Patient Protection Act Disclosure Statement

This coverage is provided by Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association. This coverage provides preferred provider benefits.

I. Toll-free Telephone Number

You can call our Individual Products Business Unit 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

PRESCRIPTION DRUG PROGRAM			
PLAN FEATURES *Applicable to all Plans*			
Benefit Period Deductible	**$200**		
Benefit Period Maximum*	**$750**		
Copayment Amounts	**Generic**	**Preferred Brand Name Drugs**	**Non-Preferred Brand Name Drugs**
Retail Pharmacy ▪ 30-Day Supply on each occasion dispensed ▪ 90-Day Supply	$10 $30	$40 $120	$55 $165
Mail Service ▪ 90-Day Supply	$20	$80	$110

*Combined Benefit Period Maximum applies to retail and mail service

HEALTH COVERAGE				
Options	**Network Deductibles**		**Out-of-Network Deductibles**	
	Individual	**Family**	**Individual**	**Family**
Plan I	$500	$1,500	$1,000	$3,000
Plan II	$1,000	$3,000	$2,000	$6,000
Plan III	$1,500	$4,500	$3,000	$9,000
Plan IV	$2,000	$6,000	$4,000	$12,000
Plan V	$2,500	$7,500	$5,000	$15,000

HEALTH COVERAGE		
Covered Services	**Network Benefits**	**Out-of-Network Benefits**
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 Benefit Period Deductible	60% of Allowable Amount after Benefit Period Deductible
Professional Services Services of Physicians or Professional Other Providers , a certified registered nurse-anesthetist (CRNA), diagnostic X-ray and lab, radiation therapy, dietary formulas necessary for the treatment of PKU or other heritable diseases, amino acid-based elemental formulas, rental of durable medical equipment (DME), anesthetics, oxygen, blood, Prosthetic Appliances, orthopedic braces and crutches, Home Infusion Therapy services, Diabetic Equipment and Supplies, outpatient services and supplies, Telehealth Services and Telemedicine Medical Services, and outpatient contraceptive services and contraceptive devices. **Note**: Prescription oral contraception medications are covered under the Prescription Drug Program.	80% of Allowable Amount after Benefit Period Deductible	60% of Allowable Amount after Benefit Period Deductible
Physical Medicine Services (Limited to $500 each Benefit Period)	80% of Allowable Amount after Benefit Period Deductible	60% of Allowable Amount after Benefit Period Deductible
Ground and Air Ambulance Services (Limited to $750 each Benefit Period)	80% of Allowable Amount after Benefit Period Deductible	

Covered Services	Network Benefits	Out-of-Network Benefits
Routine Mammography Screening (For female Participants 35 years of age or older, limited to one each Benefit Period)	80% of Allowable Amount after Benefit Period Deductible	60% of Allowable Amount after Benefit Period Deductible
Non-Routine Diagnostic Mammography	80% of Allowable Amount after Benefit Period Deductible	60% of Allowable Amount after Benefit Period Deductible
Breast Reconstruction (Services or supplies necessary to rebuild the breast and achieve reasonable breast symmetry as a result of a mastectomy)	80% of Allowable Amount after Benefit Period Deductible	60% of Allowable Amount after Benefit Period Deductible
Benefits for Certain Tests for Detection of Human Papillomavirus (HPV) and Cervical Cancer ▪ For female Participant 18 years of age or older an annual medically recognized diagnostic examination for the early detection of cervical cancer	80% of Allowable Amount after Benefit Period Deductible	60% of Allowable Amount after Benefit Period Deductible
Tests for Detection of Prostate Cancer ▪ A physical examination for detection of prostate cancer ▪ A prostate-specific antigen test used for the detection of prostate cancer for each male Participant who is at least: – 50 years of age and asymptomatic, or – 40 years of age with a family history of prostate cancer or another prostate cancer risk factor	80% of Allowable Amount after Benefit Period Deductible	60% of Allowable Amount after Benefit Period Deductible
Tests for Detection of Colorectal Cancer ▪ Annual fecal occult blood test and flexible sigmoidoscopy every five years, or ▪ Colonoscopy every ten years	80% of Allowable Amount after Benefit Period Deductible	60% of Allowable Amount after Benefit Period Deductible
Childhood Immunizations *(Does not include allergy injections)* (60 days old to up to age 8) Immunizations includes but are not limited to, diphtheria, hemophilus influenza type b, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, and varicella, and any other immunization required by law.	100% of Allowable Amount No Deductible and Coinsurance	
Hearing Screening (when offered by Hospital during a birth admission) Screening tests for dependent children from birth through the date the child is 30 days old, and necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old.	80% of Allowable Amount No Deductible	60% of Allowable Amount No Deductible
Certain Therapies for Children with Developmental Delays *(up to age 3 as defined in the **individualized family service plan** as issued by the Texas Interagency Council on Early Childhood Intervention. After the age of 3, when services under the individualized family service plan are completed, Eligible Expenses, 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.)* ▪ Occupational therapy evaluations ▪ Physical therapy evaluations and services ▪ Speech therapy evaluations and services; and ▪ Dietary or nutritional evaluations	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible

Early Detection Tests for Cardiovascular Disease One of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function: (1) Computed tomography (CT) scanning measuring coronary artery calcifications; or (2) Ultrasonography measuring carotid intima-media thickness and plaque. Tests are available to each Participant who is (1) a male older than 45 years of age and younger than 76 years of age, or (2) a female older than 55 years of age and younger than 76 years of age. The individual must be a diabetic or have a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher.	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	Benefits are limited to a $200 maximum benefit amount every five (5) years each Participant.	

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:

- Placing the patient's health in serious jeopardy,
- Serious impairment to bodily functions,
- Serious dysfunction of any bodily organ or part,
- Serious disfigurement, or
- 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:

- 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.
- If not reasonably possible to contact Your Network Provider, go to the nearest emergency facility, whether or not the facility is a Network Provider.
- 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.
- 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 Service	Network Benefits	Out of Network Benefits
Emergency Care ▪ **Accident & Medical Emergency within 48 hours** – Facility Charges – Physician Charges	80% of Allowable Amount after $100* Copayment Amount and Benefit Period Deductible 80% of Allowable Amount after Benefit Period Deductible	
▪ **Non-Emergency Situations** – Facility Charges – Physician Charges	80% of Allowable Amount after Benefit Period Deductible 80% of Allowable Amount after Benefit Period Deductible	60% of Allowable Amount after Benefit Period Deductible 60% of Allowable Amount after Benefit Period Deductible

*Waived if admitted to Hospital immediately following the visit. *This Copayment Amount applies to facility visit only. The facility and Physician services and supplies are subject to the Deductible and Coinsurance Amount.*

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 definition of a 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 and Coinsurance Amounts, and any limited or non-covered services as described in the Contract.
- If You choose Out-of-Network Providers, You will be responsible for billed charges above BCBSTX payment amount, preauthorization penalties, Deductibles, Coinsurance Amounts and any limited or non-covered services

VII. Limitations and Exclusions

The benefits provided under the medical portion of the Contract are not available for:

- Preexisting Conditions.
- Maternity Care.
- Services or supplies not Medically Necessary for the treatment of a sickness, injury, condition, disease, or bodily malfunction; any Experimental/Investigational services and supplies.
- Any charges more than the Allowable Amount as determined by Us.
- Any services or supplies for which benefits are, or upon proper claim would be, provided under 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 for Medicaid.
- Charges for services and supplies provided which require Our approval when approval is not given.
- Services or supplies for which You are not required to make payment or for which 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 because of suicide or attempted suicide, while sane or insane.
- 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.
- Room and board charges during a Hospital Admission for diagnostic or evaluation procedures unless the tests could not have been done on an outpatient basis without adversely affecting the Participant’s physical condition or the quality of medical care provided.
- 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.
- Dietary and nutritional services, except as may be provided in the Contract for (1) a nutritional assessment program provided in and by a Hospital and approved in advance by Us; (2) ***Treatment of Diabetes***, and (3***) Certain Therapies for Children with Developmental Delay***.
- Custodial Care.
- Routine physical examinations, diagnostic screening, or immunizations, except as provided in the Contract for (1) ***Mammography Screening***, (2) ***Certain Tests for Detection of Human Papillomavirus and Cervical Cancer***; (3) ***Childhood Immunizations***, (4) ***Certain Tests for the Detection of Prostate Cancer,*** and (5) ***Newborn Screen Tests for Hearing Impairment;*** (6) ***Certain Tests for the Detection of Colorectal Cancer***; and (7) ***Certain Therapies for Children with Developmental Delay.***

- Services or supplies (except Medically Necessary diagnostic and/or surgical procedures) for treatment of the jaw bone joints, muscles, or their related structures with oral appliances or splints, orthotics, prosthetics, dental restorations, orthodontics, physical therapy, or alteration of the occlusal relationships of the teeth or jaws to eliminate pain or dysfunction of the temporomandibular joint (TMJ) and all adjacent or related muscles and nerves. to eliminate pain or dysfunction.
- Services or supplies provided to correct congenital, developmental or acquired deformities of the jaw bone after a Participant's 19th birthday.
- Any items of *Medical-Surgical Expense* provided for dental care and treatments, dental surgery, or dental appliances, except (1) Oral Surgery as defined in the Contract, and (2) services made necessary by Accidental Injury.
- Cosmetic, Reconstructive or Plastic Surgery unless caused by (1) Accidental Injury; (2) reconstructive surgery following cancer surgery; (3) 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; and (4) reconstructive surgery performed on a Dependent child under the age of 19 due to craniofacial abnormalities to improve the function of, or attempt to create a normal appearance of an abnormal structure caused by developmental deformities, trauma, tumors, infections, or disease.
- Refractive surgery, or eyeglasses, contact lenses or, hearing aids, or examinations for the prescription of them; or examinations for detecting visual sharpness or level of hearing.
- Mental, emotional or functional nervous disorders without demonstrable organic brain disease, except Organic Brain Disease as defined in the Contract.
- Except as specifically provided in the Contract, any Medical Social Services; any outpatient family counseling and/or therapy, bereavement counseling, vocational counseling, or Marriage and Family Therapy and/or counseling.
- Treatment of adolescent behavior disorders, including conduct disorders and oppositional disorders.
- Occupational therapy services that do not consist of traditional physical therapy modalities and is not part of a physical rehabilitation program.
- Travel, whether recommended by a Physician or Professional Other Provider, except 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 footcare as described in the Contract.
- Any Speech and Hearing Services except as provided in the Contract for (1) ***Extended Care Expense***, (2) ***Newborn Screening Tests For Hearing Impairment;*** and (3) ***Certain Therapies for Children With Developmental Delay.***
- Any services or supplies for reduction mammoplasty.
- Services or supplies for acupuncture, videofluoroscopy, intersegmental traction, surface EMGs, manipulation under anesthesia, and muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.
- Services or supplies for treatment of Chemical Dependency; unless an acute life-threatening condition occurs, in which case benefits for Eligible Expenses incurred in a Hospital during the acute life-threatening stage only will be provided on the same basis as for any other sickness.
- 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, except for podiatric appliances when provided in conjunction with treatment of diabetes.
- Any drugs and medicines except as may be provided under the Prescription Drug Program that are: (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 of facility and received by the Participant for use on an outpatient basis; (3) over-the-counter drugs and medicines or 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 (5) smoking cessation prescription drug products requiring a Prescription Order.
- Any services and supplies for skilled nursing care, Hospice Care and Home Heath Care.

- Any services or supplies for organ and tissue transplants.
- Any services or supplies not specifically defined as Eligible Expenses in the Contract.

The benefits provided under the Prescription Drug Program are not available for:

- Drugs which do not by law require a Prescription Order from a Provider (**except** injectable insulin); and drugs, or covered devices for which no valid Prescription Order is obtained.
- Devices or durable medical equipment of any type (even though such devices may require a Prescription Order), such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances, or similar devices (except disposable hypodermic needles and syringes for self-administered injections). However, coverage for prescription contraception devices is provided under the medical portion of the Contract.
- Administration or injection of any drugs.
- Vitamins (except those vitamins which by law require a Prescription Order and for which there is no non-prescription alternative).
- Drugs dispensed in a Physician's office or during confinement while a patient in a Hospital, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.
- Covered Drugs, devices, or other Pharmacy services or supplies for which benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
- Covered Drugs, devices, or other Pharmacy 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 for Medicaid.
- Any services provided or items furnished for which the Pharmacy normally does not charge.
- Drugs for which the Pharmacy's usual and customary charge to the general public is less than or equal to the Copayment Amount provided under the Contract.
- Infertility medication and fertility medication; prescription contraceptive devices, non-prescription contraceptive materials (except prescription oral contraceptive medications which are Legend Drugs). However, coverage for prescription contraception devices is provided under the medical portion of the Contract.
- Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
- Drugs required by law to be labeled: "Caution — Limited by Federal Law to Investigational Use," or experimental drugs, even though a charge is made for the drugs. Covered Drugs dispensed in quantities in excess of the amounts stipulated or refills of any prescriptions in excess of the number of refills specified by the Physician or by law, or any drugs or medicines dispensed more than one year following the Prescription Order date.
- Legend Drugs which are not approved by the U.S. Food and Drug Administration (FDA).
- Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting; drugs given through routes other than subcutaneously in the home setting. This exception does not apply to dietary formulas necessary for the treatment of phenylketonuria (PKU) or other heritable diseases. This exception also does not apply to amino acid-based elemental formulas, regardless of the formula delivery method, used for the diagnosis and treatment of immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins, severe food protein-induced enterocolitis syndromes, eosinophilic disorders, as evidenced by the results of biopsy and disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract. A Prescription Order from your Health Care Practitioner is required.
- Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control.
- Drugs, the use or intended use of, which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.
- Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Identification Card.
- Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under the Program, or for which benefits have been exhausted.
- Rogaine, minoxidil or any other drugs, medications, solutions or preparations used or intended for use in the treatment of hair loss, hair thinning or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.
- Any smoking cessation products requiring a Prescription Order.
- Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.

- Prescription Orders for which there is an over-the-counter product available with the same active ingredient(s).
- Athletic performance enhancement drugs.
- Drugs to treat sexual dysfunction, including, but not limited to, sildenafil citrate (Viagra), phentolamine (Regitine), alprostadil (Prostin, Edex, Caverject), and apomorphine in oral and topical form.
- Compounded drugs that do not meet the definition of Compound Drugs as defined in the Contract.
- BCBSTX has an unrestricted formulary.

VIII. What Happens If I Don't Preauthorize Hospital Admissions or Home Infusion Therapy?

Preauthorization is required for all Hospital Admissions and Home Infusion Therapy. Network Providers will preauthorize services for you when required. If You choose Out-of-Network Providers, You, Your Physician or Professional Other Provider or a family member must call the toll-free telephone number shown on the back of the Identification Card.

When a Hospital Admission is preauthorized, a length-of-stay is assigned. This Contract provides a minimum length of stay in a Hospital for treatment of breast cancer (1) 48 hours following a mastectomy, and (2) 24 hours following a lymph node dissection. If preauthorization is not obtained:

- BCBSTX will review the medical necessity or Experimental/Investigational nature 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 or is Experimental/Investigational.
- You will be responsible for a:
  - $250 penalty for Hospital Admissions.
  - Penalty in the amount of 50% of the Allowable Amount up to a maximum of $500 for Home Infusion Therapy.

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

If Your Network Provider terminates his contract with BCBSTX and if 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 Physicians and health care 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 available 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 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.