Patient Protection Act
Disclosure Statement

This coverage is provided by Blue Cross and Blue Shield of Texas (BCBSTX), a Division of Health Care Service Corporation, a Mutual Legal Reserve Company. This coverage provides preferred provider benefits.

I. Toll−free Telephone Number

You can call our Individual Products Business Unit New Business and Underwriting Department Monday through Thursday from 9:00 a.m. to 5:00 p.m. and Friday 9:00 a.m. to 4:30 p.m. Central Standard Time. The numbers are:

1−800−531−4456 toll−free
(972) 766−5218 Dallas Area

— Or —

for additional information, write to:

Blue Cross and Blue Shield of Texas
Individual Products Business Unit
P. O. Box 833922
Richardson, Texas 75080

II. What Is the Difference Between a Network Provider and Out−of−Network Provider?

A Network Provider is:

- Any Provider who has executed a managed care agreement with BCBSTX; or
- Any other Provider located outside the state of Texas and with which any other Blue Cross and Blue Shield plan has executed such a written contract

to provide health care services to Participants covered under this Contract. Except as otherwise provided herein, a Network Provider must provide services in order to obtain Network Benefits.

An Out−of−Network Provider is:

- Any Provider who has not executed a managed care agreement with BCBSTX; or
- Any other Provider located outside the state of Texas and with which any other Blue Cross and Blue Shield plan has not executed a such a written contract

to provide health care services to Participants covered under this Contract. Except as otherwise provided herein, services provided by Out−of−Network Providers will receive Out−of−Network Benefits.

In addition, Providers who do not contract with BCBSTX or any other Blue Cross and Blue Shield plan may bill the patient for expenses above the Allowable Amount.

III. Covered Services and Supplies Provided by this Contract

Covered Services	Network Benefits	Out−of−Network Benefits
Deductibles • Calendar Year • Maximum 3 per family • Per−Admission	$5,000/$15,000 None	$10,000/$30,000 $250
Coinsurance Amount • Maximum 3 per family	$5,000/$15,000	$10,000/$30,000
Lifetime Maximum each Participant	$2,000,000	
Hospital Services All usual Hospital services and supplies, including semiprivate room, intensive care and coronary care units	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Per−Admission Deductible and Calendar Year Deductible
Ground and Air Ambulance Services (Limited to $1,500 each Calendar Year)	80% of Allowable Amount after Calendar Year Deductible	
Organ and Tissue Transplants (Liver, Heart, Heart/Lung [heart and one lung or heart and two lungs] Cornea, Lung. Limited to $300,000 lifetime maximum each Participant)	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Per−Admission Deductible and Calendar Year Deductible
Skilled Nursing Facility Expense (Limited to $10,000 each Calendar Year) **Hospice Facility Expense** (Limited to $20,000 lifetime maximum)	100% of Allowable Amount No Deductible	70% of Allowable Amount after Per−Admission Deductible and Calendar Year Deductible
Hearing Screening (when offered by the Hospital during a birth admission)	80% of Allowable Amount Deductible Waived	60% of Allowable Amount Deductible Waived
Treatment of Acquired Brain Injury	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Per−Admission Deductible and Calendar Year Deductible
Treatment of Diabetes	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Per−Admission Deductible and Calendar Year Deductible
Certain Therapies for Children with Developmental Delays	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Per−Admission Deductible and Calendar Year Deductible

IV. Emergency Care Services

Emergency Care means health care services provided in a Hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, 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 medical care could result in:

1. Placing the patient's health in serious jeopardy,
2. Serious impairment to 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.

In the event of an emergency, you should do one of the following:

1. If reasonably possible, contact your Network Provider before going to the Hospital emergency room. He can help you determine if you need Emergency Care and recommend that care.
2. If not reasonably possible to contact your Network Provider, go to the nearest emergency facility, whether or not the facility is a Network Provider.
3. Whether you require hospitalization or not, you should contact your Network Provider 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.
4. If hospitalization for Emergency Care is necessary, the admission must be authorized within two working days, or as soon as reasonably possible, following the admission.

Covered Services	Network Benefits	Out of Network Benefits
Emergency Care		
• **Accident & Medical Emergency within 48 hours**		
– Facility Charges	80% of Allowable Amount after $200* Copayment Amount and Calendar Year Deductible	
– Physician Charges	Not Covered	
• **Non–Emergency Situations**		
– Facility Charges	Not Covered	Not Covered
– Physician Charges	Not Covered	Not Covered

*Copayment Amount waived if admitted to the Hospital

V. Out–of–Area Services and Benefits

Except for Emergency Care treatment or covered services that are not available from a Network Provider within the Plan Service Area, benefits will be provided at the Out–of–Network Benefits level. Please see Section II of this Disclosure Statement for definitions of Network Provider.

VI. What Are My Financial Responsibilities?

You are entitled to coverage under the Contract provided the required premium is paid to BCBSTX. In addition to the payment of premiums, You are also responsible for the following:

- If You choose Network Providers, Your payment obligation will be any Deductibles, Copayment Amounts, Coinsurance Amounts, and any limited or noncovered services as described in the Contract.
- If You choose Out–of–Network Providers, You may be responsible for billed charges above BCBSTX Allowable Amount, preauthorization penalties, Deductibles, Copayment Amounts, Coinsurance Amounts and any limited or noncovered services.

VII. Limitations and Exclusions

Benefits of the medical portion of the Contract are not available for:

- Any services or supplies provided to a Participant by a Physician or a Professional Other Provider.
- **Preexisting Condition Limitation** –Benefits of the Contract are not available for Care rendered during the first twelve months for conditions existing within twelve months before the Effective Date of coverage. This exclusion does not apply to a Participant who was continuously covered for an aggregate period of 18 months under Creditable Coverage if the previous coverage was in effect up to a date not more than 63 days before the Effective Date of the Participant's coverage under this Contract, excluding any waiting periods.

  If a Participant does not have aggregate Creditable Coverage totaling 18 months, We will credit the time the Participant was previously covered under Creditable Coverage if the previous coverage was in effect at any time during the 18 months preceding (a) the first day coverage is effective under this Contract if there is not a waiting period; or (b) the day the applicant files a substantially complete application for coverage if there is a waiting period.
- Any services of a certified registered nurse–anesthetist (CRNA).
- Physical Medicine Services.
- Diagnostic x–ray, radiation therapy, and laboratory procedures performed on an outpatient basis.
- Dietary formulas necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.
- Rental or purchase of durable medical equipment (DME).
- Prosthetic Appliances, **except** as provided for reconstructive surgery after a mastectomy.
- 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.
- Any services or supplies used by a Participant during an outpatient visit to a Hospital or a Therapeutic Center, **except** as provided for Emergency Care.
- Maternity Care.
- Services or supplies not Medically Necessary for the treatment of a sickness, injury, condition, disease, or bodily malfunction; or any Experimental/Investigational services and supplies.
- Any charges more than the Allowable Amount as determined by BCBSTX.
- Any services and supplies for which benefits are, or upon proper claim would be, provided under the Workers' Compensation Law.
- Any services or supplies covered in whole or in part by any laws of the United States (including Medicare), a foreign country, state or political subdivision, **except** Medicaid.

- Charges for services and supplies provided which require Our approval when approval is not given.
- Services or supplies for you are not required to make payment or for which a You are not legally required to pay without this or any similar coverage, (**except** treatment of mental illness or mental retardation by a tax supported institution).
- Any services or supplies provided by a person who is related to You by blood or marriage.
- Treatment of injury or sickness because of war, acts of war, or while on active or reserve military duty.
- Any charges as a because of suicide or attempted suicide.
- Charges resulting from failure to keep a scheduled visit with a Physician or Professional Other Provider, for completion of any insurance forms, or for acquisition of medical records unless requested and received by Us.
- Room and board charges during a Hospital Admission for diagnostic or evaluation procedures unless the tests could not have been performed on an outpatient basis.
- Services or supplies provided during a Hospital Admission or an admission in a Facility Other Provider beginning before the patient's Effective Date, or services or supplies provided after the termination of the Participant's coverage, **except** as provided in the Contract.
- Any services or supplies provided for Dietary and Nutritional Services, **except** as may be provided for in this Contract for:
  - An inpatient nutritional assessment program provided in and by a Hospital and approved by Us;
  - ***Treatment of Diabetes***; and
  - Dietary or nutritional evaluations provided in conjunction with ***Certain Therapies for Children with Developmental Delays***.
- Custodial Care, Home Infusion Therapy, or Home Health Care.
- Routine physical examinations (including a routine Pap smear), diagnostic screening, or immunizations.
- Any services or supplies provided in connection with a routine physical examination (including a routine Pap smear), diagnostic screening, or immunizations. This exclusion does not apply to the following **except** as may be provided for in the Contract:
  - ***Newborn Screening Tests for Hearing Impairment*** and
  - ***Certain Therapies for Children with Developmental Delays.***
- Services and supplies (**except** for Medically Necessary *Inpatient Hospital Expense* diagnostic procedures) for surgical procedures, treatment of the jaw bone joints muscles or their related structures with appliances or splints, physical therapy, or alteration to eliminate pain or dysfunction.
- Services or supplies provided to correct congenital, developmental or acquired deformities of the jaw bone.
- Any services or supplies provided for dental care and treatments, dental surgery, or dental appliances, **except** *Inpatient Hospital Expense* incurred for (1) Oral Surgery as defined in the Contract, (2) congenital defects of a Dependent child, or (3) services made necessary by Accidental Injury.
- Cosmetic, Reconstructive or Plastic Surgery unless caused by injury, congenital defects of a dependent child, reconstructive surgery following cancer surgery; reconstructive surgery following mastectomy; surgery and reconstruction of the other breast to achieve symmetrical appearance; and prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy.
- Eyeglasses, contact lenses, hearing aids, or examinations for the prescription of them; or examinations for detecting visual sharpness or level of hearing, or refractive surgery.
- Any services or supplies for mental, emotional or functional nervous disorders without demonstrable organic disease, **except** for *Inpatient Hospital Expense* incurred for Organic Brain Disease as defined in the Contract.

- Any Medical Social Services; any family counseling and/or therapy, bereavement counseling, vocational counseling, Marriage and Family Therapy and/or counseling.
- Treatment of adolescent behavior disorders, including conduct disorders and oppositional disorders.
- Any Services or supplies provided for treatment of Chemical Dependency unless an acute life−threatening condition occurs, in which case, *Inpatient Hospital Expense* incurred in a Hospital during the acute life−threatening stage only will be provided on the same basis as for any other sickness.
- Occupational therapy services that do not consist of traditional physical therapy modalities and is not part of a physical rehabilitation program.
- Travel, whether or not recommended by a Physician or Professional Other Provider, **except** for ambulance services as provided in the Contract.
- Treatment of obesity or weight, including surgical procedures, even if other health conditions might be helped by the reduction.
- Any services or supplies for inpatient allergy testing or any testing; or treatment for Environmental Sensitivity or Clinical Ecology, or any treatment not recognized as safe and effective.
- Any services or supplies provided with chelation therapy **except** treatment of acute metal poisoning.
- Any services or supplies for sterilization reversal (male or female), transsexual surgery, sexual dysfunction, in vitro fertilization services, or artificial insemination.
- Routine foot care as described in the Contract.
- Any drugs and medicines, including, but not limited to: (1) dispensed by a Pharmacy and received by the Participant while covered under this Contract, (2) dispensed in a Provider's office or during confinement in a Hospital or other acute care institution or facility and received by the Participant for use on an outpatient basis, (3) over−the−counter drugs and medicines; or drugs for which no charge is made, (4) prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations, (5) Retin−A or pharmacological similar topical drugs, or (6) smoking cessation prescription drug products requiring a Prescription Order.
- Any Outpatient Contraceptive Services.
- Any Speech and Hearing Services. This exclusion does not apply to the following except as provided for in the Contract for:
  - *Skilled Nursing Facility Expense;*
  - *Hospice Facility Expense*;
  - ***Newborn Screening Tests for Hearing Impairment***; and
  - ***Certain Therapies for Children with Developmental Delays***.
- Any services or supplies for reduction mammoplasty.
- Services or supplies for acupuncture, video−fluoroscopy, intersegmental traction, surface EMGs, manipulation under anesthesia, and muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.
- Orthodontic or other dental appliances; 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. This exclusion does not apply to podiatric appliances as described in the Contract when provided on an inpatient basis.
- Services or supplies provided for or in conjunction with conditions, which have been specifically excluded for a Participant as indicated in any Coverage Exclusion Rider attached to and made a part of the Contract.

- Any services or supplies not specifically defined as an Eligible Charge in the Contract.

VIII. What Happens If I Don't Preauthorize Hospital Admissions, Skilled Nursing Facility Expense or Hospice Facility Expense?

Preauthorization is required for all Hospital Admissions, *Skilled Nursing Facility Expense*, and *Hospice Facility Expense*. Network Providers will preauthorize services for you when required. If You choose Out−of−Network Providers, You, Your Provider of services, or a family member must call the toll−free telephone number shown on the back of the identification card. If preauthorization is not obtained:

- BCBSTX will review the Medical Necessity of the treatment prior to final benefit determination.
- Benefits may be reduced or denied if it is determined that the treatment is not Medically Necessary.
- Failure to preauthorize will result in a $250 penalty for Out−of−Network Hospital Admissions, *Skilled Nursing Facility Expense,* or *Hospice Facility Expense.*

IX. What If My Network Provider's Contract Terminates?

If your Network Provider terminates their contract with BCBSTX and you are currently being treated for ***a special circumstance,*** such as a disability, acute condition, or life−threatening illness_ if reasonably requested by the Provider in question, you may continue to receive benefits from such Provider at the Network Provider benefit level for up to 90 days. ***Special circumstance*** means a condition that the treating Provider reasonably believes that discontinuing care by the treating Provider could cause harm to the patient. ***Special circumstance*** is identified by the treating Provider who must request continuation and agree not to balance bill the patient.

X. What If I Have a Complaint?

BCBSTX has established policies and procedures for you to express your dissatisfaction regarding partial or total denial of a claim. You have the opportunity through the complaint, appeal, and grievance processes to request a review of the reimbursement. This process is considered your right. Thus, any retaliatory actions are prohibited by BCBSTX against you or a Provider.

XI. How Do I Locate Network Providers?

A current list of Network Providers and a complete description of the preferred provider network, including names and locations of Hospitals and Facility Other Providers, and a disclosure of which Network Providers will not accept new patients is included in the attached Preferred Provider Directory. An updated directory will be provided at least annually.

You may also call the BCBSTX Customer Service Helpline at: **1−888−697−0683 toll free** or You may visit our web site at **www.bcbstx.com** to:

- Identify Your Plan Service Area
- Receive information about Network Providers
- Assist You in identifying a Preferred Provider (but specific Network Providers will not be recommended).

XII. Plan Service Area

Your Plan Service Area is statewide.