benefits	Out–of–Network Benefits
Deductibles <ul style="list-style-type: none"> Calendar Year Deductible <i>Applies to all Eligible Expenses</i> 	\$500 – per individual \$1,000 – per family	\$1,500 – per individual \$3,000 – per family
Out–of–Pocket Maximum Amounts	\$2,500 – per individual \$5,000 – per family	\$6,000 – per individual \$10,000 – per family
Copayment Amounts Required <ul style="list-style-type: none"> Outpatient Hospital Emergency Room visit Urgent Care visit 	\$75 Copayment Amount then Deductible and Coinsurance \$50 Copayment Amount then Deductible and Coinsurance	\$75 Copayment Amount then Deductible and Coinsurance \$50 Copayment Amount then Deductible and Coinsurance
Maximum Lifetime Benefits per Participant	Unlimited	
Inpatient Hospital Expenses All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	90% of Allowable Amount after Calendar Year Deductible No penalty for failure to preauthorize services	70% of Allowable Amount after Calendar Year Deductible \$250 penalty for failure to preauthorize services
Medical–Surgical Expenses <ul style="list-style-type: none"> Inpatient visits Physician surgical services in an inpatient setting 	90% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
<ul style="list-style-type: none"> Office visit/consultation including lab and x-rays Outpatient visits and Diagnostic Procedures Home Infusion Therapy Physician surgical services in the office or outpatient setting Independent Lab & X-ray Allergy Injections (without office visit) Outpatient Infertility Services \$7,500 lifetime maximum per family 	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Human Organ Transplant Services <ul style="list-style-type: none"> Human Organ Transplant if performed at a Center of Excellence (COE) facility 	100% of Allowable Amount after Calendar Year Deductible	
<ul style="list-style-type: none"> Human Organ Transplant if performed at a non–COE facility 	90% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
<ul style="list-style-type: none"> Travel Allowance – \$10,000 Calendar Year Maximum benefit per Participant 	100% of Allowable Amount No travel allowance benefit if performed at a non–COE facility	

SCHEDULE OF COVERAGE

Plan Provisions	In–Network Benefits	Out–of–Network Benefits
Extended Care Expenses Inpatient Services <ul style="list-style-type: none"> Skilled Nursing Facility 120 visits combined In and Out–of–Network per Calendar Year 	90% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
<ul style="list-style-type: none"> Hospice Care 	90% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Outpatient Services <ul style="list-style-type: none"> Hospice Care 	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Home Health Care 100 visits per Calendar Year per Participant (1 visit is equal to 2 hours) Private Duty Nursing – limited to 70 visits per Calendar Year per Participant (1 visit is equal to 8 hours)	80% of Allowable Amount after Calendar Year Deductible	
Mental Health Care Serious Mental Illness Treatment of Chemical Dependency Inpatient Services <ul style="list-style-type: none"> Hospital Services (facility) Partial hospitalization, residential, intensive outpatient Mental health/substance abuse (covered on a ratio of 2:1 with inpatient mental Health/substance abuse days) Physician Services (Inpatient days/inpatient visits are combined In and Out–of–Network) 	90% of Allowable Amount after Calendar Year Deductible 90% of Allowable Amount after Calendar Year Deductible Limited to 45 inpatient days/inpatient visits each Calendar Year	70% of Allowable Amount after Calendar Year Deductible 70% of Allowable Amount after Calendar Year Deductible Limited to 25 inpatient days/inpatient visits each Calendar Year
Outpatient Services <ul style="list-style-type: none"> Physician Expenses (office setting) Other Outpatient Services (visits are combined In and Out–of–Network) 	80% of Allowable Amount after Calendar Year Deductible 80% of Allowable Amount after Calendar Year Deductible Limited to 45 visits each Calendar Year	60% of Allowable Amount after Calendar Year Deductible 60% of Allowable Amount after Calendar Year Deductible Limited to 25 visits each Calendar Year

SCHEDULE OF COVERAGE

Plan Provisions	In–Network Benefits	Out–of–Network Benefits
Emergency Care Accidental Injury & Emergency Care within first 48 hours <ul style="list-style-type: none"> Facility Charges 	\$75 Copayment Amount then 80% of Allowable Amount after Calendar Year Deductible Copayment Amount waived if admitted	
<ul style="list-style-type: none"> Physician Charges 	80% of Allowable Amount after Calendar Year Deductible	
Accidental Injury & Emergency Care after 48 hours <ul style="list-style-type: none"> Facility Charges 	\$75 Copayment Amount then 80% of Allowable Amount after Calendar Year Deductible Copayment Amount waived if admitted	\$75 Copayment Amount then 60% of Allowable Amount after Calendar Year Deductible Copayment Amount waived if admitted
<ul style="list-style-type: none"> Physician Charges 	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Urgent Care Services <ul style="list-style-type: none"> Urgent Care visit – including Lab & x–ray (excluding Certain Diagnostic Procedures) 	\$50 Copayment Amount then 80% of Allowable Amount after Calendar Year Deductible	\$50 Copayment Amount then 60% of Allowable Amount after Calendar Year Deductible
Ground and Air Ambulance Services	80% of Allowable Amount after Calendar Year Deductible	
Routine and Preventive Services	Limited to Calendar Year maximum Amount of \$550 per Participant	
<ul style="list-style-type: none"> Well Child Care (up to age 13) – Calendar Year maximum does not apply 	100% of Allowable Amount Calendar Year Deductible does not apply	100% of Allowable Amount Calendar Year Deductible does not apply
<ul style="list-style-type: none"> Childhood Immunizations (up to age 13) – Calendar Year maximum does not apply 	100% of Allowable Amount Calendar Year Deductible does not apply	100% of Allowable Amount Calendar Year Deductible does not apply
<ul style="list-style-type: none"> Routine Physical Exam (beginning at age 13) – Calendar Year maximum does apply. Related tests may include but are not limited to: Office visit Pap smear PSA test EKG Fecal screen for occult blood Chemical profile Complete blood count Urinalysis Chest X–ray 	100% of Allowable Amount Calendar Year Deductible does not apply	100% of Allowable Amount Calendar Year Deductible does not apply
<ul style="list-style-type: none"> Gynecological Exam – Calendar Year maximum does apply 	100% of Allowable Amount Calendar Year Deductible does not apply	100% of Allowable Amount Calendar Year Deductible does not apply

SCHEDULE OF COVERAGE

Plan Provisions	In–Network Benefits	Out–of–Network Benefits
<ul style="list-style-type: none"> Routine Immunizations (beginning age 13) – Calendar Year maximum does apply 	100% of Allowable Amount Calendar Year Deductible does not apply	100% of Allowable Amount Calendar Year Deductible does not apply
<ul style="list-style-type: none"> Routine colonoscopy and sigmoidoscopy – Calendar Year maximum does not apply 	100% of Allowable Amount Calendar Year Deductible does not apply	100% of Allowable Amount Calendar Year Deductible does not apply
<ul style="list-style-type: none"> Routine Mammography Screening (One per Calendar Year) – Calendar Year maximum does not apply 	100% of Allowable Amount Calendar Year Deductible does not apply	100% of Allowable Amount Calendar Year Deductible does not apply
Hearing Services \$4,000 maximum benefit amount per Participant each 36–month period for hearing services to include exam and hearing aids	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
Chiropractic Services 10 day Calendar Year maximum combined In and Out–of–Network per Participant	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Physical Medicine Services 60 day Calendar Year maximum combined In and Out–of–Network per Participant for physical therapy (including physical therapy for TMJ), occupational therapy and speech therapy	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Durable Medical Equipment (DME) Wigs are limited to \$500 per Calendar Year per Participant	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible \$700 Calendar Year Maximum benefit per Participant
Orthotics including External Prosthetics and Foot Orthotics \$2,000 Calendar Year maximum combined In and Out–of–Network per Participant	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible

Preexisting Conditions

Preexisting Conditions are covered immediately.

Prescription Drug Program

For information regarding your prescription drug benefit, contact Express Scripts at 1–800–287–0160.

INTRODUCTION

This Plan is offered by your Employer as one of the benefits of your employment. The benefits provided are intended to assist you with many of your health care expenses for Medically Necessary services and supplies. There are provisions throughout this Benefit Booklet that affect your health care coverage. It is important that you read the Benefit Booklet carefully so you will be aware of the benefits and requirements of this Plan. In the event of any conflict between any components of this Plan, the Administrative Service Agreement provided to your Employer by Blue Cross and Blue Shield of Texas (BCBSTX) prevails.

The defined terms in this Benefit Booklet are capitalized and shown in the appropriate provision in the Benefit Booklet or in the **DEFINITIONS** section of the Benefit Booklet. Whenever these terms are used, the meaning is consistent with the definition given. Terms in italics may be section headings describing provisions or they may be defined terms.

The terms “you” and “your” as used in this Benefit Booklet refer to the Employee. Use of the masculine pronoun “his,” “he,” or “him” will be considered to include the feminine unless the context clearly indicates otherwise.

The term In–Network refers to the BCBS PPO Network.

Freedom of Choice

<i>Each time you need medical care, you can choose to:</i>		
See a Network Provider	See an Out-of–Network Provider	
	ParPlan Provider <i>(refer to ParPlan, below, for more information)</i>	Out-of–Network Provider that is not a contracting Provider
<ul style="list-style-type: none"> • You receive the higher level of benefits (In–Network Benefits) • You are not required to file claim forms • You are not balance billed; Network Providers will not bill for costs exceeding the Claims Administrator’s Allowable Amount for covered services • Your Provider will preauthorize necessary services 	<ul style="list-style-type: none"> • You receive the lower level of benefits (Out-of–Network Benefits) • You are not required to file claim forms in most cases; <i>ParPlan</i> Providers will usually file claims for you • You are not balance billed; <i>ParPlan</i> Providers will not bill for costs exceeding the Claims Administrator’s Allowable Amount for covered services • In most cases, <i>ParPlan</i> Providers will preauthorize necessary services 	<ul style="list-style-type: none"> • You receive Out-of–Network Benefits (the lower level of benefits) • You are required to file your own claim forms • You may be billed for charges exceeding the Claims Administrator’s Allowable Amount for covered services • You must preauthorize necessary services

Managed Health Care – In–Network Benefits

To receive In–Network Benefits as indicated on your Schedule of Coverage, **you must** choose Providers within the Network for all care (**other than for emergencies**). The Network has been established by BCBSTX and consists of Physicians, Specialty Care Providers, Hospitals, and other health care facilities to serve Participants throughout the Network Plan Service Area. Refer to your Provider directory or visit the BCBSTX/EDS website at www.bcbstx.com/eds to make your selections. The listing may change occasionally, so make sure the Providers you select are still Network Providers. An updated directory will be available at least annually. Contact the Customer Service Helpline to request a directory or access our website, www.bcbstx.com/eds, for the most current listing to assist you in locating a Provider. To access a list of Providers or print a Provider directory, go to www.bcbstx.com/eds and follow these steps:

- click on the “Doctors & Hospitals” tab;
- click on the link after “For a listing of national BlueCard Medical Providers”;
- enter “edx” in the “Identification Prefix” under the member tab; then
- follow directions for your location.

To receive In–Network Benefits for Mental Health Care, Serious Mental Illness, and treatment of Chemical Dependency all care should be preauthorized by calling the toll–free Mental Health Preauthorization Helpline indicated on your Identification Card and in this Benefit Booklet. Services and supplies for Mental Health Care, Serious Mental Illness, and treatment of Chemical Dependency must be provided by Network Providers that have specifically contracted with BCBSTX to furnish services and supplies for those types of conditions to be considered for In–Network Benefits.

If you choose a Network Provider, the Provider will bill BCBSTX – not you – for services provided.

The Provider has agreed to accept as payment in full the least of...

- The billed charges, or
- The Allowable Amount as determined by BCBSTX, or
- Other contractually determined payment amounts.

You are responsible for paying any Deductibles and Coinsurance Amounts. You may be required to pay for limited or non–covered services. No claim forms are required.

ParPlan

When you consult a Physician or Professional Other Provider who does not participate in the Network, you should inquire if he participates in BCBSTX’s *ParPlan*...a simple direct–payment arrangement. If the Physician or Professional Other Provider participates in the *ParPlan*, he agrees to:

- File all claims for you,
- Accept the Claim Administrator’s Allowable Amount determination as payment for Medically Necessary services, and
- Not bill you for services over the Allowable Amount determination.

You will receive Out–of–Network Benefits and be responsible for:

- Any Deductibles,
- Coinsurance Amounts, and
- Services that are limited or not covered under the Plan.

Note: If you have a question regarding a Physician’s or Professional Other Provider’s participation in the *ParPlan*, please contact BCBSTX’s Customer Service Helpline.

Managed Health Care – Out–of–Network Benefits

If you choose Out–of–Network Providers, only Out–of–Network Benefits will be available. If you go to a Provider outside the Network, benefits will be paid at the Out–of–Network Benefits level. If you choose a health care Provider outside the Network, you may have to submit claims for the services provided.

You will be responsible for paying...

- Billed charges above the Allowable Amount as determined by BCBSTX (balance billing),
- Coinsurance and Deductibles,
- Failure to preauthorize penalty, and
- Limited or non–covered services.

Identification Card

The Identification Card tells Providers that you are entitled to benefits under your Employer’s Health Benefit Plan. The card offers a convenient way of providing important information specific to your coverage including, but not limited to, the following:

- **Your Subscriber identification number.** This unique identification number is preceded by a three character alpha prefix that identifies Blue Cross and Blue Shield of Texas as your Claims Administrator.
- **Your group number.** This is the number assigned to identify your Employer’s Health Benefit Plan with BCBSTX.
- **Important telephone numbers.**

Always remember to carry your Identification Card with you and present it to your Providers when receiving health care services or supplies.

Please remember that any time a change in your family takes place it may be necessary for a new Identification Card to be issued to you.

Unauthorized, Fraudulent, Improper, or Abusive Use of Identification Cards

1. The unauthorized, fraudulent, improper, or abusive use of Identification Cards issued to you and your covered Dependents will include, but not be limited to, the following actions, when intentional:
 - a. Use of the Identification Card prior to your Effective Date;
 - b. Use of the Identification Card after your date of termination of coverage under the Plan;
 - c. Obtaining other benefits for persons not covered under the Plan;
 - d. Obtaining other benefits that are not covered under the Plan;
 - e. Obtaining Covered Drugs for resale or for use by any person other than the person for whom the Prescription Order is written, even though the person is otherwise covered under the Plan;
 - f. Obtaining Covered Drugs without a Prescription Order or through the use of a forged or altered Prescription Order;
 - g. Obtaining quantities of prescription drugs in excess of Medically Necessary or prudent standards of use or in circumvention of the quantity limitations of the Plan;
 - h. Obtaining prescription drugs using Prescription Orders for the same drugs from multiple Providers;
 - i. Obtaining prescription drugs from multiple Pharmacies through use of the same Prescription Order.
2. The fraudulent or intentionally unauthorized, abusive, or other improper use of Identification Cards by any Participant can result in, but is not limited to, the following sanctions being applied to all Participants covered under your coverage:
 - a. Denial of benefits;
 - b. Cancellation of coverage under the Plan for **all** Participants under your coverage;
 - c. Limitation on the use of the Identification Card to one designated Physician or Other Provider of your choice;
 - d. Recoupment from you or any of your covered Dependents of any benefit payments made;
 - e. Pre-approval of medical services for all Participants receiving benefits under your coverage;
 - f. Notice to proper authorities of potential violations of law or professional ethics.

Important Contact Information

Resource	Contact Information	Accessible Hours
Customer Service Helpline	1-866-737-1337 (1EDS)	Monday – Friday 8:00 a.m. – 8:00 p.m.
Website	www.bcbstx.com/eds	24 hours a day 7 days a week
Medical Preauthorization Helpline	1-866-737-1337 (1EDS)	Monday – Friday 7:30 a.m. – 6:00 p.m.
Mental Health Preauthorization Helpline	1-866-737-1337 (1EDS)	24 hours a day 7 days a week

Customer Service Helpline

Customer Service Representatives can:

- Identify your Plan Service Area
- Give you information about Network and *ParPlan* Providers
- Distribute claim forms
- Answer your questions on claims
- Assist you in identifying a Network Provider (but will not recommend specific Network Providers)
- Provide information on the features of the Plan
- Record comments about Providers

BCBSTX/EDS Website

Visit the BCBSTX/EDS website at www.bcbstx.com/eds for information about BCBSTX, access to forms referenced in this Benefit Booklet, and much more.

You also have easy access to your benefit and claims information through “Blue Access for Members”. This interactive website offers completely secure, password-protected access to the personal health benefits information that you need most. You can create your own account and obtain real-time access to information on your claims, eligibility, Deductibles, local Providers and more. Plus, it’s easy.

Some the Web site features include:

- **Claims** – view your claim status. You can also view claim payment information, claim summary and claim details.
- **Eligibility** – view the coverages you are eligible for under your Plan.
- **Deductibles and Maximums** – view your out-of-pocket costs and benefit limitations.
- **Provider Lookup** – view and find participating Providers and Hospitals in the Blue Cross Blue Shield network, no matter where you live or travel.
- **Identification Card** – request a replacement ID card to be sent to your home.
- **Downloads** – view, print or download forms and documents related to your health care coverage.
- **Coordination of Benefits** – allows you to update additional health care coverage for each member on the Plan.
- **Blue Health Connection** – offers personal health and wellness information all custom tailored to meet your individual needs.

Mental Health Preauthorization Helpline

To satisfy preauthorization requirements for Participants seeking treatment for Mental Health Care, Serious Mental Illness, and Chemical Dependency, you, your Physician, Provider of services, or a family member may call the Mental Health Preauthorization Helpline at any time, day or night.

Medical Preauthorization Helpline

To satisfy all medical preauthorization requirements for inpatient Hospital Admissions, Extended Care Expenses, or Home Infusion Therapy, call the Medical Preauthorization Helpline.

HOW THE PLAN WORKS

Allowable Amount

The Allowable Amount is the maximum amount of benefits BCBSTX will pay for Eligible Expenses you incur under the Plan. BCBSTX has established an Allowable Amount for Medically Necessary services, supplies, and procedures provided by Providers that have contracted with BCBSTX or any other Blue Cross and/or Blue Shield Plan, and Providers that have not contracted with BCBSTX or any other Blue Cross and/or Blue Shield Plan. When you choose to receive services, supplies, or care from a Provider that does not contract with BCBSTX, you will be responsible for any difference between BCBSTX's Allowable Amount and the amount charged by the non-contracting Provider. You will also be responsible for charges for services, supplies, and procedures limited or not covered under the Plan, any applicable Deductibles and Coinsurance Amounts.

Review the definition of Allowable Amount in the **DEFINITIONS** section of this Benefit Booklet to understand the guidelines used by BCBSTX.

Alternate Treatment

Often there is more than one type of service or supply that can be used for treatment of an injury of illness. BCBS reserves the right to propose other treatment plans, services or Providers which, according to BCBS, are equally effective but less costly than those which are being followed. If a treatment, service or Provider is proposed as part of an Alternate Treatment plan and accepted by you and your Physician, the proposed plan will be considered as Covered Medical Services. Services and supplies that are necessary under the proposed treatment plan that are not covered under this Plan will be paid under the Plan as an Alternate Treatment. You are not penalized if the Alternate Treatment program is not followed.

Benefits will be paid for expenses incurred under a Plan of Alternate Treatment at the Plan reimbursement level.

Plan of Alternate Treatment is defined as a medical treatment plan developed between you or your Dependent and his or her attending Physician, along with the Case Manager, with the goal being to provide the most appropriate care in a timely, efficient, and cost-effective manner.

Alternate Treatment Benefits is defined as benefits for expenses which (a) are in connection with a Plan of Alternate Treatment; (b) are approved before they are incurred; and (c) may or may not otherwise be payable as an Eligible Expense under the Covered Medical Services section of this Benefit Booklet.

Medical Necessity

All services and supplies for which benefits are available under the Plan must be Medically Necessary as determined by BCBSTX. Charges for services and supplies which BCBSTX determines are not Medically Necessary will not be eligible for benefit consideration and may not be used to satisfy Deductibles or to apply to the Out-of-Pocket Maximum Amount.

Preexisting Conditions Provision

Benefits for Eligible Expenses incurred for treatment of a Preexisting Condition will be available immediately with no Preexisting Condition Waiting Period.

Specialty Care Providers

A wide range of Specialty Care Providers is included in the Network. When you need a specialist's care, In-Network Benefits will be available, but only if you use a Network Provider.

There may be occasions however, when you need the services of an Out-of-Network Provider. This could occur if you have a complex medical problem that cannot be taken care of by a Network Provider.

- If the services you require are not available from Network Providers, In–Network Benefits will be provided when you use Out–of–Network Providers.
- If you elect to see an Out–of–Network Provider and if the services could have been provided by a Network Provider, only Out–of–Network Benefits will be available.

Transition of Care

Transition of Care (TOC) are services BCBSTX offers to newly enrolled members that allow the higher participating benefits level to be paid for specific medical/surgical services delivered by an Out–of–Network Provider for a specified period of time before transfer of care to a Participating Provider.

During the TOC period, benefits for approved conditions and Providers will be paid at the In–Network Benefits level. If the member chooses to continue care Out–of–Network beyond the timeframe approved by BCBSTX, the member will be responsible for all charges subject to the lower, non–participating benefit level and the member must comply with any preauthorization requirements.

Examples of medical conditions that are appropriate for Transition of Care consideration include, but are not limited to, the following:

- Pregnancy second and third trimester
- Hospitalization
- Rehabilitation for an acute or short term condition
- Cancer Treatment
- Outpatient intravenous therapy for a resolving condition
- Mental Health Care and substance abuse treatment

Examples of medical conditions that will not be approved for Transition of Care include, but are not limited to, the following:

- Care for an ongoing condition by specialists such as allergists, dermatologists, podiatrists, gynecologists
- Primary Care

You must submit your request for Transition of Care within 90 days of the new coverage Effective Date. TOC requests must be submitted in writing, using the Transition of Care request form. A TOC form is available at www.bcbstx.com/eds or by calling the Customer Service Helpline.

HEALTH ADVOCATE AND SPECIAL PROGRAMS

Health Advocate Program

We believe helping you to improve your health is as important as lending a hand after you've become ill. That is why we are offering you the **Health Advocate Program**, a health management program designed to give you the information, assistance and decision-making tools needed to manage your health and chronic illnesses.

Through the Health Advocate Program, a Registered Nurse (RN) is available to help you to better understand your condition, identify your risk factors and recommend steps you can take to improve your health.

We do this, in part, by helping you focus on health topics such as:

- Self-management of your clinical condition;
- Diet and nutrition;
- Hospitalization;
- Pregnancy and infertility;
- Chronic and acute illnesses; and
- Family health.

The Health Advocate Program is a benefit available to you as a BCBS member, so all you need to do is call 1-866-737-1337 (1EDS). In addition, a Health Advocate may reach out to you to offer support. Your Health Advocate will help you find information and assist you in making decisions that are best for you.

Remember, the **Health Advocate Program** is designed to supplement the advice and treatment you receive from your Provider, not replace it. We're confident you'll discover that having a **Health Advocate** available to you adds great value to your BCBS health plan while helping you address your health and clinical condition, take charge of it and reach your health care goals.

What is the Health Advocate Program?

The Health Advocate Program is part of BCBS's integrated personal health care management program. It was designed to improve on traditional approaches to health care by providing you with the information, tools and assistance you need to make the best, and most informed health care choices.

At BCBS, we believe health care decisions should be:

- Made timely, effectively and patient-centered;
- Shared between Provider and patient; and
- supported by BCBS Health Advocate.

The Health Advocate Program uses Blue Health Connection, which gives you access to personalized health information in a secure environment. The site offers care and disease management guides, information on alternative medications and much more.

How does the Health Advocate Program Work?

The Health Advocate Program is the foundation of EDS' goal to provide you and your family support and resources focused on your overall health and well being. Health Advocates are RNs dedicated to offering personal care and attention to all eligible EDS employees and their covered dependents. Their purpose is to help Participants maximize their health care resources, provide support and assistance with any health care need (such as hospitalization or dealing with a diagnosis of chronic illness), and ultimately, to help ensure a positive and productive health care experience. BCBS Health Advocates are connected to all aspects of care and are all-around telephonic resources for your health questions and concerns. This confidential, free resource is the loop on your entire health care experience, and can help you make sense of it all – should you choose to take advantage of this expertise.

How does the Health Advocate Program serve the different medical needs of all members?

The Health Advocate Program offers three levels of care to provide the right members with the right care at the right time. Those levels are: .

- Guided self-management – This level provides members with 24-hours nurse counseling access, health education, symptom management and shared decision-making as needed. In addition to 24-hour nurse counseling, members receive postcards and phone calls encouraging them to contact us for help with specific health conditions.
- Integrated case and disease management – Members in this level are those with high-cost or high-risk conditions as well as those who may be at risk for future complications as a result of their condition. Members receive telephone-based management as well as help with coordination of services and management of their conditions in accordance with established clinical guidelines.
- Complex case management – this level of care provides on-site and telephone-based management to the members with the most severe medical conditions, addressing their serious, at times, terminal illnesses. Nurses work with the member, Provider and family to ensure that there is a clear understanding of the condition, its prognosis and treatment options as well as to coordinate the Providers services these member require.

What is a Health Coach?

The Blue Cross Blue Shield Health Coach is a health educator who works in conjunction with the Health Advocate team to provide you with information on how to use the many benefits and services offered by BCBS and EDS that encourage lifestyle improvement and maintenance of your overall health. This includes education about issues like osteoporosis, cholesterol, blood pressure, and diet and exercise. It also includes reminders for health screenings and childhood immunizations.

In addition, the Health Coach is available to identify and educate you on important issues, such as:

- stress management and relaxation techniques;
- exercise and activities;
- nutrition and health eating; and
- illness prevention.

Participation in the Health Coach program is free, voluntary, and completely confidential. If you would like to contact the BCBS Health Coach, please call toll-free 1-866-737-1337 (1EDS). The Blue Cross Blue Shield Health Coach is available Monday through Friday from 8:00 a.m. to 8:00 p.m. (CST), and confidential voice mail is available 24 hours a day.

Other Special Programs

If you are pregnant or have asthma, contact the Health Advocate nurses at 1-866-737-1337 (1EDS) who can provide you with information regarding the following special programs.

Asthma Disease Management Program

The Asthma Disease Management Program is a comprehensive integrated care management program designed for members with asthma. It offers education and guidance for disease management including:

- Asthma Trigger Assessments;
- Asthma Action Plans,
- Smoking cessation/secondhand avoidance interventions and referral;
- Proper use of prescribed medications; and
- Other tools to help members manage their health better.

The goal of the program is to increase member awareness of the current asthma guidelines and awareness of vaccine programs.

Maternity Program

The Maternity Program is designed to achieve optimal birth outcomes using nationally recognized standards of practice and guidelines denoted by the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP).

The Maternity Program is designed to:

- encourage early and continuous prenatal care;
- promote adherence to the Provider plan of care; and
- educate members on risk factors, pregnancy self-management, appropriate health care choices, birth options and benefit utilization.

Whether you are considered at low or high risk, you have a wealth of information, support and medical care available. This includes:

- An interactive audio library of health information
- Assessment and Screenings
 - Baseline – Maternity health risk assessment and screening
 - Trimester – Mother and fetal risk assessments and screenings
 - Postpartum – Assessment for birth outcome and advisement of post delivery care of mother and infant
- Trimester specific mailings geared to education and self-management
- Postpartum services
- 24-hour nurse access via toll-free 1-866-737-1337 (1EDS)
- Social Worker consultations and interface, as appropriate
- Medical Consultant and Health Coach Advisor interface, as appropriate
- A number of services for high risk situations.

PRAUTHORIZATION REQUIREMENTS

Preauthorization Requirements

Preauthorization establishes in advance the Medical Necessity of certain care and services covered under this Plan. It is required for retirees who do not have Medicare coverage. It is not required for retirees who have Medicare coverage as the primary coverage for this Plan. It ensures that the preauthorized care and services described below will not be denied on the basis of Medical Necessity. However, preauthorization does not guarantee payment of benefits.

Coverage is always subject to other requirements of the Plan, such as limitations and exclusions, payment of contributions, and eligibility at the time care and services are provided.

To satisfy preauthorization requirements, you, your Physician, Provider of services, or a family member calls one of the toll-free numbers listed on the back of your Identification Card. The call for preauthorization should be made between 7:30 a.m. and 6:00 p.m. Central Time on business days. Calls made after working hours or on weekends will be recorded and returned the next working day. A benefits management nurse will follow up with your Provider's office. All timelines for preauthorization requirements are provided in keeping with applicable state and federal regulations.

The following types of services require preauthorization:

- All inpatient Hospital Admissions except routine Maternity admissions,
- Extended Care Expenses,
- Home Infusion Therapy,
- All inpatient and outpatient treatment of Chemical Dependency,
- All inpatient and outpatient treatment of Mental Health Care,
- All inpatient and outpatient treatment of Serious Mental Illness, and
- If you transfer to another facility or to or from a specialty unit within the facility.

In–Network Benefits will be available if you use a Network Provider or Network Specialty Care Provider. In–Network Providers will preauthorize services for you, when required.

If you elect to use Out–of–Network Providers for services and supplies available In–Network, Out–of–Network Benefits will be paid.

However, if care is not available from Network Providers as determined by BCBSTX, and BCBSTX acknowledges your visit to an Out–of–Network Provider **prior to the visit**, In–Network Benefits will be paid; otherwise, Out–of–Network Benefits will be paid and the claim will have to be resubmitted for review and adjusted, if appropriate.

Failure to Preauthorize

If preauthorization for inpatient Hospital Admissions, Extended Care Expense, Home Infusion Therapy, Mental Health Care, Serious Mental Illness, and Treatment of Chemical Dependency as described above, is not obtained:

- BCBSTX will review the Medical Necessity of your treatment prior to the final benefit determination.
- If BCBSTX determines the treatment or service is not Medically Necessary, benefits will be reduced or denied; or
- In connection with an inpatient Hospital Admission, you may be responsible for a penalty, if indicated on your Schedule of Coverage. The penalty charge will be deducted from any benefit payment which may be due for the inpatient admission.
- If an inpatient Hospital Admission or extension for any treatment or service described below is not preauthorized and it is determined that the admission or extension was not Medically Necessary, benefits will be reduced or denied.

Preauthorization for Inpatient Hospital Admissions

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

When an inpatient Hospital Admission is preauthorized, a length-of-stay is assigned. Your Plan is required to provide a minimum length-of-stay in a Hospital facility for the following:

- Maternity Care for the mother and newborn child in a health care facility for a minimum of
 - 48 hours following an uncomplicated vaginal delivery
 - 96 hours following an uncomplicated delivery by caesarean section
- Treatment of Breast Cancer
 - 48 hours following a mastectomy
 - 24 hours following a lymph node dissection

Note: Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting the the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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.

Preauthorization for Extended Care Expenses and Home Infusion Therapy

Preauthorization for Extended Care Expenses and Home Infusion Therapy may be obtained by having the agency or facility providing the services contact BCBSTX to request preauthorization. The request should be made:

- Prior to initiating Extended Care Expenses or Home Infusion Therapy;
- When an extension of the initially preauthorized service is required; and
- When the treatment plan is altered.

BCBSTX will review the information submitted prior to the start of Extended Care Expenses or Home Infusion Therapy and will send a letter to you and the agency or facility confirming preauthorization or denying benefits. If Extended Care Expenses or Home Infusion Therapy is to take place in less than one week, the agency or facility should call BCBSTX's **Medical Preauthorization Helpline** telephone number indicated in this Benefit Booklet or shown on your Identification Card.

If BCBSTX has given notification that benefits for the treatment plan requested will be denied based on information submitted, claims will be denied.

Outpatient Diagnostic Imaging Services

BCBSTX has contracted with American Imaging Management, Inc. (AIM) to implement a Radiology Quality Initiative (RQI) program for outpatient diagnostic imaging services for EDS subscribers.

This program helps to promote appropriate, effective, and safe diagnostic imaging for your condition, and helps connect you with an EDS Health Advocate to assist you with any care coordination needs.

You should inform your Physician that a RQI will be required for the following outpatient diagnostic imaging services when performed in a Physician's office, the outpatient department of a Hospital or a freestanding imaging center:

- Computerized Tomography (CT)
- Computerized Tomographic Angiography (CTA)
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Nuclear Cardiology
- Positron Emission Tomography (PET) scans.

Your Physician must contact AIM to obtain a RQI number when ordering any of the above studies on an elective basis in a Physician office or outpatient/freestanding imaging center.

Imaging studies performed in conjunction with emergency room services, inpatient hospitalization, outpatient surgery (hospital and freestanding surgery centers) or 23-hour observation do not require an RQI.

To obtain a RQI number, your Physician can log onto AIM's Provider Portal at <http://www.americanimaging.net> or call AIM's Call Center at 1-800-859-5299, Monday through Friday, 6:00 a.m. to 6:00 Central Time and 9:00 a.m. to 12:00 p.m. on Saturdays, Sundays and Holidays.

For questions regarding this program, please contact the Customer Service Helpline listed on the back of your Identification Card.

Preauthorization for Mental Health Care, Serious Mental Illness, and Treatment of Chemical Dependency

All inpatient and outpatient Mental Health Care, treatment of Serious Mental Illness, and treatment of Chemical Dependency should be preauthorized by calling the Mental Health Preauthorization Helpline at any time, day or night.

CLAIM FILING AND APPEALS PROCEDURES

CLAIM FILING PROCEDURES

Who Files Claims

Providers that contract with BCBSTX and some other health care Providers (such as *ParPlan* Providers) will submit your claims directly to BCBSTX for services provided to you or any of your covered Dependents. At the time services are provided, inquire if they will file claim forms for you. To assist Providers in filing your claims, you should carry your Identification Card with you.

Contracting Providers

When you receive treatment or care from a Provider that contracts with BCBSTX, you will generally not be required to file claim forms. The Provider will usually submit the claims directly to BCBSTX for you.

Non-Contracting Providers

When you receive treatment or care from a health care Provider that does not contract with BCBSTX, you may be required to file your own claim forms. Some Providers, however, will do this for you. If the Provider does not submit claims for you, refer to the subsection entitled *Participant-filed claims* below for instruction on how to file your own claim forms.

Participant-filed claims

If your Provider does not submit your claims, you will need to submit them to BCBSTX using a Subscriber-filed claim form provided by the Plan. Your Employer should have a supply of claim forms or you can obtain copies from the BCBSTX/EDS website or by contacting the Customer Service Helpline. Follow the instructions on the reverse side of the form to complete the claim. Remember to file each Participant's expenses separately because any Deductibles, maximum benefits, and other provisions are applied to each Participant separately. Include itemized bills from the health care Providers, labs, etc., printed on their letterhead and showing the services performed, dates of service, charges, and name of the Participant involved.

VISIT THE BCBSTX WEBSITE FOR SUBSCRIBER CLAIM FORMS AND OTHER USEFUL INFORMATION
www.bcbstx.com/eds

Where to Mail Completed Medical Claim Forms

Blue Cross and Blue Shield of Texas
Claims Division
P. O. Box 660044
Dallas, Texas 75266-0044

Who Receives Payment

Benefit payments will be made directly to contracting Providers when they bill BCBSTX. Written agreements between BCBSTX and some Providers may require payment directly to them.

Any benefits payable to you, if unpaid at your death, will be paid to your surviving spouse, as beneficiary. If there is no surviving spouse, then the benefits will be paid to your estate.

Except as provided in the section **Assignment and Payment of Benefits**, rights and benefits under the Plan are not assignable, either before or after services and supplies are provided.

Benefit Payments to a Managing Conservator

Benefits for services provided to your minor Dependent child may be paid to a third party if:

- the third party is named in a court order as managing or possessory conservator of the child; and
- BCBSTX has not already paid any portion of the claim.

In order for benefits to be payable to a managing or possessory conservator of a child, the managing or possessory conservator must submit to BCBSTX, with the claim form, proof of payment of the expenses and a certified copy of the court order naming that person the managing or possessory conservator.

BCBSTX for the Health Benefit Plan may deduct from its benefit payment any amounts it is owed by the recipient of the payment. Payment to you or your Provider, or deduction by the Plan from benefit payments of amounts owed to it, will be considered in satisfaction of its obligations to you under the Plan.

An *Explanation of Benefits* summary is sent to you so you will know what has been paid.

When to Submit Claims

All claims for benefits under the Health Benefit Plan must be properly submitted to BCBSTX within twelve (12) months of the date you receive the services or supplies. Claims submitted and received by BCBSTX after that date will not be considered for payment of benefits except in the absence of legal capacity.

Receipt of Claims by BCBSTX

A claim will be considered received by BCBSTX for processing upon actual delivery to the Administrative Office of BCBSTX in the proper manner and form and with all of the information required. If the claim is not complete, it may be denied or BCBSTX may contact either you or the Provider for the additional information.

After processing the claim, BCBSTX will notify the Participant by way of an *Explanation of Benefits* summary.

REVIEW OF CLAIM DETERMINATIONS

Claim Determinations

When BCBSTX receives a properly submitted claim, it has authority and discretion under the Plan to interpret and determine benefits in accordance with the Health Benefit Plan provisions. BCBSTX will receive and review claims for benefits and will accurately process claims consistent with administrative practices and procedures established in writing between BCBSTX and the Plan Administrator. BCBSTX will render an initial decision to pay or deny a claim within 30 days of receipt of the claim. If BCBSTX requires further information in order to process the claim, BCBSTX will request it within that 30-day period.

You have the right to seek and obtain a full and fair review by BCBSTX of any determination of a claim, any determination of a request for preauthorization, or any other determination made by BCBSTX in accordance with the benefits and procedures detailed in your Health Benefit Plan.

Urgent Care Claims

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if the Plan or your Physician determines that it is an Urgent Care Claim, you will be notified of the decision not later than 72 hours after the claim is received.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 24 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Pre-Service and Post-Service Claims

A request for advance approval (preauthorization) of an inpatient admission or other care is considered a Pre-Service Claim. You will be notified of the decision not later than 15 days after receipt of the request.

For other claims (Post-Service Claims), you will be notified of the decision not later than 30 days after receipt of the claim.

For either a Pre-Service or a Post-Service Claim, these time periods may be extended up to an additional 15 days due to circumstances outside the Plan's control. In that case, you will be notified of the extension before the end of the initial 15- or 30-day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to provide the information. You will be notified of the Plan's claim decision not later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For Pre-Service Claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to a Plan representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing Pre-Service Claims, you will be notified of the failure within 5 days (within 24 hours in the case of an Urgent Care Claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

Ongoing Course of Treatment

If you are receiving an Ongoing Course of Treatment, you will be notified in advance if the Plan intends to terminate or reduce benefits for the course of treatment so that you will have an opportunity to appeal the decision before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

The following definitions apply to welfare benefit claims:

- Urgent Care Claim means a claim for medical care or treatment where applying the time periods for making non-urgent care determinations (i) could seriously jeopardize the life or health of the person making the claim or that person's ability to regain maximum function, or (ii) in the opinion of a Physician with knowledge of the person's medical condition, would subject that person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
- Pre-Service Claim means any claim for a benefit which, under the terms of the Plan, are conditioned, in whole or in part, on approval (i.e., preauthorization) of the benefit in advance of obtaining medical care.
- Post-service Claim means any claim for a benefit that is not a Pre-Service Claim.
- Concurrent Care Claim means any claim for a benefit related to an ongoing course of treatment (e.g., weekly chemotherapy treatments scheduled for a set period of weeks).

How and When to File an Appeal

This section explains the Appeals Process and External Review – two things you can do when you disagree with BCBSTX's decision regarding a claim.

First Level Appeal

Initial Appeal Involving Your Non-Urgent Request or Claim

You will have 180 days following receipt of an adverse benefit decision to appeal the decision to BCBSTX. You will be notified of the decision not later than 15 days (for Pre-Service Claims) or 30 days (for Post-Service Claims) after the appeal is received.

You may submit written comments, documents, records and other information relating to your claim, whether or not these were submitted in connection with the initial claim. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

Send your request for an appeal to:

Claim Review Section
Blue Cross and Blue Shield of Texas
P. O. Box 660044
Dallas, Texas 75266-0044

Initial Appeal Involving Your Urgent Request or Claim

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to the Customer Service Helpline number shown in this Benefit Booklet or on your Identification Card.

You or your authorized representative may appeal Urgent Care Claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and the Plan by telephone, facsimile or other similar method. You will be notified of the decision not later than 72 hours after the appeal is received.

Second Level Appeal

If you are dissatisfied with the level one appeal decision, you may request a second review. In the case of an Urgent Care Claim denial, the second level appeal will be automatic.

To initiate a level two appeal, follow the same process required for a level one appeal. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal.

You must submit your second appeal request to BCBSTX within 90 days after you receive the notice of the decision on your first appeal. BCBSTX will forward your appeal request and any information used for the determination of the first level appeal to MCMC, LLC. MCMC, serving as the "claims fiduciary" for the EDS Health Benefit Plan with regard to benefit determinations including those that involve medical judgment for these appeals, will review your appeal and will notify you of its decision.

For required pre-service and concurrent care coverage determinations the MCMC review will be completed within fifteen (15) calendar days and for Post-Service Claims, the MCMC appeal review will be completed within thirty (30) calendar days.

For urgent care coverage determinations, both levels of review of your Urgent Care Claim will be completed as soon as possible, but in no event later than 72 hours after you make your request for the first review on appeal.

Interpretation of Employer's Plan Provisions

The Plan Administrator has given BCBSTX the initial authority to establish or construe the terms and conditions of the Health Benefit Plan and the discretion to interpret and determine benefits in accordance with the Health Benefit Plan's provisions.

The Plan Administrator has all powers and authority necessary or appropriate to control and manage the operation and administration of the Health Benefit Plan.

All powers to be exercised by BCBSTX or the Plan Administrator shall be exercised in a non-discriminatory manner and shall be applied uniformly to assure similar treatment to persons in similar circumstances.

Claim Dispute Resolution

You must exhaust all administrative remedies as described in the **Review of Claims Determinations** section prior to taking further action under your Health Benefit Plan.

If you have a claim for benefits which is denied or ignored, in whole or in part, and your Health Benefit Plan is governed by the Employee Retirement Income Security Act (ERISA), you may file suit under 502 (a) of ERISA.

ELIGIBLE EXPENSES, PAYMENT OBLIGATIONS, AND BENEFITS

Eligible Expenses

The Plan provides coverage for four categories of Eligible Expenses:

- Inpatient Hospital Expenses,
- Medical–Surgical Expenses,
- Extended Care Expenses, and
- Special Provisions Expenses

Wherever Schedule of Coverage is mentioned, please refer to the Schedule(s) in this Benefit Booklet. Your benefits are calculated on a Calendar Year benefit period basis unless otherwise stated. At the end of a Calendar Year, a new benefit period starts for each Participant.

Copayment Amounts

Refer to your Schedule of Coverage under “Copayment Amounts Required” for your specific Plan information.

A Copayment Amount will be required for facility charges for each Hospital outpatient emergency room visit. If admitted to the Hospital as a direct result of the emergency condition or accident, the Copayment Amount will be waived.

A Copayment Amount will be required for each Urgent Care visit.

Deductibles

The benefits of the Plan will be available after satisfaction of the applicable Deductibles as shown on your Schedule of Coverage. The Deductibles are explained as follows:

Calendar Year Deductible: The individual Deductible amount shown under “Deductibles” on your Schedule of Coverage must be satisfied by each Participant under your coverage each Calendar Year. This Deductible, unless otherwise indicated, will be applied to all categories of Eligible Expenses before benefits are available under the Plan.

The following are exceptions to the Deductibles described above:

If you have several covered Dependents, all charges used to apply toward a “per individual” Deductible amount will be applied toward the “per family” Deductible amount shown on your Schedule of Coverage. When that family Deductible amount is reached, no further individual Deductibles will have to be satisfied for the remainder of that Calendar Year. No Participant will contribute more than the individual Deductible amount to the “per family” Deductible amount.

Eligible Expenses applied toward satisfying the “per individual” and “per family” Deductible Amount maximum will apply toward both the In–Network and the Out–of–Network Deductible shown on your Schedule of Coverage.

Out–of–Pocket Maximum Amount

Most of your Eligible Expense payment obligations including Deductibles are considered Coinsurance Amounts and are applied to the Out–of–Pocket Maximum Amount.

Your Out–of–Pocket Maximum Amount will **not** include:

- Copayment Amounts;
- Services, supplies, or charges limited or excluded by the Plan;
- Expenses not covered because a benefit maximum has been reached;
- Penalties applied for failure to preauthorize.

Individual Out–of–Pocket Maximum Amount

When the Coinsurance Amount for the In–Network or Out–of–Network Benefits level for a Participant in a Calendar Year equals the “per individual” “Out–of–Pocket Maximum Amount” shown on your Schedule of Coverage for that level, the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by that Participant for the remainder of that Calendar Year for that level.

Family Out-of-Pocket Maximum Amount

When the Coinsurance Amount for the In–Network or Out–of–Network Benefits level for all Participants under your coverage in a Calendar Year equals the “per family” “Out–of–Pocket Maximum Amount” shown on your Schedule of Coverage for that level, the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by all family Participants for the remainder of that Calendar Year for that level. No Participant will be required to contribute more than the individual Coinsurance Amount to the family “Out–of–Pocket Maximum Amount.”

The following are exceptions to the Out–of–Pocket Maximum Amounts described above:

There are separate Out–of–Pocket Maximum Amounts for In–Network Benefits and Out–of–Network Benefits.

Eligible Expenses applied toward satisfying the “per individual” Out–of–Pocket Maximum Amount will apply toward both the In–Network and the Out–of–Network “Out–of–Pocket Maximum Amount” shown on your Schedule of Coverage.

Eligible Expenses applied toward satisfying the “per family” Out–of–Pocket Maximum Amount will apply toward both the In–Network and the Out–of–Network “Out–of–Pocket Maximum Amount” shown on your Schedule of Coverage.

Copayment Amounts for facility charges for outpatient Hospital emergency room visits for In–Network Benefits and Out–of–Network Benefits will continue to be required after the benefit percentages become 100%.

Copayment Amounts for Urgent Care visits will continue to be required after the benefit percentages become 100%.

Changes In Benefits

Changes to covered benefits will apply to all services provided to each Participant under the Plan. Benefits for Eligible Expenses incurred during an admission in a Hospital or Facility Other Provider that begins before the change will be those benefits in effect on the day of admission.

COVERED MEDICAL SERVICES

Inpatient Hospital Expenses

The Plan provides coverage for Inpatient Hospital Expenses for you and your eligible Dependents. Each inpatient Hospital Admission requires preauthorization. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for additional information.

The benefit percentage of your total eligible Inpatient Hospital Expense, in excess of any Deductible, shown under “Inpatient Hospital Expenses” on the Schedule of Coverage is the Plan’s obligation. The remaining unpaid Inpatient Hospital Expense, in excess of any Deductible, is your obligation to pay.

Services and supplies provided by an Out-of-Network Provider will receive In-Network Benefits when those services and supplies are not available from a Network Provider provided BCBSTX acknowledges your visit to an Out-of-Network Provider **prior** to the visit. Otherwise, Out-of-Network Benefits will be paid and the claim will have to be resubmitted for review and adjustment, if appropriate.

Refer to the Schedule of Coverage for information regarding Deductibles, Coinsurance percentages, and penalties for failure to preauthorize that may apply to your coverage.

Medical–Surgical Expenses

The Plan provides coverage for Medical–Surgical Expense for you and your covered Dependents. Some services require preauthorization. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for more information.

The benefit percentages of your total eligible Medical–Surgical Expense shown under “Medical–Surgical Expenses” on the Schedule of Coverage in excess of your Coinsurance Amounts, and any applicable Deductibles shown are the Plan’s obligation. The remaining unpaid Medical–Surgical Expense in excess of the Coinsurance Amounts, and any Deductibles is your obligation to pay.

Medical–Surgical Expense shall include:

1. Services of Physicians and Professional Other Providers.
2. Consultation services of a Physician and Professional Other Provider.
3. Services of a certified registered nurse–anesthetist (CRNA).
4. Diagnostic x–ray and laboratory procedures.
5. Radiation therapy.
6. Purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician for use outside a Hospital or other health care facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person’s misuse are the person’s responsibility. Coverage for Durable Medical Equipment is limited to the lowest–cost alternative as determined by the utilization review Physician. If you receive services or equipment from an Out-of-Network Provider, benefits are limited to \$700 per Calendar Year and paid at the Out-of-Network benefit level.

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of injury or sickness;

are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, respirators, wheel chairs, and dialysis machines.

7. Professional local ground ambulance service or air ambulance service to the nearest Hospital appropriately equipped and staffed for treatment of the Participant's condition.
8. Anesthetics and its administration, when performed by someone other than the operating Physician or Professional Other Provider.
9. Oxygen and its administration provided the oxygen is actually used.
10. Blood, including cost of blood, blood plasma, and blood plasma expanders.
11. Prosthetic Appliances, including replacements necessitated by growth to maturity of the Participant.
12. Orthopedic braces (i.e., an orthopedic appliance used to support, align, or hold bodily parts in a correct position) and crutches, including rigid back, leg or neck braces, casts for treatment of any part of the legs, arms, shoulders, hips or back; special surgical and back corsets, Physician-prescribed, directed, or applied dressings, bandages, trusses, and splints which are custom designed for the purpose of assisting the function of a joint.
13. Home Infusion Therapy.
14. Services or supplies used by the Participant during an outpatient visit to a Hospital, a Therapeutic Center, or a Chemical Dependency Treatment Center, or scheduled services in the outpatient treatment room of a Hospital.
15. Certain Diagnostic Procedures.
16. Outpatient Contraceptive Services.
17. Foot care in connection with an illness, disease, or condition, such as but not limited to peripheral neuropathy, chronic venous insufficiency, and diabetes.
18. Injectable drugs, administered by or under the direction or supervision of a Physician or Professional Other Provider.
19. Elective Sterilizations.
20. Acupuncture, only in lieu of anesthesia.
21. Wigs, limited to \$500 per Calendar Year per Participant.
22. Any services, supplies and medications associated with sexual dysfunction that is organic in nature.
23. Any services or supplies provided for orthognathic surgery. Orthognathic surgery includes, but is not limited to, correction of congenital, developmental, or acquired maxillofacial skeletal deformities of the mandible and maxilla.

Extended Care Expenses

The Plan also provides benefits for Extended Care Expenses for you and your covered Dependents. All Extended Care Expenses requires preauthorization. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for more information.

The Plan's benefit obligation as shown on your Schedule of Coverage will be:

1. At the benefit percentage under "Extended Care Expenses," and
2. Up to the amount of the combined benefit maximums shown for each category of Extended Care Expenses on your Schedule of Coverage.

All payments made by the Plan, whether under the In–Network or Out–of–Network Benefit level, will apply toward the benefit maximums under both levels of benefits.

If shown on your Schedule of Coverage, the Calendar Year Deductible will apply. Any unpaid Extended Care Expenses in excess of the benefit maximums shown on your Schedule of Coverage will not be applied to any Out–of–Pocket Maximum Amount.

Any charges incurred as Home Health Care or home Hospice Care for drugs (including antibiotic therapy) and laboratory services will not be Extended Care Expenses but will be considered Medical–Surgical Expenses.

Services and supplies for Extended Care Expenses:

1. For Skilled Nursing Facility:
 - a. All usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
 - b. Room and board and all routine services, supplies, and equipment provided by the Skilled Nursing Facility;
 - c. Physical, occupational, speech, and respiratory therapy services by licensed therapists.
2. For Home Health Care:
 - a. Part–time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
 - b. Part–time or intermittent home health aide services which consist primarily of caring for the patient;
 - c. Physical, occupational, speech, and respiratory therapy services by licensed therapists;
 - d. Supplies and equipment routinely provided by the Home Health Agency.

Benefits will **not** be provided for Home Health Care for the following:

- Food or home delivered meals;
- Social case work or homemaker services;
- Services provided primarily for Custodial Care;
- Transportation services;
- Home Infusion Therapy;
- Durable medical equipment.

3. For Private Duty Nursing:

Benefits for home–based Private Duty Nursing services are limited to 70 visits per Calendar Year and requires preauthorization. Private Duty Nursing means services of a practicing R.N., L.P.N., or L.V.N., when ordered by a Physician and when Medically Necessary. The nurse cannot be a member of your immediate family or usually live in your home.

4. For Hospice Care:

Home Hospice Care:

- a. Part–time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);

- b. Part-time or intermittent home health aide services which consist primarily of caring for the patient;
- c. Physical, speech, and respiratory therapy services by licensed therapists;
- d. Homemaker and counseling services routinely provided by the Hospice agency, including bereavement counseling.

Facility Hospice Care:

- a. All usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
- b. Room and board and all routine services, supplies, and equipment provided by the Hospice facility;
- c. Physical, speech, and respiratory therapy services by licensed therapists.

Special Provisions Expenses

The benefits available under this **Special Provisions Expenses** subsection are generally determined on the same basis as other Inpatient Hospital Expenses, Medical-Surgical Expenses, and Extended Care Expenses, except to the extent described in each item. Benefits for Medically Necessary expenses will be determined as indicated on your Schedule(s) of Coverage. Remember that certain services require preauthorization and that any Coinsurance Amounts, or Deductibles shown on your Schedule(s) of Coverage will also apply. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for more information.

Benefits for Treatment of Complications of Pregnancy

Benefits for Eligible Expenses incurred for treatment of Complications of Pregnancy will be determined on the same basis as treatment for any other sickness.

Benefits for Maternity Care

Benefits for Eligible Expenses incurred for Maternity Care will be determined on the same basis as for any other treatment of sickness. Dependent children will be eligible for Maternity Care benefits.

Services and supplies incurred by a Participant for delivery of a child shall be considered Maternity Care and are subject to all provisions of the Plan.

The Plan provides coverage for inpatient care for the mother and newborn child in a health care facility for a minimum of:

- 48 hours following an uncomplicated vaginal delivery; and
- 96 hours following an uncomplicated delivery by caesarean section.

If the mother or newborn is discharged before the minimum hours of coverage, the Plan provides coverage for *Postdelivery Care* for the mother and newborn. The *Postdelivery Care* may be provided at the mother's home, a health care Provider's office, or a health care facility.

Postdelivery Care means postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments. The term includes:

- parent education,
- assistance and training in breast-feeding and bottle feeding, and
- the performance of any necessary and appropriate clinical tests.

Charges for well-baby nursery care, including the initial examination, of a newborn child during the mother's Hospital Admission for the delivery will be considered Inpatient Hospital Expense of the child and will be subject to the benefit provisions and benefit maximums as described under **Inpatient Hospital Expenses**. Benefits will also be subject to any Deductible amounts shown on your Schedule of Coverage.

Clinical Trials

Benefits are available for routine patient services associated with cancer clinical trials approved and sponsored by the federal government. In addition the following criteria must be met:

- the cancer clinical trial is listed on the NIH website at www.clinicaltrials.gov as being sponsored by the federal government;
- the trial investigates a treatment for terminal cancer and: (1) the member has failed standard therapies for the disease; or (2) cannot tolerate standard therapies for the disease; or (3) no effective non-experimental treatment for the disease exists;
- the member meets all inclusion criteria for the clinical trial and is not treated “off-protocol”;
- the trial is approved by the Institutional Review Board of the institution administering the treatment; and
- coverage will not be extended to clinical trials conducted at non-participating facilities if a member is eligible to participate in a covered clinical trial from a participating Provider.

Routine patient services do not include, and reimbursement will not be provided for:

- the investigational service or supply itself;
- services or supplies listed in the Medical Limitations and Exclusions section of this Benefit Booklet;
- services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs); or
- services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial Participant.

Benefits for Infertility Services

Benefits for Medical-Surgical Expenses incurred for infertility services are available as shown on the Schedule of Coverage provided **all** infertility procedures are performed in a facility licensed and approved to provide infertility services under the appropriate state authority, if any.

Treatment of infertility will include:

- all fertility procedures;
- diagnostic testing that is not experimental;
- Artificial insemination (AI);
- Gamete intrafallopian tube transfer (GIFT); and
- Zygote intrafallopian tube transfer (ZIFT).

Benefits are limited to a lifetime maximum of \$7,500 per family and are not available for Dependent children.

No benefits for infertility services are available:

- for the purchase of donor sperm;
- for the care of donor egg retrieval or transfer;
- for cyro-preserved or storage of cyro-preserved embryos.

Benefits for Mental Health Care, Treatment of Serious Mental Illness and Treatment of Chemical Dependency

Benefits for Eligible Expenses incurred for Mental Health Care, treatment of Serious Mental Illness and treatment of Chemical Dependency are shown on your Schedule of Coverage. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection to determine what services require preauthorization.

Mental Health Care and treatment of Serious Mental Illness provided as part of the Medically Necessary treatment of Chemical Dependency will be considered for benefit purposes to be treatment of Chemical Dependency.

Inpatient treatment of Chemical Dependency must be provided in a Chemical Dependency Treatment Center. Benefits for the medical management of acute life-threatening intoxication (toxicity) in a Hospital will be available on the same basis as for sickness generally as described under Benefits for Inpatient Hospital Expense.

Inpatient Hospital Expenses for Mental Health Care, treatment of Serious Mental Illness and treatment of Chemical Dependency will be limited to the number of inpatient days per Calendar Year shown on your Schedule of Coverage.

Medical-Surgical Expenses incurred for Mental Health Care, treatment of Serious Mental Illness and treatment of Chemical Dependency will be limited to the number of inpatient Physician and/or Professional Other Provider visits per Calendar Year shown on your Schedule of Coverage.

Benefits for Medical–Surgical Expenses incurred for Mental Health Care, treatment of Serious Mental Illness and treatment of Chemical Dependency will be limited to the combined number of outpatient Physician and/or Professional Other Provider or other outpatient visits per Calendar Year.

Medically Necessary treatment of Chemical Dependency and/or Mental Health Care, Serious Mental Illness in a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, or a Residential Treatment Center for Children and Adolescents in lieu of hospitalization will be considered Inpatient Hospital Expense. The Inpatient Hospital Expense benefit percentages for this Plan and any Deductible as shown on your Schedule of Coverage will apply. Each full day of treatment in such facility will be considered equal to one–half of one day of a regular Hospital Admission for Mental Health Care, treatment of Serious Mental Illness and treatment of Chemical Dependency.

All inpatient benefits used, including Hospital days and Physician/Professional Other Provider visits, whether In–Network or Out–of–Network, apply to inpatient days or visits shown on the Schedule of Coverage under each level of benefits.

All outpatient Physician and/or Professional Other Provider and other outpatient visit benefits used, whether In–Network or Out–of–Network, apply to outpatient visits shown on the Schedule of Coverage under each level of benefits.

Benefits for Emergency Care and Treatment of Accidental Injury

The Plan provides coverage for medical emergencies wherever they occur. Examples of medical emergencies are unusual or excessive bleeding, broken bones, acute abdominal or chest pain, unconsciousness, convulsions, difficult breathing, suspected heart attack, sudden persistent pain, severe or multiple injuries or burns, and poisonings.

If reasonably possible, contact your Network Physician before going to the Hospital emergency room. He can help you determine if you need Emergency Care or treatment of an Accidental Injury and recommend that care. If not reasonably possible, go to the nearest emergency facility, whether or not the facility is in the Network.

Whether you require hospitalization or not, you should notify your Network Physician within 48 hours, or as soon as reasonably possible, of any emergency medical treatment so he can recommend the continuation of any necessary medical services.

Benefits for Eligible Expenses for Accidental Injury or Emergency Care will be determined as shown on your Schedule of Coverage. Copayment Amounts will be required for facility charges for each outpatient Hospital emergency room visit as indicated on your Schedule of Coverage. If admitted for the emergency condition immediately following the visit, the Copayment Amount will be waived. If admitted for the emergency condition immediately following the visit, preauthorization of the inpatient Hospital Admission will be required.

All treatment received during the first 48 hours following the onset of a medical emergency will be eligible for In–Network Benefits. After 48 hours, In–Network Benefits will be available only if you use Network Providers. If after the first 48 hours of treatment following the onset of a medical emergency, and if you can safely be transferred to the care of a Network Provider but are treated by an Out–of–Network Provider, only Out–of–Network Benefits will be available

Benefits for Urgent Care

Benefits for Eligible Expenses for Urgent Care will be determined as shown on your Schedule of Coverage. A Copayment Amount, in the amount indicated on your Schedule of Coverage, will be required for each Urgent Care visit.

Benefits for Hearing Services

Exams for hearing services or hearing aids, whether benefits are paid under the In–Network or Out–of–Network Benefits level, are limited to a maximum amount of \$4,000 each 36–month period per Participant.

Benefits for Cosmetic, Reconstructive, or Plastic Surgery

The following Eligible Expenses described below for Cosmetic, Reconstructive, or Plastic Surgery will be the same as for treatment of any other sickness as shown on your Schedule of Coverage:

- Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Participant; or
- Treatment provided for reconstructive surgery following cancer surgery; or
- Surgery performed on a newborn child for the treatment or correction of a congenital defect; or
- Surgery performed on a covered Dependent child (other than a newborn child) for the treatment or correction of a congenital defect other than conditions of the breast; or
- Services and supplies for reduction mammoplasty when Medically Necessary and in accordance with the medical policy guidelines of BCBSTX; or
- Reconstruction of the breast on which mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy; or
- Reconstructive surgery performed on a covered Dependent child due to craniofacial abnormalities to improve the function of, or attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Benefits for Temporomandibular Joint (TMJ) Services

Benefits for Eligible Expenses incurred by a Participant will be provided for the treatment of a Temporomandibular Joint Disorder (TMJ) the same as any other illness. Treatment includes exams, X-rays, splints, injections, anesthetics, physical therapy and oral surgery. Charges for orthodontic appliance therapy (except splints) and crowns, bridges and denture therapy are not covered.

Benefits for Organ and Tissue Transplants

BCBS participates with the Blue Cross and Blue Shield Association in a Centers of Excellence (Blue Distinction Centers for Transplants) program called the national Transplant Networks. Institutions selected to be part of this network have met criteria developed by national panels of clinicians to provide high quality care with positive outcomes in transplant procedures. By providing access to these nationally recognized transplant centers, BCBS helps ensure that you receive the highest level of care for transplant services.

- a. Subject to the conditions described below, benefits for covered services and supplies provided to a Participant by a Hospital, Physician, or Other Provider related to an organ or tissue transplant will be determined as shown on the Schedule of Coverage, but only if all the following conditions are met:
- (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 of the criteria established by BCBSTX in pertinent written medical policies; and
 - (6) The Participant meets all of 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.

- b. 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.

- c. Covered services and supplies include services and supplies provided for the:

- (1) Evaluation of organs or tissues including, but not limited to, the determination of tissue matches; and
 - (2) Removal of organs or tissues from living or deceased donors; and
 - (3) Transportation and short-term storage of donated organs or tissues.
- d. Charges made for reasonable travel expenses incurred by you in connection with a pre-approved organ/tissue transplant are covered subject to the following conditions and limitations up to \$10,000 per Calendar Year.

Benefits for transportation, lodging and food are available to you only if you are the recipient of a pre-approved transplant performed at a COE facility. Travel expenses for the person receiving the transplant will include charges for:

- (1) Transportation to and from the transplant facility; and
- (2) Lodging while at, or traveling to and from the transplant site; and food while at, or traveling to and from the transplant site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver.

The following are specifically excluded travel expenses:

- laundry bills;
- telephone bills;
- alcohol or tobacco products; and
- charges for transportation that exceed coach class rates.

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

- (1) Donor search and acceptability testing of potential live donors;
- (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.

- f. Preauthorization is required for any organ or tissue transplant. Review the **PREAUTHORIZATION REQUIREMENTS** subsection in this Benefit Booklet for more specific information about preauthorization.

- (1) Such specific preauthorization is required even if the patient is already a patient in a Hospital under another preauthorization authorization.
- (2) At the time of preauthorization, BCBSTX will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if BCBSTX determines that an extension is Medically Necessary.

- g. No benefits are available for any organ or tissue transplant procedure (or the services performed in preparation for, or in conjunction with, such a procedure) which BCBSTX considers to be Experimental/Investigational.

Benefits for Treatment of Acquired Brain Injury

Benefits for Eligible Expenses incurred for Medically Necessary treatment of an Acquired Brain Injury will be determined on the same basis as treatment for any other physical condition. Eligible Expenses include the following *services* as a result of and related to an Acquired Brain Injury:

- Cognitive communication therapy – *Services* designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information;
- Cognitive rehabilitation therapy – *Services* designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits;
- Community reintegration services – *Services* that facilitate the continuum of care as an affected individual transitions into the community;

- Neurobehavioral testing – An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and pre-morbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others;
- Neurobehavioral treatment – Interventions that focus on behavior and the variables that control behavior;
- Neurocognitive rehabilitation – *Services* designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques;
- Neurocognitive therapy – *Services* designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities;
- Neurofeedback therapy – *Services* that utilizes operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood;
- Neurophysiological testing – An evaluation of the functions of the nervous system;
- Neurophysiological treatment – Interventions that focus on the functions of the nervous system;
- Neuropsychological testing – The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning;
- Neuropsychological treatment – Interventions designed to improve or minimize deficits in behavioral and cognitive processes;
- Post-acute transition services – *Services* that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration;
- Psychophysiological testing – An evaluation of the interrelationships between the nervous system and other bodily organs and behavior;
- Psychophysiological treatment – Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors;
- Remediation – The process(es) of restoring or improving a specific function.

Service means the work of testing, treatment, and providing therapies to an individual with an Acquired Brain Injury.

Therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an Acquired Brain Injury.

Benefits for Treatment of Diabetes

Benefits are available and will be determined on the same basis as any other sickness for those Medically Necessary items for *Diabetes Equipment* and *Diabetes Supplies* (for which a Physician or Professional Other Provider has written an order) and *Diabetic Management Services/Diabetes Self-Management Training*. Such items, when obtained for a *Qualified Participant*, shall include but not be limited to the following:

a. Diabetes Equipment/DME

- (1) Blood glucose monitors (including noninvasive glucose monitors and monitors for the blind);
- (2) Insulin pumps (both external and implantable) and associated appurtenances, which include:
 - Insulin infusion devices,
 - Batteries,
 - Skin preparation items,
 - Adhesive supplies,
 - Infusion sets,
 - Insulin cartridges,
 - Durable and disposable devices to assist in the injection of insulin, and
 - Other required disposable supplies.

- b. Repairs and necessary maintenance of insulin pumps not otherwise provided for under the manufacturer's warranty or purchase agreement, rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump.
- c. As new or improved treatment and monitoring equipment or supplies become available and are approved by the U. S. Food and Drug Administration (FDA), such equipment or supplies may be covered if determined to be Medically Necessary and appropriate by the treating Physician or Professional Other Provider who issues the written order for the supplies or equipment.
- d. Medical–Surgical Expense provided for the nutritional, educational, and psychosocial treatment of the *Qualified Participant*. Such *Diabetic Management Services/Diabetes Self–Management Training* for which a Physician or Professional Other Provider has written an order to the Participant or caretaker of the Participant is limited to the following when rendered by or under the direction of a Physician.

Initial and follow–up instruction concerning:

- (1) The physical cause and process of diabetes;
- (2) Nutrition, exercise, medications, monitoring of laboratory values and the interaction of these in the effective self–management of diabetes;
- (3) Prevention and treatment of special health problems for the diabetic patient;
- (4) Adjustment to lifestyle modifications; and
- (5) Family involvement in the care and treatment of the diabetic patient. The family will be included in certain sessions of instruction for the patient.

Diabetes Self–Management Training for the *Qualified Participant* will include the development of an individualized management plan that is created for and in collaboration with the *Qualified Participant* (and/or his or her family) to understand the care and management of diabetes, including nutritional counseling and proper use of *Diabetes Equipment* and *Diabetes Supplies*.

A *Qualified Participant* means an individual eligible for coverage under this Plan who has been diagnosed with (a) insulin dependent or non–insulin dependent diabetes, (b) elevated blood glucose levels induced by pregnancy, or (c) another medical condition associated with elevated blood glucose levels.

Benefits for Physical Medicine Services

Benefits for Medical–Surgical Expenses incurred for Physical Medicine Services are available and will be determined as–shown on your Schedule of Coverage.

Physical Medicine Services, whether benefits are paid under the In–Network or Out–of–Network Benefits level, are limited to 60 days per Calendar Year per Participant.

Benefits for Chiropractic Services

Benefits for Medical–Surgical Expenses incurred for Chiropractic Services are available and will be determined as shown on your Schedule of Coverage.

Chiropractic Services, whether benefits are paid under the In–Network or Out–of–Network Benefits level, are limited to 10 days per Calendar Year per Participant.

Benefits for Orthotics including External Prosthetics and Foot Orthotic Services

Benefits for Medical–Surgical Expenses incurred for Orthotics including External Prosthetics and Foot Orthotic Services are available and shall include:

- Persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
- Foot orthotics that is an integral part of a leg brace and it is necessary for the proper functioning of the brace;
- Foot orthotics used as a replacement or substitute for missing parts of the foot;
- Persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spinal bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement; and
- Podiatric appliances, including up to two pairs of therapeutic footwear per Calendar Year, for the prevention of complications associated with diabetes.

Orthotics including External Prosthetics and Foot Orthotic Services, whether benefits are paid under the In–Network or Out–of–Network Benefits level, are limited to \$2,000 per Calendar Year per Participant.

All benefit payments made by BCBSTX for ,whether under the In–Network or Out–of–Network Benefits level, will apply toward the benefit maximum under each level of benefits.

Preventive Care Services

All Eligible Expenses are subject to the Calendar Year Deductible, Coinsurance and the \$550 Calendar Year maximum amount.

Routine Physical Exam

Diagnostic laboratory/screening services are available to Participants age 13 and over and limited to the \$550 Calendar Year Maximum Amount if billed as part of a routine physical exam and include the following:

- Chemical profile
- Fecal occult blood screening
- Chest X–ray
- Complete blood count (CBC)
- Urinalysis
- EKG
- Proctoscopic examinations without a biopsy
- PSA (Prostate Specific Antigen) test
- Routine pap smears for female Participants
- Annual gynecological examination.

Note: Screening Colonoscopy and Sigmoidoscopy are covered once per Calendar Year. These test are not subject to the \$550 Calendar Year Maximum Amount.

Routine Immunizations

Includes influenza and all of the recommended childhood and adult immunizations as recommended by the CDC and the ACIP and available to Participants age 13 over. Routine Immunizations are limited to the \$550 Calendar Year maximum amount.

Routine Mammography Screening

One routine low–dose mammography screening per Calendar Year is available and is not subject to the \$550 Calendar Year maximum amount.

Tests for Detection of Colorectal Cancer

Diagnostic, medically recognized screening examination for the detection of colorectal cancer, to include a flexible sigmoidoscopy and colonoscopy, is available for Participants who are at normal risk for developing colon cancer and is not subject to the \$550 Calendar Year maximum amount.

Certain Tests for Detection of Human Papillomavirus and Cervical Cancer

Benefits are available for an annual medically recognized diagnostic examination for the early detection of cervical cancer and subject to the \$550 Calendar Year maximum amount. Coverage includes, at a minimum, a conventional

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

Certain Tests for Detection of Prostate Cancer

Diagnostic medical procedures incurred in conducting an annual medically recognized diagnostic examination for the detection of prostate cancer is available to male Participants, subject to the \$550 Calendar Year maximum amount, and provided for a:

- a. physical examination for the detection of prostate cancer; and
- b. prostate-specific antigen test used for the detection of prostate cancer for each male under the Plan.

Well Child Care

Includes visits to a Provider to monitor the development of a child up to age 13 and is not subject to the \$550 Calendar Year maximum amount.

Childhood Immunizations

All immunizations up to age 13, which are currently recommended by the United States Center for Disease Control and Prevention (CDC), Advisory Committee on Immunizations Practices (ACIP), American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP) and not subject to the \$550 Calendar Year Maximum Amount.

Benefits are available for:

- Diphtheria,
- Hemophilus influenza type b,
- Hepatitis B,
- Measles,
- Mumps,
- Pertussis,
- Polio,
- Rubella,
- Tetanus,
- Varicella, and
- Any other immunization that is required by law for the child.

Injections for allergies are not considered immunizations under this benefit provision.

MEDICAL LIMITATIONS AND EXCLUSIONS

The benefits as described in this Benefit Booklet are not available for:

1. Any services or supplies which are not Medically Necessary and essential to the diagnosis or direct care and treatment of a sickness, injury, condition, disease, or bodily malfunction.
2. Any Experimental/Investigational services and supplies, except for expenses for covered clinical trials.
3. Any portion of a charge for a service or supply that is in excess of the Allowable Amount as determined by BCBSTX.
4. Any services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
5. Any services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, provided, however, that this exclusion shall not be applicable to any coverage held by the Participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
6. Any services or supplies for which a Participant is not required to make payment or for which a Participant would have no legal obligation to pay in the absence of this or any similar coverage.
7. Any court ordered treatment unless prescribed by a Physician and listed as covered under the Plan.
8. Medical and Hospital care and costs for an infant child of a Dependent unless this infant child is otherwise eligible under this Plan.
9. Any services or supplies provided by a person who is related to the Participant by blood or marriage.
10. Any services or supplies provided for injuries sustained:
 - As a result of war, declared or undeclared, or any act of war; or
 - While on active or reserve duty in the armed forces of any country or international authority.
11. Any charges:
 - Resulting from the failure to keep a scheduled visit with a Physician or Professional Other Provider; or
 - For completion of any insurance forms; or
 - For acquisition of medical records.
12. Room and board charges incurred during a Hospital Admission for diagnostic or evaluation procedures unless the tests could not have been performed on an outpatient basis without adversely affecting the Participant's physical condition or the quality of medical care provided.
13. Any services or supplies provided before the patient is covered as a Participant hereunder or any services or supplies provided after the termination of the Participant's coverage.
14. Any services or supplies provided for Dietary and Nutritional Services, except as may be provided under the Plan for:

- Medically Necessary Eligible Expenses incurred for nutritional supplements, prescribed and under the direction of a Physician. Nutritional supplements, as determined by BCBS are provided to maintain sufficient nutrients to maintain weight and strength equal to the Participant's overall health status. Enteral formula is covered as a nutritional supplement when determined to be the sole source of nutrition and for the treatment of permanent non-function or disease of the structures that normally permit food to reach the small bowel; or disease of the small bowel which impairs digestion or absorption of sufficient nutrients. The Plan does not cover expenses incurred for dietary formulas and food products which are not prescribed by a Physician, or regular grocery products such as baby foods lactose-free food, infant formulas, vitamins/minerals; and any items specifically excluded by the Plan; or
- an inpatient nutritional assessment program provided in and by a Hospital and approved by BCBSTX; or
- ***Benefits for Treatment of Diabetes*** as described in **Special Provisions Expenses**.

15. Any services or supplies provided for Custodial Care.

16. Any items of Medical-Surgical Expenses incurred for dental care and treatments to include:

- dental implants for any condition;
- for or in connection with treatment of an injury to the teeth;
- for or in connection with other treatment of the teeth or periodontium unless such expenses are Medically Necessary and are incurred for:
 - a. charges made by a Hospital for bed and board or necessary services and supplies;
 - b. charges made by the outpatient department of a Hospital in connection with surgery; or
 - c. charges made by a Physician for anesthesia for dental procedures performed in the hospital.

17. Any services or supplies provided for Cosmetic, Reconstructive, or Plastic Surgery, except as provided for in the ***Benefits for Cosmetic, Reconstructive, or Plastic Surgery*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet.

18. Any services or supplies provided for:

- Treatment of myopia and other errors of refraction, including refractive surgery except Medically Necessary refractions billed by an Ophthalmologist; or
- Orthoptics or visual training; or
- Eyeglasses or contact lenses, provided that intraocular lenses shall be specific exceptions to this exclusion; or
- Examinations for the prescription or fitting of eyeglasses or contact lenses.

19. Any speech therapy services, that are not restorative in nature, including evaluation, diagnosis and treatment of children diagnosed as having educational disabilities, tongue thrust or developmental delays.

20. Except as specifically included as an Eligible Expense, any Medical Social Services, any outpatient family counseling and/or therapy, bereavement counseling, vocational counseling, or Marriage and Family Therapy and/or counseling.

21. Any services or supplies provided for treatment of adolescent behavior disorders, including conduct disorders and opposition disorders.

22. Any occupational therapy services which do not consist of traditional physical therapy modalities and which are not part of an active multi-disciplinary physical rehabilitation program designed to restore lost or impaired body function.

23. Travel or ambulance services because it is more convenient for the patient than other modes of transportation whether or not recommended by a Physician or Professional Other Provider.

24. Any services or supplies provided primarily for:

- Environmental Sensitivity;
 - Clinical Ecology or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists; or
 - Inpatient allergy testing or treatment.
25. Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.
26. Any medical services or supplies provided for, in preparation for, or in conjunction with:
- Sterilization reversal (male or female); and
 - Transsexual surgery.
27. Any services or supplies in connection with routine foot care, including the removal of warts, corns, or calluses, or the cutting and trimming of toenails in the absence of severe systemic disease.
28. Any services or supplies in connection with foot care for flat feet, fallen arches, and chronic foot strain.
29. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
30. Services or supplies for smoking cessation programs and the treatment of nicotine addiction.
31. Any services or supplies provided for the following treatment modalities:
- video fluoroscopy;
 - intersegmental traction;
 - surface EMGs;
 - manipulation under anesthesia; and
 - muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.
32. Benefits for any covered services or supplies furnished by a Non-Contracting Facility for which such facility shall be subject to benefits provided in **COVERED MEDICAL SERVICES** (except that in accident cases, the immediate, initial treatment necessary to stabilize the Participant furnished by any Hospital, including a governmental facility).
33. Benefits for any covered services or supplies furnished by a Contracting Facility for which such facility has not been specifically approved to furnish under a written contract or agreement with BCBSTX will be paid at the Out-of-Network benefit level.
34. Any items that include, but are not limited to, an orthodontic or other dental appliance; splints or bandages provided by a Physician in a non-hospital setting or purchased “over the counter” for support of strains and sprains; orthopedic shoes which are a separable part of a covered brace, specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or affect changes in the foot or foot alignment, arch supports, elastic stockings and garter belts.
- Note: This exclusion does not apply to podiatric appliances when provided as Diabetic Equipment.
35. Any benefits in excess of any specified dollar, day/visit, Calendar Year, or lifetime maximums.
36. Any services and supplies provided to a Participant incurred outside the United States if the Participant traveled to the location for the purposes of receiving medical services, supplies, or drugs.
37. Donor expenses for a Participant in connection with an organ and tissue transplant if the recipient is not covered under this Plan.

38. Replacement Prosthetic Appliances except those necessitated by growth due to maturity of the Participant.
39. Private duty nursing services, except for covered Extended Care Expenses.
40. Any medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute guideline is covered if the services are demonstrated, through peer-reviewed medical literature and scientifically based guidelines, to be safe and effective for treatment of the condition.
41. Any outpatient prescription or nonprescription drugs.
42. Any drugs and medicines purchased for use outside a Hospital which require a written prescription for purchase including all self-injectables. Injectable drugs administered by or under the direct supervision of a Physician or a Professional Other Provider are covered under the Plan.
43. Any services or supplies not specifically defined as Eligible Expenses in this Plan.

DEFINITIONS

The definitions used in this Benefit Booklet apply to all coverage unless otherwise indicated.

Accidental Injury means accidental bodily injury resulting, directly and independently of all other causes, in initial necessary care provided by a Physician or Professional Other Provider.

Acquired Brain Injury means a neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

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

- ***For Hospitals and Facility Other Providers, Physicians, and Professional Other Providers contracting with BCBSTX or any other Blue Cross and Blue Shield Plan*** – The Allowable Amount is based on the terms of the Provider contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis-related groups (DRG), fee schedule, package pricing, global pricing, per diems, case-rates, discounts, or other payment methodologies.
- ***For Hospitals and Facility Other Providers not contracting with BCBSTX or any other Blue Cross and Blue Shield Plan outside of Texas*** – The Allowable Amount will be the amount BCBSTX would have considered for payment for the same procedure, service, or supply at an equivalent contracting Hospital or Facility Other Provider, using Texas regional or state fee schedules or rate and payment methodologies. For Hospitals or Facility Other Providers where fee schedules or rate payments are not appropriate, the Allowable Amount will be the lesser of billed charge or a per diem established by BCBSTX.
- ***For procedures, services, or supplies provided in Texas by Physicians and Professional Other Providers not contracting with BCBSTX*** – The Allowable Amount will be the lesser of the billed charge or the amount BCBSTX would have considered for payment for the same covered procedure, service, or supply if performed or provided by a Physician or Professional Other Provider with similar experience and/or skill.

If BCBSTX does not have sufficient data to calculate the Allowable Amount for a particular procedure, service, or supply, BCBSTX will determine an Allowable Amount based on the complexity of the procedure, service, or supply and any unusual circumstances or medical complications specifically brought to its attention, which require additional experience, skill, and/or time.

- ***For procedures, services, or supplies performed outside of Texas by Physicians or Professional Other Providers not contracting with BCBSTX or any other Blue Cross and Blue Shield Plan*** – BCBSTX will establish an Allowable Amount using Texas regional or state allowable amounts applicable to procedures, services, or supplies of Physicians or Professional Other Providers with similar skills and experience.
- ***For multiple surgeries*** – The Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount plus one-half of the Allowable Amount for each of the other covered procedures performed.
- ***For drugs administered by a Home Infusion Therapy Provider*** – The Allowable Amount will be the lesser of: (1) the actual charge, or (2) the Average Wholesale Price (AWP) plus a predetermined percentage mark-up or mark-down from the AWP established by BCBSTX and updated on a periodic basis.
- ***For procedures, services, or supplies provided to Medicare recipients*** – The Allowable Amount will not exceed Medicare's limiting charge.

Average Wholesale Price means any one of the recognized published averages of the prices charged by wholesalers in the United States for the drug products they sell to a Pharmacy.

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

Certain Diagnostic Procedures means:

- Bone Scan
- Cardiac Stress Test
- CT Scan (with or without contrast)
- MRI (Magnetic Resonance Imaging)
- Myelogram
- PET Scan (Positron Emission Tomography)
- Ultrasound

Chemical Dependency means the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance.

Chemical Dependency Treatment Center means a facility which provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved and monitored by a Physician and which facility is also:

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral; or
2. Accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations; or
3. Licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or
4. Licensed, certified, or approved as a chemical dependency treatment program or center by any other state agency having legal authority to so license, certify, or approve.

Chiropractic Services means any services or supplies provided by or under the direction of a Doctor of Chiropractic within the scope of his license.

Claims Administrator means Blue Cross and Blue Shield of Texas (BCBSTX). BCBSTX, as part of its duties as Claims Administrator, may subcontract portions of its responsibilities.

Clinical Ecology means the inpatient or outpatient diagnosis or treatment of allergic symptoms by:

1. Cytotoxicity testing (testing the result of food or inhalant by whether or not it reduces or kills white blood cells);
2. Urine auto injection (injecting one's own urine into the tissue of the body);
3. Skin irritation by Rinkel method;
4. Subcutaneous provocative and neutralization testing (injecting the patient with allergen); or
5. Sublingual provocative testing (droplets of allergenic extracts are placed in mouth).

Coinsurance Amount means the percentage of Eligible Expenses for which the Participant is responsible for.

Complications of Pregnancy means:

1. Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but *shall not include* false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.
2. Termination of pregnancy by non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

Contracting Facility means a Hospital, a Facility Other Provider, or any other facility or institution with which BCBSTX has executed a written contract for the provision of care, services, or supplies furnished within the scope of its license for benefits available under the Plan. A Contracting Facility shall also include a Hospital or Facility Other Provider located outside the State of Texas, and with which any other Blue Cross Plan has executed such a written

contract; provided, however, any such facility that fails to satisfy each and every requirement contained in the definition of such institution or facility as provided in the Plan shall be deemed a Non-Contracting Facility regardless of the existence of a written contract with another Blue Cross 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.

Covered Oral Surgery means maxillofacial surgical procedures limited to:

1. Excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths;
2. Incision and drainage of facial abscess;
3. Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses; and
4. Surgical and diagnostic treatment of conditions affecting the temporomandibular joint (including the jaw and the craniomandibular joint) as a result of an accident, a trauma, a congenital defect, a developmental defect, or a pathology.

Crisis Stabilization Unit or Facility means an institution which is appropriately licensed and accredited as a Crisis Stabilization Unit or Facility for the provision of Mental Health Care and Serious Mental Illness services to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

Custodial Care means care comprised of services and supplies, including room and board and other institutional services, provided to a Participant primarily to assist in activities of daily living and to maintain life and/or comfort with no reasonable expectation of cure or improvement of sickness or injury. *Custodial Care* is care which is not a necessary part of medical treatment for recovery, and shall include, but not be limited to, helping a Participant walk, bathe, dress, eat, prepare special diets, and take medication.

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

Dietary and Nutritional Services means the education, counseling, or training of a Participant (including printed material) regarding:

1. Diet;
2. Regulation or management of diet; or
3. The assessment or management of nutrition.

Durable Medical Equipment Provider means a Provider that provides therapeutic supplies and rehabilitative equipment and is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Effective Date means the date the coverage for a Participant actually begins. It may be different from the Eligibility Date.

Eligibility Date means the date the Participant satisfies the definition of either “Employee” or “Dependent” and is in a class eligible for coverage under the Plan as described in the **WHO GETS BENEFITS** section of this Benefit Booklet.

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 health care services provided in a Hospital emergency facility (emergency room) or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate care could result in:

1. placing the patient's health in serious jeopardy;
2. serious impairment of bodily functions;
3. serious dysfunction of any bodily organ or part;
4. serious disfigurement; or
5. in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Environmental Sensitivity means the inpatient or outpatient treatment of allergic symptoms by:

1. Controlled environment; or
2. Sanitizing the surroundings, removal of toxic materials; or
3. Use of special non-organic, non-repetitive diet techniques.

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 or any of such items requiring Federal or other governmental agency approval not granted at the time services were provided.

Approval by a Federal agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient.

As used herein, *medical treatment* includes medical, surgical, or dental treatment.

Standard medical treatment means the services or supplies that are in general use in the medical community in the United States, and:

- have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- are appropriate for the Hospital or Facility Other Provider in which they were performed; and
- the Physician or Professional Other Provider has had the appropriate training and experience to provide the treatment or procedure.

BCBSTX shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational, and will consider the guidelines and practices of Medicare, Medicaid, or other government-financed programs in making its determination.

Although a Physician or Professional Other Provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, BCBSTX still may determine such services or supplies to be Experimental/Investigational within this definition. Treatment provided as part of a clinical trial or a research study is not considered Experimental/Investigational for this Plan.

Extended Care Expenses means the Allowable Amount of charges incurred for those Medically Necessary services and supplies provided by a Skilled Nursing Facility, a Home Health Agency, or a Hospice as described in the **Extended Care Expenses** portion of this Benefit Booklet.

Home Health Agency means a business that provides Home Health Care and is licensed, approved, or certified by the appropriate agency of the state in which it is located or be certified by Medicare as a supplier of Home Health Care.

Home Health Care means the health care services for which benefits are provided under the Plan when such services are provided during a visit by a Home Health Agency to patients confined at home due to a sickness or injury requiring skilled health services on an intermittent, part-time basis.

Home Infusion Therapy means the administration of fluids, nutrition, or medication (including all additives and chemotherapy) by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting. Home Infusion Therapy shall include:

1. Drugs and IV solutions;
2. Pharmacy compounding and dispensing services;
3. All equipment and ancillary supplies necessitated by the defined therapy;
4. Delivery services;
5. Patient and family education; and
6. Nursing services.

Over-the-counter products which do not require a Physician's or Professional Other Provider's prescription, including but not limited to standard nutritional formulations used for enteral nutrition therapy, are not included within this definition.

Home Infusion Therapy Provider means an entity that is duly licensed by the appropriate state agency to provide Home Infusion Therapy.

Hospice means a facility or agency primarily engaged in providing skilled nursing services and other therapeutic services for terminally ill patients and which is:

1. Licensed in accordance with state law (where the state law provides for such licensing); or
2. Certified by Medicare as a supplier of Hospice Care.

Hospice Care means services for which benefits are provided under the Plan when provided by a Hospice to patients confined at home or in a Hospice facility due to a terminal sickness or terminal injury requiring skilled health care services.

Hospital means a short-term acute care facility which:

1. Is duly licensed as a Hospital by the state in which it is located and meets the standards established for such licensing, and is either accredited by the Joint Commission on Accreditation of Healthcare Organizations or is certified as a Hospital provider under Medicare;
2. Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians for compensation from its patients;
3. Has organized departments of medicine and major surgery, either on its premises or in facilities available to the Hospital on a contractual prearranged basis, and maintains clinical records on all patients;
4. Provides 24-hour nursing services by or under the supervision of a Registered Nurse;
5. Has in effect a Hospital Utilization Review Plan; and
6. Is not, other than incidentally, a Skilled Nursing Facility, nursing home, Custodial Care home, health resort, spa or sanitarium, place for rest, place for the aged, place for the treatment of Chemical Dependency, Hospice, or place for the provision of rehabilitative care.

Hospital Admission means the period between the time of a Participant's entry into a Hospital or a Chemical Dependency Treatment Center as a *Bed patient* and the time of discontinuance of bed-patient care or discharge by the admitting Physician or Professional Other Provider, whichever first occurs. The day of entry, but not the day of discharge or departure, shall be considered in determining the length of a Hospital Admission. If a Participant is admitted to and discharged from a Hospital within a 24-hour period but is confined as a *Bed patient* in a bed accommodation during the period of time he is confined in the Hospital, the admission shall be considered a Hospital Admission by BCBSTX.

Bed patient means confinement in a bed accommodation of a Chemical Dependency Treatment Center on a 24-hour basis or in a bed accommodation located in a portion of a Hospital which is designed, staffed, and operated to provide acute, short-term Hospital care on a 24-hour basis; the term does not include confinement in a portion of the Hospital (other than a Chemical Dependency Treatment Center) designed, staffed, and operated to provide long-term institutional care on a residential basis.

Identification Card means the card issued to the Employee by BCBSTX of the Plan indicating pertinent information applicable to his coverage.

Imaging Center means a Provider that can furnish technical or total services with respect to diagnostic imaging services and is licensed through the Texas State Radiation Control Agency.

Independent Laboratory means a Medicare certified laboratory that provides technical and professional anatomical and/or clinical laboratory services.

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 BCBSTX.

Inpatient Hospital Expense means the Allowable Amount incurred for the Medically Necessary items of service or supply listed below for the care of a Participant, provided that such items are:

1. Furnished at the direction or prescription of a Physician or Professional Other Provider; and
2. Provided by a Hospital or a Chemical Dependency Treatment Center; and
3. Furnished to and used by the Participant during an inpatient Hospital Admission.

An expense shall be deemed to have been incurred on the date of provision of the service for which the charge is made.

Inpatient Hospital Expense shall include:

1. Room accommodation charges. If the Participant is in a private room, the amount of the room charge in excess of the Hospital's average semiprivate room charge *is not* an Eligible Expense.
2. All other usual Hospital services, including drugs and medications, which are Medically Necessary and consistent with the condition of the Participant. Personal items *are not* an Eligible Expense.

Medically Necessary Mental Health Care or treatment of Serious Mental Illness in a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, or a Residential Treatment Center for Children and Adolescents, in lieu of hospitalization, shall be Inpatient Hospital Expense.

Marriage and Family Therapy means the provision of professional therapy services to individuals, families, or married couples, singly or in groups, and involves the professional application of family systems theories and techniques in the delivery of therapy services to those persons. The term includes the evaluation and remediation of cognitive, affective, behavioral, or relational dysfunction within the context of marriage or family systems.

Maternity Care means care and services provided for treatment of the condition of pregnancy, other than Complications of Pregnancy.

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

1. Social and emotional factors related to the Participant's sickness, need for care, response to treatment, and adjustment to care; and

2. Relationship of the Participant's medical and nursing requirements to the home situation, financial resources, and available community resources.

Medical–Surgical Expenses means the Allowable Amount for those charges incurred for the Medically Necessary items of service or supply listed below for the care of a Participant, provided such items are:

1. Furnished by or at the direction or prescription of a Physician or Professional Other Provider; and
2. Not included as an item of Inpatient Hospital Expense or Extended Care Expense in the Plan.

A service or supply is furnished at the direction of a Physician or Professional Other Provider if the listed service or supply is:

1. Provided by a person employed by the directing Physician or Professional Other Provider; and
2. Provided at the usual place of business of the directing Physician or Professional Other Provider; and
3. Billed to the patient by the directing Physician or Professional Other Provider.

An expense shall have been incurred on the date of provision of the service for which the charge is made.

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, his Physician, 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 BCBSTX shall determine whether a service or supply is Medically Necessary under the Plan and will consider the views of the state and national medical communities, the guidelines and practices of Medicare, Medicaid, or other government–financed programs, and peer reviewed literature. Although a Physician or Professional Other Provider may have prescribed treatment, such treatment may not be Medically Necessary within this definition.

Mental Health Care means any one or more of the following:

1. The diagnosis or treatment of a mental disease, disorder, or condition listed in the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association*, as revised, or any other diagnostic coding system as used by BCBSTX, whether or not the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin;
2. The diagnosis or treatment of any symptom, condition, disease, or disorder by a Physician or Professional Other Provider (or by any person working under the direction or supervision of a Physician or Professional Other Provider) when the Eligible Expense is:
 - a. Individual, group, family, or conjoint psychotherapy,
 - b. Counseling,
 - c. Psychoanalysis,
 - d. Psychological testing and assessment,
 - e. The administration or monitoring of psychotropic drugs, or
 - f. Hospital visits or consultations in a facility listed in subsection 5, below;
3. Electroconvulsive treatment;

4. Psychotropic drugs;
5. Any of the services listed in subsections 1 through 4, above, performed in or by a Hospital, Facility Other Provider, or other licensed facility or unit providing such care.

Morbid Obesity means a Body Mass Index (BMI) of greater than or equal to 40 kg/meter² or a BMI greater than or equal to 35 kg/meters² with at least two of the following co-morbid conditions which have not responded to a maximum medical management and which are generally expected to be reversed or improved by bariatric treatment:

- Hypertension
- Dyslipidemia
- Type 2 diabetes
- Coronary heart disease
- Sleep Apnea

Network Provider means a Hospital, Physician, or Other Provider who has entered into an agreement with BCBSTX (and in some instances with other participating Blue Cross and/or Blue Shield Plans) 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 BCBSTX 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 BCBSTX which has expired or has been canceled is a Non-Contracting Facility.

Other Provider means a person or entity, other than a Hospital or Physician, that is licensed where required to furnish to a Participant an item of service or supply described herein as Eligible Expenses. Other Provider shall include:

1. **Facility Other Provider** – an institution or entity, only as listed:
 - a. Chemical Dependency Treatment Center
 - b. Crisis Stabilization Unit or Facility
 - c. Durable Medical Equipment Provider
 - d. Home Health Agency
 - e. Home Infusion Therapy Provider
 - f. Hospice
 - g. Imaging Center
 - h. Independent Laboratory
 - i. Prosthetics/Orthotics Provider
 - j. Psychiatric Day Treatment Facility
 - k. Renal Dialysis Center
 - l. Residential Treatment Center for Children and Adolescents
 - m. Skilled Nursing Facility
 - n. Therapeutic Center
2. **Professional Other Provider** – a person or practitioner, when acting within the scope of his license and who is appropriately certified, only as listed:
 - a. Advanced Practice Nurse
 - b. Doctor of Chiropractic
 - c. Doctor of Dentistry
 - d. Doctor of Medicine
 - e. Doctor of Optometry
 - f. Doctor of Osteopathy
 - g. Doctor of Podiatry
 - h. Doctor in Psychology
 - i. Licensed Audiologist
 - j. Licensed Chemical Dependency Counselor
 - k. Licensed Dietitian

- l. Licensed Hearing Instrument Fitter and Dispenser
- m. Licensed Clinical Social Worker
- n. Licensed Occupational Therapist
- o. Licensed Physical Therapist
- p. Licensed Professional Counselor
- q. Licensed Speech–Language Pathologist
- r. Licensed Surgical Assistant
- s. Licensed Midwife
- t. Nurse First Assistant
- u. Physician Assistant
- v. Psychological Associates who work under the supervision of a Doctor in Psychology

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

Out-of-Network Benefits means the benefits available under the Plan for services and supplies that are provided by an Out-of-Network Provider.

Out-of-Network Provider means a Hospital, Physician, or Other Provider who has not entered into an agreement with BCBSTX (or other participating Blue Cross and/or Blue Shield Plan) as a managed care Provider.

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

Outpatient Contraceptive Services means a consultation, examination, procedure, or medical service that is provided on an outpatient basis and that is related to the use of a drug or device intended to prevent pregnancy.

Participant means an Employee or Dependent whose coverage has become effective under this Plan.

Physical Medicine Services means those modalities, procedures, tests, and measurements listed in the *Physicians' Current Procedural Terminology Manual* (Procedure Codes 97010–97799), whether the service or supply is provided by a Physician or Professional Other Provider, and includes, but is not limited to, physical therapy, occupational therapy, hot or cold packs, whirlpool, diathermy, electrical stimulation, massage, ultrasound, manipulation, muscle or strength testing, and orthotics or prosthetic training.

Physician means a person, when acting within the scope of his license, who is a Doctor of Medicine or Doctor of Osteopathy.

Plan means a program of health and welfare benefits established for the benefit of its Participants whether the plan is subject to the rules and regulations of the Employee's Retirement and Income Security Act (ERISA) or, for government and/or church plans, where compliance is voluntary.

Plan Administrator means the the Group Health Plan (GHP) or a named administrator of the Plan having fiduciary responsibility for its operation. BCBSTX is not the Plan Administrator.

Plan Anniversary Date means the day, month, and year of the 12-month period following the Plan Effective Date and corresponding date in each year thereafter for as long as this Benefit Booklet is in force.

Plan Effective Date means the date on which coverage for the Employer's Plan begins with BCBSTX.

Plan Month means each succeeding calendar month period, beginning on the Plan Effective Date.

Plan Service Area means the geographical area(s) or areas in which a Network of Providers is offered and available and is used to determine eligibility for **Managed Health Care Plan** benefits.

1. The geographical area(s) documented in the attached **Exhibit A – Plan Service Area Listing**, shall be the Plan Service Area for Participants enrolled in the Managed Health Care coverage under the Plan.
2. If the Employee resides in the Plan Service Area, Managed Health Care Plan coverage will be available for him and all his Dependents. An Employee residing outside the Plan Service Area may elect Managed Health Care Plan coverage for himself and all of his Dependents if his place of employment is located within the Plan Service Area.
3. An Employee residing outside of the Plan Service Area will be covered by Traditional Medical Benefit coverage that will be issued under a separate Benefit booklet, when necessary.
4. Only Network Providers can provide or arrange for In–Network services under the Managed Health Care Plan provisions.

Preexisting Condition means a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the 6 months before the earlier of the:

- Effective Date of Coverage; or
- First day of the Preexisting Condition waiting period.

Proof of Loss means written evidence of a claim including:

1. The form on which the claim is made;
2. Bills and statements reflecting services and items furnished to a Participant and amounts charged for those services and items that are covered by the claim, and
3. Correct diagnosis code(s) and procedure code(s) for the services and items.

Prosthetic Appliances means artificial devices including limbs or eyes, braces or similar prosthetic or orthopedic devices, which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). For purposes of this definition, a wig or hairpiece is not considered a Prosthetic Appliance.

Prosthetics/Orthotics Provider means a certified prosthetist that supplies both standard and customized prostheses and orthotic supplies.

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

Psychiatric Day Treatment Facility means an institution which is appropriately licensed and is accredited by the Joint Commission on Accreditation of Healthcare Organizations as a Psychiatric Day Treatment Facility for the provision of Mental Health Care and Serious Mental Illness services to Participants for periods of time not to exceed eight hours in any 24–hour period. Any treatment in a Psychiatric Day Treatment Facility must be certified in writing by the attending Physician to be in lieu of hospitalization.

Renal Dialysis Center means a facility which is Medicare certified as an end–stage renal disease facility providing staff assisted dialysis and training for home and self–dialysis.

Residential Treatment Center for Children and Adolescents means a child–care institution which is appropriately licensed and accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Association of Psychiatric Services for Children as a residential treatment center for the provisions of Mental Health Care and Serious Mental Illness services for emotionally disturbed children and adolescents.

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. Pervasive developmental disorders;
7. Schizo–affective disorders (bipolar or depressive); and
8. 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 Claims Administrator (and in some instances with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care Provider of specialty services.

Therapeutic Center means an institution which is appropriately licensed, certified, or approved by the state in which it is located and which is:

1. An ambulatory (day) surgery facility;
2. A freestanding radiation therapy center; or
3. A freestanding birthing center.

GENERAL PROVISIONS

Agent

The Employer is not the agent of BCBSTX.

Amendments

The Plan may be amended or changed at any time by agreement between the Employer and BCBSTX. No notice to or consent by any Participant is necessary to amend or change the Plan.

Assignment and Payment of Benefits

Rights and benefits under the Plan shall not be assignable, either before or after services and supplies are provided.

In the absence of a written agreement with a Provider, BCBSTX reserves the right to make benefit payments to the Provider or the Employee, as BCBSTX elects. Payment to either party discharges the Plan's responsibility to the Employee or Dependents for benefits available under the Plan.

If a written assignment of benefits is made by a Participant to a Pharmacy and the written assignment is delivered to the Claims Administrator with the claim for benefits, the Claims Administrator will make any payment directly to the Pharmacy. Payment to the Pharmacy discharges the Claims Administrator's responsibility to Participant for any benefits available under the Plan.

Claims Liability

BCBSTX, in its role as Claims Administrator, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Disclosure Authorization

If you file a claim for benefits, it will be necessary that you authorize any health care Provider, insurance carrier, or other entity to furnish BCBSTX all information and records or copies of records relating to the diagnosis, treatment, or care of any individual included under your coverage. If you file claims for benefits, you and your Dependents will be considered to have waived all requirements forbidding the disclosure of this information and records.

Participant/Provider Relationship

The choice of a health care Provider should be made solely by you or your Dependents. BCBSTX does not furnish services or supplies but only makes payment for Eligible Expenses incurred by Participants. BCBSTX is not liable for any act or omission by any health care Provider. BCBSTX does not have any responsibility for a health care Provider's failure or refusal to provide services or supplies to you or your Dependents. Care and treatment received are subject to the rules and regulations of the health care Provider selected and are available only for sickness or injury treatment acceptable to the health care Provider.

BCBSTX, Network Providers, and/or other contracting Providers are independent contractors with respect to each other. BCBSTX in no way controls, influences, or participates in the health care treatment decisions entered into by said Providers. BCBSTX does not furnish medical, surgical, hospitalization, or similar services or supplies, or practice medicine or treat patients. The Providers, their employees, their agents, their ostensible agents, and/or their representatives do not act on behalf of BCBSTX nor are they employees of BCBSTX.

The Claims Administrator and Participating Pharmacies are independent contractors with respect to each other. The Claims Administrator in no way controls, influences, or participates in the drug dispensing decisions entered into by

said Participating Pharmacies. The Claims Administrator does not furnish medical, surgical, hospitalization, or similar services or supplies, or practice medicine, dispense drugs, or treat patients. The Participating Pharmacies, their employees, their agents, their ostensible agents, and/or their representatives do not act on behalf of BCBSTX nor are they employees of BCBSTX.

Refund of Benefit Payments

If BCBSTX pays benefits for Eligible Expenses incurred by you or your Dependents and it is found that the payment was more than it should have been, or was made in error, the Plan has the right to a refund from the person to or for whom such benefits were paid, any other insurance company, or any other organization. If no refund is received, BCBSTX may deduct any refund due it from any future benefit payment.

Subrogation

If the Plan pays or provides benefits for you or your Dependents, the Plan is subrogated to all rights of recovery which you or your Dependent have in contract, tort, or otherwise against any person, organization, or insurer for the amount of benefits the Plan has paid or provided. That means the Plan may use your rights to recover money through judgment, settlement, or otherwise from any person, organization, or insurer.

For the purposes of this provision, *subrogation* means the substitution of one person or entity (the Plan) in the place of another (you or your Dependent) with reference to a lawful claim, demand or right, so that he or she who is substituted succeeds to the rights of the other in relation to the debt or claim, and its rights or remedies.

Right to Recovery by Subrogation or Reimbursement

You or your Dependent agree to promptly furnish to the Plan all information which you have concerning your rights of recovery from any person, organization, or insurer and to fully assist and cooperate with the Plan in protecting and obtaining its reimbursement and subrogation rights. You, your Dependent or your attorney will notify the Plan before settling any claim or suit so as to enable us to enforce our rights by participating in the settlement of the claim or suit. You or your Dependent further agree not to allow the reimbursement and subrogation rights of the Plan to be limited or harmed by any acts or failure to act on your part.

For Participants who reside in Michigan, you should also review the medical benefits coverage under the personal injury protection portion of your auto insurance policy to ensure you have chosen uncoordinated medical benefits.

Coordination of Benefits

For Retired Employees Not Eligible for Medicare and Their Covered Dependents

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

Definitions

For the purposes of this section, the following terms are defined as follows:

1. **Plan** means any of the following that provides benefits or services for medical treatment:
 - a. Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage;
 - b. Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies; and
 - c. Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

2. **Closed Panel Plan** means a Plan that provides medical benefits primarily in the form of services through a panel of employed or contracted Providers, and that limits or excludes benefits provided by Providers outside of the panel, except in the case of emergency or if referred by a Provider within the panel.
3. **Primary Plan** means the Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.
4. **Secondary Plan** means a Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover payments from the Primary Plan.
5. **Allowable Expense** means a necessary, reasonable, and customary item of expense, including Deductibles, Coinsurance or Copayments, that is covered in full or in part by any Plan covering you.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

- a. An expenses or service or a portion of an expense or service that is not covered by any of the Plan is not an Allowable Expense.
- b. If you confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
- c. If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- d. If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- e. If your benefits are reduced under the Primary Plan (through the imposition of a higher Copayment Amount, higher Coinsurance percentage, a Deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred Provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and preauthorization of admissions or services.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situations is the one to use:

1. The Plan that covers you as a enrollee or an Employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
2. If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the Calendar Year as an enrollee or Employee;
3. If you are a Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
 - a. first, if a court decree states that one parent is responsible for the child's Health care expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
 - b. then, the Plan of the parent with custody of the child;
 - c. then, the Plan of the spouse of the parent with custody of the child;
 - d. then, the Plan of the parent not having custody of the child; and
 - e. finally, the Plan of the spouse of the parent not having custody of the child.
4. the Plan that covers you as an active Employee (or as that Employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired Employee (or as that Employee's Dependent) shall be the Secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply;

5. The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active Employee or retiree (or as that Employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply; or
6. If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

Effect on the Benefits of This Plan

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans are not more than one hundred percent (100%) of the total of all Allowable Expenses.

As each claim is submitted, BCBS will determine its obligation to provide services and supplies under this policy.

BCBS requires information regarding other group health insurance coverage for you and any of your eligible Dependents. We will periodically request other insurance information from you. This request may occur in connection with a submitted claim; if so, you will be advised that the other insurance information (including an explanation of benefits from the other insurance carrier) is required before the submitted claim will be processed for payment. If no response is received within 90 days, the claim will be denied. If the requested information is subsequently received by BCBS, the claim will be processed.

Recovery of Excess Benefits

If BCBS pays charges for benefits that should have been paid by the Primary Plan, or if BCBS pays charges in excess of those for which we are obligated to provide under the Plan, BCBS will have the right to recover the excess payment.

BCBS will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, Health care plan or other organization. If we request, you shall execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

For Medicare Eligible Employees and Their Covered Dependents

Medicare Eligibles

The medical coverage for:

- a. a former Employee who is eligible for Medicare and whose insurance is continued for any reason as provided in this Plan;
- b. a former Employee's Dependent, or a former Dependent spouse, who is eligible for Medicare and whose coverage is continued for any reason as provided in this Plan;
- c. an Employee whose Employer and each other Employer participating in the Employer's Plan have fewer than 100 Employees and that Employee is eligible for Medicare due to disability;

- d. the Dependent of an Employee whose Employer and each other Employer participating in the Employer's Plan have fewer than 100 Employees and that Dependent is eligible for Medicare due to disability;
- e. an Employee or a Dependent of an Employee of an Employer who has fewer than 20 Employees, if that person is eligible for Medicare due to age; or
- f. an Employee, retired Employee, Employee's Dependent or retired Employee's dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months;

will be modified, where permitted by the rules established by the Social Security Act of 1965 as amended, as follows:

The total benefits available will not exceed the Allowable Expense.

BCBS will assume the amount payable under:

1. Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he would receive if he had applied.
2. Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he would receive if he were enrolled.
3. Part B of Medicare for a person who has entered into a private contract with a Provider, to be the amount he would receive in the absence of such private contract.

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him.

This reduction will not apply to any Employee and his Dependent or any former Employee and his Dependent unless he is listed under a through f above.

Right of Reimbursement

The Plan does not cover:

1. Expenses for which another party may be responsible as a result of liability for causing or contributing to the injury or illness of you or your Dependent(s).
2. Expenses to the extent they are covered under the terms of any automobile medical, automobile no fault, uninsured or underinsured motorist, workers' compensation, government insurance, other than Medicaid, or similar type of insurance or coverage when insurance coverage provides benefits on behalf of you or your Dependent(s).

If you or a Dependent incur health care expenses as described in 1 and 2 above, BCBS, on behalf of the Plan shall automatically have a right of reimbursement upon the proceeds of any recovery by you or your Dependent(s) from such party to the extent of any benefits provided to you or your Dependents(s) by the Policy. You or your Dependent(s) or their representative shall execute such documents as may be required by BCBS to secure the Plan's rights. The Plan shall be reimbursed the lesser of:

- the amount actually paid by BCBS under the Plan; or
- an amount actually received from the third party;

at the time that the third party's liability is determined and satisfied; whether by settlement, judgment, arbitration or otherwise.

Termination of the Group

The coverage of all Participants will terminate if the group is terminated in accordance with the terms of the Plan.

Continuation of Group Coverage – Federal

COBRA Continuation – Federal

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Participants may have the right to continue coverage after the date coverage ends. Participants will not be eligible for COBRA continuation if the Employer is exempt from the provisions of COBRA.

Information Concerning Employee Retirement Income Security Act of 1974 (ERISA)

If the Health Benefit Plan is part of an “employee welfare benefits plan” and “welfare plan” as those terms are defined in ERISA:

1. The Plan Administrator will furnish summary plan descriptions, annual reports, and summary annual reports to you and other plan participants and to the government as required by ERISA and its regulations.
2. BCBSTX will furnish the Plan Administrator with this Benefit Booklet as a description of benefits available under this Health Benefit Plan. Upon written request by the Plan Administrator, BCBSTX will send any information which BCBSTX has that will aid the Plan Administrator in making its annual reports.
3. Claims for benefits must be made in writing on a timely basis in accordance with the provisions of this Health Benefit Plan. Claim filing and claim review health procedures are found in the **CLAIM FILING AND APPEALS PROCEDURES** section of this Benefit Booklet.
4. BCBSTX is not the ERISA “Plan Administrator” for benefits or activities pertaining to the Health Benefit Plan.
5. This Benefit Booklet is not a Summary Plan Description.
6. The Plan Administrator has given BCBSTX the authority and discretion to interpret the Health Benefit Plan provisions and to make eligibility and benefit determinations. The Plan Administrator has full and complete authority and discretion to make decisions regarding the Health Benefit Plan’s provisions and determining questions of eligibility and benefits. Any decisions made by the Plan Administrator shall be final and conclusive.

AMENDMENTS

NOTICES

NOTICE
Other Blue Cross and Blue Shield Plans Separate Financial Arrangements with Providers

BlueCard

Blue Cross and Blue Shield of Texas hereby informs you that other Blue Cross and Blue Shield Plans outside of Texas (“Host Blues”) may have contracts similar to the contracts described above with certain Providers (“Host Blue Providers”) in their service areas.

When you access health care services through BlueCard outside of Texas and from a Provider which does not have a contract with Blue Cross and Blue Shield of Texas, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your covered services, or
- The negotiated price that the Host Blue passes on to Blue Cross and Blue Shield of Texas.

Often, this “negotiated price” will consist of a simple discount which reflects the actual price paid by the Host Blue. Sometimes, however, it is an estimated price that takes into consideration the actual price increased or reduced to reflect aggregate payment from expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be charged as a billed charge reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for covered services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate your liability calculation methods that differ from the usual BlueCard method noted above or require a surcharge, Blue Cross and Blue Shield of Texas would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

NOTICE

The Women's Health and Cancer Rights Act of 1998 requires this notice. This Act is effective for plan year anniversaries on or after October 21, 1998. This benefit may already be included as part of your coverage.

In the case of a covered person receiving benefits under their plan in connection with a mastectomy and who elects breast reconstruction, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

1. Reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Deductibles, Co-Share and Copayment Amounts will be the same as those applied to other similarly covered medical services, such as surgery and prostheses.

NOTICE

Although health care services may be or have been provided to you at a health care facility that is a Member of the Provider Network used by your Health Benefit Plan, other Professional services may be or have been provided at or through the Facility by Physicians and other Health Care Practitioners who are not Members of that Network. You may be responsible for payment of all or part of the fees for those Professional services that are not paid or covered by your Health Benefit Plan.

NOTICE

CONTINUATION COVERAGE RIGHTS UNDER COBRA

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA). See your employer or Group Administrator should you have any questions about COBRA.

INTRODUCTION

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

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

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

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

HOW IS COBRA COVERAGE PROVIDED?

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of

COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

PLAN CONTACT INFORMATION

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

EXHIBIT A

PLAN SERVICE AREA LISTING

for

**MANAGED HEALTH CARE
BENEFIT COVERAGE**

(In-Network and Out-of-Network Benefits)

STATE	BLUE CROSS AND/OR BLUE SHIELD PLAN	PLAN SERVICE AREA
Alabama	Blue Cross and Blue Shield of Alabama	State-wide
Alaska	Blue Cross of Washington and Alaska (PREMERA)	State-wide
Arizona	Blue Cross and Blue Shield of Arizona	State-wide
Arkansas	Arkansas Blue Cross and Blue Shield	State-wide
California	Blue Shield of California Blue Cross of California	State-wide
Colorado	Blue Cross and Blue Shield of Colorado	State-wide
Connecticut	Anthem Blue Cross and Blue Shield (Connecticut)	State-wide
Delaware	Blue Cross and Blue Shield of Delaware	State-wide
District of Columbia	CareFirst Blue Cross and Blue Shield (DC)	Washington, D. C. metropolitan area and surrounding counties
Florida	Blue Cross and Blue Shield of Florida (BlueCard PPO Network)	State-wide
Georgia	Blue Cross and Blue Shield of Georgia	State-wide
Hawaii	Blue Cross and Blue Shield of Hawaii	State-wide
Idaho	Blue Cross of Idaho Regence Blue Shield of Idaho	State-wide
Illinois	Blue Cross and Blue Shield of Illinois	State-wide
Indiana	Anthem Blue Cross and Blue Shield (Indiana)	State-wide
Iowa	Wellmark Blue Cross and Blue Shield of Iowa	State-wide
Kansas	Blue Cross and Blue Shield of Kansas	State-wide, excluding Johnson and Wyandotte Counties
Kentucky	Anthem Blue Cross and Blue Shield (Kentucky)	State-wide
Louisiana	Blue Cross and Blue Shield of Louisiana (Preferred Care PPO Network)	State-wide
Maine	Anthem Blue Cross and Blue Shield (Maine)	State-wide

STATE	BLUE CROSS AND/OR BLUE SHIELD PLAN	PLAN SERVICE AREA
Maryland	CareFirst BlueCross and BlueShield (Maryland)	State-wide
Massachusetts	Blue Cross and Blue Shield of Massachusetts	State-wide
Michigan	Blue Cross and Blue Shield of Michigan	State-wide
Minnesota	Blue Cross and Blue Shield of Minnesota	State-wide
Mississippi	Blue Cross and Blue Shield of Mississippi	State-wide
Missouri	Blue Cross and Blue Shield of Kansas City (Preferred Care Network) Alliance Blue Cross and Blue Shield (St. Louis)	State-wide
Montana	Blue Cross and Blue Shield of Montana	State-wide
Nebraska	Blue Cross and Blue Shield of Nebraska	State-wide
Nevada	Blue Cross and Blue Shield of Nevada	State-wide
New Hampshire	Blue Cross and Blue Shield of New Hampshire	State-wide
New Jersey	Horizon Blue Cross and Blue Shield of New Jersey	State-wide
New Mexico	Blue Cross and Blue Shield of New Mexico	State-wide
New York	Empire Blue Cross and Blue Shield Blue Cross and Blue Shield of Western New York Blue Shield of Northeastern New York Blue Cross and Blue Shield of the Rochester Area Blue Cross and Blue Shield of Central New York Blue Cross and Blue Shield of Utica-Watertown	State-wide
North Carolina	Blue Cross and Blue Shield of North Carolina (Preferred Care Select Network)	State-wide
North Dakota	BlueCross BlueShield of North Dakota	State-wide
Ohio	Anthem Blue Cross and Blue Shield (Ohio) (Community Preferred Health Plan Network)	State-wide
Oklahoma	Blue Cross and Blue Shield of Oklahoma	Metropolitan areas of Oklahoma City and Tulsa, Lawton, Edmond, Shawnee, Hugo, Tahlequah, Cushing, Poteau, Pryor and some oth- er communities
Oregon	Regence Blue Cross and Blue Shield of Oregon	State-wide

STATE	BLUE CROSS AND/OR BLUE SHIELD PLAN	PLAN SERVICE AREA
Pennsylvania	Capital Blue Cross Independence Blue Cross Highmark Blue Cross and Blue Shield <i>(Independence Blue Cross, Capital Blue Cross and Blue Cross of Northeastern Pennsylvania)</i> Highmark Blue Cross and Blue Shield Blue Cross of Northeastern Pennsylvania	State-wide
Rhode Island	Blue Cross and Blue Shield of Rhode Island	State-wide
South Carolina	Blue Cross and Blue Shield of South Carolina	State-wide
South Dakota	Wellmark Blue Cross and Blue Shield of South Dakota	State-wide
Tennessee	Blue Cross and Blue Shield of Tennessee	State-wide
Texas	Blue Cross and Blue Shield of Texas	State-wide
Utah	Regence Blue Cross and Blue Shield of Utah	State-wide
Vermont	Blue Cross and Blue Shield of Vermont	State-wide
Virginia	Trigon Blue Cross and Blue Shield	State-wide, exclusive of Amherst, Appomattox, Campbell, Culpeper counties and the city of Lynchburg
Washington	Premera Blue Cross Regence Blue Shield Northwest Washington Medical Bureau	State-wide
West Virginia	Mountain State Blue Cross and Blue Shield	State-wide
Wisconsin	Blue Cross & Blue Shield United of Wisconsin	State-wide, exclusive of some rural areas
Wyoming	Blue Cross and Blue Shield of Wyoming	Laramie County, only