

**THE POLICY DESCRIBED IN THIS OUTLINE PROVIDES LIMITED BENEFITS ONLY WHICH ARE LESS THAN THE MINIMUM STANDARDS FOR BENEFITS ESTABLISHED FOR BASIC HOSPITAL EXPENSE COVERAGE AS PRESCRIBED BY THE INSURANCE REGULATORY AUTHORITY OF YOUR STATE.**

**Blue Cross and Blue Shield of Texas**  
(herein called "We, Us, Our")

**FOUNDATION HOSPITAL CARE**

**Preferred Provider Plan providing**

**Limited Benefit Basic Hospital Expense Coverage**

**REQUIRED OUTLINE OF COVERAGE**

**I. Read Your Contract Carefully.** This Outline of Coverage provides a very brief description of some of the important features of Your Contract. This is not the insurance Contract and only the actual Contract provisions will control. The Contract itself sets forth, in detail, the rights and obligations of You, Your Provider of services and BCBSTX. It is, therefore, important that You **READ YOUR CONTRACT CAREFULLY!**

**II.** This Contract is designed to provide You with limited basic hospital expense coverage, but it provides amounts which are less than those prescribed by the insurance regulatory authority of Your state as minimum benefit amounts for this type of coverage.

Coverage is provided for the benefits outlined in Paragraph III. The benefits described in Paragraph III may be limited by Paragraph IV.

**III. Benefits**

We have a network of Providers to serve Participants throughout Texas called the Network. When You use these Providers, You receive Network Benefits. You will receive a Provider Directory listing these Providers when You enroll and at least annually thereafter.

Providers not listed in the directory are called Out-of-Network Providers. When You use these Providers, You will receive Out-of-Network Benefits except in special situations as explained in Your Contract.

**A. Benefit Period** – Your Benefit Period is a Calendar Year (begins January 1 and ends December 31).

**B. Preauthorization** – Preauthorization is required for all Hospital Admissions, *Skilled Nursing Facility Expenses, Hospice Facility Expenses*, and organ and tissue transplants. You, Your Provider of services or a family member must call the toll-free telephone number listed on the back of the Identification Card.

When a Hospital Admission is preauthorized, a length-of-stay is assigned. The Contract provides a minimum length-of-stay in a Hospital for the treatment of breast cancer, (1) 48 hours following a mastectomy, and (2) 24 hours following a lymph node dissection.

Failure to preauthorize will result in a \$250 penalty for Out-of-Network Hospital Admissions, *Skilled Nursing Facility Expense*, or *Hospice Facility Expense*.

**C. Deductibles**

- The Calendar Year Deductible will be subtracted once during each Calendar Year from each Participant’s total Eligible Charges. The family Deductible is three times the individual Deductible amount. No Participant will be required to satisfy more than the individual Deductible amount toward the family Deductible amount.
- The Per-Admission Deductible will apply to **each** inpatient Hospital Admission of a Participant.
- The amount of Your Deductibles will be as described below:

Deductibles	Network	Out-of-Network
Calendar Year Deductible	Individual/Family \$5,000/\$15,000	Individual/Family \$10,000/\$30,000
Per-Admission Deductible	None	\$250

- D. Coinsurance Amounts** — When a Participant’s Coinsurance Amounts for a Calendar Year equal the amounts shown below, the benefit percentages change to 100% for the remainder of that Calendar Year. The family Coinsurance Amount is three times the individual Coinsurance Amount. No Participant will be allowed to satisfy more than the individual Coinsurance Amount toward the family Coinsurance Amount.

Network Coinsurance Amounts		Out-of-Network Coinsurance Amounts	
Individual	Family	Individual	Family
\$5,000	\$15,000	\$10,000	\$30,000

- E. Maximum Lifetime Benefits** – The lifetime maximum of a Participant’s benefits is \$2,000,000. All benefit payments made by BCBSTX for *Inpatient Hospital Expense* for ***Benefits for Certain Therapies for Children with Developmental Delays***, whether under the Network Benefits level or Out-of-Network Benefits level, will not apply toward the Calendar Year or lifetime benefit maximums under the Contract.

**F. Inpatient Hospital Expenses**

When *Inpatient Hospital Expense* is preauthorized, as previously explained, We will provide benefits for:

1. A preauthorized Hospital Admission, room and board charges. If You stay in a private room, only the Hospital’s average semi-private room rate will be considered for benefits.
2. Intensive care and coronary care units.
3. All other usual Hospital services, including diagnostic lab and x-ray, Telehealth Services and Telemedicine Medical Services.

Network Benefits	Out-of-Network Benefits
80% of the Allowable Amount after the Calendar Year Deductible	60% of the Allowable Amount after the Per-Admission Deductible and Calendar Year Deductible

**G. Skilled Nursing Facility Expense**

When *Skilled Nursing Facility Expense* is preauthorized, as previously explained, We will provide benefits for:

1. All usual nursing care by a registered nurse (R.N.) or by a licensed vocational nurse (L.V.N.);
2. Room and board and all routine services, supplies, and equipment provided by the Skilled Nursing Facility;
3. Physical, occupational, speech, and respiratory therapy services by licensed therapists.

<b>Network Benefits</b>	<b>Out-of-Network Benefits</b>
100% of the Allowable Amount No Deductible	70% of the Allowable Amount after the Per-Admission Deductible and Calendar Year Deductible
Calendar Year maximum benefit – \$10,000 per Participant	

**H. Hospice Facility Expense**

When *Hospice Facility Expense* is preauthorized, as previously explained, We will provide benefits for:

1. All usual nursing care by a registered nurse (R.N.) or by a licensed vocational nurse (L.V.N.);
2. Room and board and all routine services, supplies, and equipment provided by the Hospice facility;
3. Physical, speech, and respiratory therapy services by licensed therapists.

<b>Network Benefits</b>	<b>Out-of-Network Benefits</b>
100% of the Allowable Amount No Deductible	70% of the Allowable Amount after the Per-Admission Deductible and Calendar Year Deductible
Lifetime maximum benefit – \$20,000 per Participant	

**IMPORTANT TO YOUR COVERAGE**

To pay less out-of-pocket expenses and to receive the higher level of benefits for your health care costs, it is to your advantage to use Network Providers. If you use Network Providers, you will not be responsible for any charges over the Allowable Amount as determined by BCBSTX. What follows is an example of how much you would pay if you use a Network Provider and how much you would pay if you use a non-contracting Out-of-Network Provider. To make the example easier to follow, assume the Allowable Amount is the same:

**EXAMPLE ONLY**

	<b>In-Network</b> 80% of Eligible Charges \$5,000 Deductible	<b>Out-of-Network</b> 60% of Eligible Charges \$10,000 Deductible
Amount Billed	\$50,000	\$50,000
Allowable Amount	\$35,000	\$35,000
Calendar Year Deductible	\$5,000	\$10,000
Per-Admission Deductible	None	\$250
Plan's Coinsurance Amount	\$24,000	\$14,850
Your Coinsurance Amount	\$6,000	\$9,900
Non-Contracting Provider's additional charge to you	Not Applicable	\$15,000 <sup>1</sup>
<b>YOUR TOTAL PAYMENT</b>	<b>\$11,000</b> <b>to a Network Provider</b>	<b>\$24,900</b> <b>to a Non-Contracting Out-of-Network Provider</b>

Even when you consult a Network Provider, ask questions about any of the Providers rendering care to you. For example, if you are scheduled for surgery, ensure that You will be using a Network facility for your procedure.

<sup>1</sup> If you choose to receive services from an Out-of-Network Provider, inquire if they participate in a contractual arrangement with BCBSTX. Providers who do not contract with BCBSTX or any other Blue Cross and Blue Shield plan may bill the patient for expenses over the Allowable Amount. Please refer to the section entitled Contracting/Non-Contracting Providers in the Contract.

- I. **Ground and Air Ambulance Services** – If You incur expenses for professional local ground ambulance or air ambulance service to the nearest Hospital appropriately equipped and staffed for treatment of Your condition, benefits will be provided at the Network Benefits level, up to a maximum benefit amount of \$1,500 per Calendar Year.

Network Benefits	Out-of-Network Benefits
80% of the Allowable Amount after the Calendar Year Deductible	

- J. **Newborn Screening Tests for Hearing Impairment**

Benefits are available for *Inpatient Hospital Expense* incurred by a Dependent child for screening tests for hearing loss from birth through the date the Dependent child is 30 days old; and necessary diagnostic follow-up care related to the screening test from birth through the date the Dependent child is 24 months old. The Deductible does not apply; however benefits will be subject to all other contractual provisions.

Network Benefits	Out-of-Network Benefits
80% of the Allowable Amount Deductible Waived	60% of the Allowable Amount Deductible Waived

**K. Treatment of Acquired Brain Injury**

Benefits for *Inpatient Hospital Expense* incurred for Medically Necessary treatment of Acquired Brain Injury will be determined on the same basis as treatment for any other condition.

Network Benefits	Out-of-Network Benefits
80% of the Allowable Amount after the Calendar Year Deductible	60% of the Allowable Amount after the Per-Admission Deductible and Calendar Year Deductible

**L. Treatment of Diabetes**

Benefits are available for *Inpatient Hospital Expense* and will be determined on the same basis as treatment for any other condition for those Medically Necessary items for *Diabetes Equipment* and *Diabetic Supplies* (for which a Physician or Professional Other Provider has written an order) and *Diabetic Management Services/Diabetes Self-Management Training*.

Network Benefits	Out-of-Network Benefits
80% of the Allowable Amount after the Calendar Year Deductible	60% of the Allowable Amount after the Per-Admission Deductible and Calendar Year Deductible

**M. Certain Therapies for Children with Developmental Delays**

*Inpatient Hospital Expense* benefits are provided for a Dependent child under three years of age with developmental delays for the necessary rehabilitative and habilitative therapies in accordance with an *individualized family service plan* issued by the Texas Interagency Council on Early Childhood Intervention under Chapter 73, Texas Human Resources Code. Such therapies include occupational therapy evaluation and services; physical therapy evaluations and services; speech therapy evaluations and services; and dietary or nutritional evaluations.

After the age of 3, when services under the *individualized family service plan* are completed, *Inpatient Hospital Expense*, as otherwise covered under this Contract, will be available. All contractual provisions of this Contract will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximums.

Network Benefits	Out-of-Network Benefits
80% of the Allowable Amount after the Calendar Year Deductible	60% of the Allowable Amount after the Per-Admission Deductible and Calendar Year Deductible

**N. Emergency Care**

**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
<b>Emergency Care</b> <ul style="list-style-type: none"> <li>• <b>Accident &amp; Medical Emergency within 48 hours</b> <ul style="list-style-type: none"> <li>– Facility Charges</li> <li>– Physician Charges</li> </ul> </li> </ul>	80% of Allowable Amount after \$200* Copayment Amount and Calendar Year Deductible  Not Covered	
<ul style="list-style-type: none"> <li>• <b>Non-Emergency Situations</b> <ul style="list-style-type: none"> <li>– Facility Charges</li> <li>– Physician Charges</li> </ul> </li> </ul>	Not Covered  Not Covered	Not Covered  Not Covered

\*Copayment Amount waived if admitted to the Hospital

**O. Organ and Tissue Transplant Benefit Maximum** – The lifetime maximum for organ and tissue transplants is \$300,000 for each Participant.

**P. Organic Brain Disease**

When *Inpatient Hospital Expense* for Organic Brain Disease is preauthorized, as previously explained, We will provide benefits for mental, emotional or functional nervous disorders with demonstrable organic disease.

Network Benefits	Out-of-Network Benefits
80% of the Allowable Amount after the Calendar Year Deductible	60% of the Allowable Amount after the Per-Admission Deductible and Calendar Year Deductible

**IV. 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.

## V. Renewability

- A. The coverage of any Participant under the Contract will end on the earliest of the following dates:
1. On the last day of the period for which premiums have been paid, subject to the Grace Period;
  2. At the death of a Participant;
  3. On the last day of any Contract Month in which a Participant no longer resides, lives, or works in an area for which We are authorized to do business, but only if coverage is terminated uniformly without regard to any Health Status Related Factor of the Participant.
  4. On the last day of the Contract Month in which We receive a written request from You to cancel Your coverage or another Participant's coverage;
  5. On the Contract Date for fraudulent or intentional misrepresentation of a material fact; or
  6. On the last day of the Contract Month in which: (1) Your spouse ceases to be a dependent, or (2) Your children marry or reach age 25, or (3) Your disabled children are no longer disabled or chiefly dependent upon You for support and maintenance.
- B. We have the right to cancel this Contract after 90 days notice to You but only if all **PPO-IN HOSPITAL** Plan Contracts are being canceled; provided each Participant shall have the option to purchase on a guaranteed issue basis any other individual hospital, medical, or surgical insurance contract We offer at the time of discontinuance of this Contract.
- C. If We cancel this Contract as stated in Section B, above, and a Participant does not elect to purchase another hospital, medical or surgical policy, and if he is totally disabled on the cancellation date as described in Section B, above, coverage continues and shall be limited to: (1) the duration of the Benefit Period; (2) payment of maximum Contract benefits; or (3) a period not less than 90 days.
- D. We may elect to terminate all individual hospital, medical or surgical coverage plans delivered or issued for delivery in this State, but only if We:
1. Notify the Texas Department of Insurance Commissioner not later than 180 days prior to the date coverage under the first individual hospital, medical or surgical health benefit plan terminates;
  2. Notify each covered Participant not later than 180 days prior to the date on which coverage terminates for that Participant; and
  3. Act uniformly without regard to any Health-Status Related Factor of covered individuals or Dependents of covered individuals who may become eligible for coverage.

## VI. Premiums

A. The initial premium rate for Your Plan selection under this Contract is:

1. Preferred category is \$ \_\_\_\_\_.
2. Standard category is \$ \_\_\_\_\_.

Enclose the premium with your application. Once underwriting is completed and you are approved for coverage, if additional premium is required, You will receive a supplemental bill.

Premiums are payable monthly, bi-monthly or quarterly and are due on the first day of each Contract Month.

B. The premium rates for this Contract are based on the sex and age of the Subscriber, place of residence, certain health conditions or a combination of such health conditions, including whether or not an applicant is a smoker or user of tobacco products, and the number and classification of family members to be included on the Contract. Changes in these factors may result in a change in the premium.

1. If You and/or Your spouse reach an age that results in a new premium rate, the premium will automatically change to the rate applicable to the new age.
2. The rates provided to You are for the residence shown in Your application. It may not apply to a different place of residence. Your premium rates are subject to automatic adjustment upon change of residence.
3. We also have the right to increase premiums after 30 days notice to You. However, except for an increase resulting from a change to a new age bracket, residence relocation to a new geographical area in Texas, or a change in the type of contract (family, single, dependent coverage, etc.) no increase in the initial premium can be made for six months.
4. If both husband and wife are on the same membership, Your premium will be calculated based on the age of each adult.

C. A Grace Period is provided for each premium payment. The Grace Period will be 10 days for monthly or 31 days for quarterly.