DISCLOSURE INFORMATION

I. Name of the Insurance Company

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 contains preferred provider benefits.

This information is intended only as a summary and should not be relied upon to determine coverage. The policy of coverage contains a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. Changes in state or federal law or regulations, or interpretations thereof, may change the terms and conditions of coverage.

II. Toll-free Telephone Number and Other Contact Information

You may call our Blue Cross and Blue Shield of Texas Customer Service Helpline Monday through Friday 8:00 a.m. to 8:00 p.m. Central Time. The number is:

1-800-521-2227 toll-free

For additional information, write to:
Blue Cross and Blue Shield of Texas
P. O. Box 660044
Dallas, Texas 75266-0044
or
Visit us at our website at www.bcbstx.com

III. What Is the Difference Between a Network Provider and Out-of-Network Provider?

A Network Provider is:

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 in a managed health care contractual arrangement. Except as otherwise provided herein, a Network Provider must provide your medical care services in order to receive the higher level of benefits, In-Network Benefits.

An Out-of-Network Provider is:

a Hospital, Physician, or Other Provider who has not entered into an agreement with BCBSTX (or other participating Blue Cross and/or Blue Shield Plans) to participate in a managed health care contractual arrangement. Except as otherwise provided herein, if you receive medical care services from an Out-of-Network Provider, you will receive the lower level of benefits, Out-of-Network Benefits.

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

IV. Covered Services and Supplies Provided by this Contract

Covered Services	Network Benefits	Out-of-Network Benefits
Deductibles		
Calendar Year Deductible Applies to all Eligible Expenses	$4,000 Individual / $12,000 Family	$8,000 Individual / $24,000 Family
Out-of-Pocket Maximum	$7,350 Individual / $14,700 Family	$14,700 Individual / $44,100 Family
Copayment Amounts Required		

Covered Services	Network Benefits	Out-of-Network Benefits
Primary Care Copayment Amount for office visit/consultation when services rendered by a Family Practitioner, OB/GYN, Pediatrician, Behavioral Health Practitioner or Internist and Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these listed Physicians	$40 Primary Care Copayment Amount	
Specialty Copayment Amount for office visit/consultation when services rendered by a Specialty Care Provider	$70 Specialty Copayment Amount	
Outpatient surgery Copayment Amount (facility charges only)	*$200 Copayment Amount*	*$300 Copayment Amount*
Per –admission Copayment Amount	*$250 per-admission Copayment Amount*	*$350 per-admission Copayment Amount*
Urgent Care center visit	$40 Copayment Amount	
Outpatient Hospital emergency room visit	*$750 outpatient Hospital emergency room visit Copayment Amount*	*$750 outpatient Hospital emergency room visit Copayment Amount*
Inpatient Hospital Expenses		
All usual Hospital services and supplies, including semiprivate room, intensive care and coronary care units.	*80% of Allowable Amount after $250 per-admission Copayment Amount and after Calendar Year Deductible*	*60% of Allowable Amount after $350 per-admission Copayment Amount and after Calendar Year Deductible*
Penalty for failure to preauthorize services	None	$250
Medical/Surgical Expenses		
Primary Care office visits/consultations when services rendered by a Family Practitioner, OB/GYN, Pediatrician, or Internist and Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these listed Physicians.	*100% of Allowable Amount after $40 Primary Care Copayment Amount*	*60% of Allowable Amount after Calendar Year Deductible*
Specialty office visit/consultation when services rendered by a Specialty Care Provider.	*100% of Allowable Amount after $70 Specialty Copayment Amount*	*60% of Allowable Amount after Calendar Year Deductible*
Outpatient Surgery facility charges	*80% of Allowable Amount after $200 Outpatient Surgery Copayment Amount and after Calendar Year Deductible*	*60% of Allowable Amount after $300 Outpatient Surgery Copayment Amount and after Calendar Year Deductible*
Lab & x-ray	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Inpatient visits	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Certain Diagnostic Procedures	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Home Infusion Therapy	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*

Covered Services	Network Benefits	Out-of-Network Benefits
Physician surgical services performed in any setting	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Extended Care Expenses		
Skilled Nursing Facility *25 days per Calendar Year**	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Home Health Care *60 visits per Calendar Year**	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Hospice Care *Unlimited* Hospice Care that is provided in a Hospital will include charges as described in Inpatient Hospital Expenses	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Behavioral Health Services		
Treatment of Chemical Dependency Certain Services will require Preauthorization.		
Inpatient Services		
Inpatient treatment must be provided in a Chemical Dependency Treatment Center / Hospital (facility)	*80% of Allowable Amount after $250 per-admission Copayment Amount and after Calendar Year Deductible*	*60% of Allowable Amount after $350 per-admission Copayment Amount and after Calendar Year Deductible*
Penalty for failure to preauthorize inpatient services (facility)	None	$250
Behavioral Health Practitioner services	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Outpatient Services		
Behavioral Health Practitioner expenses (office setting)	*100% of Allowable Amount after $40 Copayment Amount*	*60% of Allowable Amount after Calendar Year Deductible*
Other outpatient services	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Serious Mental Illness Certain Services will require Preauthorization.		
Inpatient Services		
Hospital services (facility)	*80% of Allowable Amount after $250 per-admission Copayment Amount and after Calendar Year Deductible*	*60% of Allowable Amount after $350 per-admission Copayment Amount and after Calendar Year Deductible*
Penalty for failure to preauthorize inpatient services (facility)	None	$250
Behavioral Health Practitioner services	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Outpatient Services		
Behavioral Health Practitioner expenses (office setting)	*100% of Allowable Amount after $40 Copayment Amount*	*60% of Allowable Amount after Calendar Year Deductible*
Other outpatient services	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Mental Health Care		

Covered Services	Network Benefits	Out-of-Network Benefits
Certain Services will require Preauthorization.		
Inpatient Services		
Hospital services (facility)	*80% of Allowable Amount after $250 per-admission Copayment Amount and after Calendar Year Deductible*	*60% of Allowable Amount after $350 per-admission Copayment Amount and after Calendar Year Deductible*
Penalty for failure to preauthorize inpatient services (facility)	None	$250
Behavioral Health Practitioner services	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Outpatient Services		
Behavioral Health Practitioner expenses (office setting)	*100% of Allowable Amount after $40 Copayment Amount*	*60% of Allowable Amount after Calendar Year Deductible*
Other outpatient services	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Urgent Care Services		
Urgent Care center visit	*100% of Allowable Amount after $40 Copayment Amount*	*60% of Allowable Amount after Calendar Year Deductible (Urgent Care Copayment Amount will apply to Accidental Injury and Emergency Care services provided Out-of-Network)*
Services received during an Urgent Care visit	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Ambulance Services	80% of Allowable Amount after Calendar Year Deductible	
Retail Health Clinic	*Paid as any other Primary Care Copayment Amount*	*60% of Allowable Amount after Calendar Year Deductible*
Virtual Visits	*Paid as any other Primary Care Copayment Amount*	*60% of Allowable Amount after Calendar Year Deductible*
Preventive Care	100% of Allowable Amount	*60% of Allowable Amount after Calendar Year Deductible*
Speech and Hearing Services, including Hearing Aids		
Services to restore loss of or correct an impaired speech or hearing function with hearing aids	Covered as any other sickness	Covered as any other sickness
Hearing Aids	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Hearing Aids maximum	Limited to one hearing aid per ear each 36-month period*	
Cardiovascular Tests		
One of the following early detection tests for cardiovascular disease will be covered for a Participant who meets the age requirements	Maximum benefit of 1 test every 5 years*	

Covered Services	Network Benefits	Out-of-Network Benefits
and is a diabetic or has been determined to have a risk of developing coronary heart disease:		
• Computed tomography (CT) scanning measuring coronary artery calcification	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
• Ultrasonography measuring carotoid intima-media thickness and plaque.]	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Habilitation Services		
Habilitation Services (includes, but is not limited to physical, occupational, and manipulative therapy)	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Calendar Year maximum	35 visits each Calendar Year* The visit limit does not apply to an *individualized family service plan as issued by the Texas Interagency Council on Early Childhood Intervention* as provided for in the benefit for Certain Therapies for Children with Developmental Delays*****	
Rehabilitation Services		
Rehabilitation Services (includes, but is not limited to physical, occupational, and manipulative therapy)	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Calendar Year maximum	35 visits each Calendar Year* The visit limit does not apply to an *individualized family service plan as issued by the Texas Interagency Council on Early Childhood Intervention* as provided for in the benefit for Certain Therapies for Children with Developmental Delays*****	
Preauthorization Requirements		
Inpatient Admissions		
Penalty for failure to preauthorize inpatient admissions shown in the Preauthorization Requirements section of the Benefit Booklet	*None*	*$250*
Outpatient Services		
Penalty for failure to preauthorize outpatient services shown in the Preauthorization Requirements section of the Benefit Booklet	*None*	*50% of Allowable Amount, not to exceed $500*

*Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Calendar Year Maximum amounts indicated
*****After the age of 3, when services under the individualized family service plan are completed, Eligible Expenses, as otherwise covered under the Policy, will be available. All contractual provisions of the Policy will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximum.)

Prescription Drugs

To find out which prescription drugs are covered under a plan, Covered Persons can review the applicable drug list at https://www.bcbstx.com/member/prescription-drug-plan-information/drug-lists.

Pharmacy Benefits			
	Preferred Participating Pharmacy	*Participating Pharmacy*	*Non-Participating Pharmacy (member files claims)*
Retail Pharmacy			
One Copayment Amount per 30-day	*$0 Copayment Amount – Tier 1*	*$10 Copayment Amount – Tier 1*	*50% of Allowable*

Pharmacy Benefits			
	Preferred Participating Pharmacy	*Participating Pharmacy*	*Non-Participating Pharmacy (member files claims)*
supply, up to a 30 day supply	*$10 Copayment Amount – Tier 2* *$50 Copayment Amount – Tier 3* *$100 Copayment Amount* – Tier 4*	*$20 Copayment Amount – Tier 2* *$70 Copayment Amount – Tier 3* *$120 Copayment Amount* – Tier 4*	*Amount minus Participating Pharmacy Copayment Amount*
Extended Prescription Drug Supply Program			
One Copayment Amount per 30-day supply, up to a 90 day supply	*$0 Copayment Amount – Tier 1* *$10 Copayment Amount – Tier 2* *$50 Copayment Amount – Tier 3* *$100 Copayment Amount* – Tier 4*	XXXXXXXXXXXXXXX	XXXXXXXXXXXXXXX

Mail-Order Program	Mail-Order Program]	Other Pharmacy
One Copayment Amount per 90- day supply, up to a 90-day supply	*$0 Copayment Amount – Tier 1* *$30 Copayment Amount – Tier 2* *$150 Copayment Amount – Tier 3* *$300 Copayment Amount* – Tier 4*	XXXXXXXXXXXXXXX
Specialty Drugs Available In-Network through Specialty Pharmacy Program	Specialty Pharmacy Provider	Other Pharmacy
One Copayment Amount per 30- day supply – limited to a 30-day supply	*$150 Copayment Amount – Tier 5* *$250 Copayment Amount – Tier 6*	*50% of Allowable Amount minus Copayment Amount*
Vaccinations obtained through Pharmacies**	Pharmacy Vaccine Network Pharmacy	Other Pharmacy
	$0 Copayment Amount	*50% of Allowable Amount minus Copayment Amount*

* If you receive a Non-Preferred Brand Name Drug when a Generic Drug is available, you may incur additional costs. Refer to the Pharmacy Benefits portion of your booklet for details.

**Each Participating Pharmacy that has contracted with BCBSTX to provide this service may have age, scheduling, or other requirements that will apply, so you are encouraged to contact them in advance.

V. Emergency Care Services

Emergency Care means health care services provided in a Hospital emergency facility (emergency room), freestanding emergency medical care 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, call 911, your local emergency response number or go to the nearest emergency facility, whether or not the facility is a Network Provider.
- Whether you require hospitalization or not, you should notify your Network Physician 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 Services	Network Benefits	Out-of-Network Benefits
Accidental Injury & Emergency Care (including Accidental Injury & Emergency Care for Behavioral Health Services)		
Facility charges (excluding Certain Diagnostic Procedures)	*80% of Allowable Amount after $750 outpatient Hospital emergency room Copayment Amount (waived if admitted, and Inpatient Hospital Expenses will apply) after Calendar Year Deductible*	
Physician charges	*80% of Allowable Amount after Calendar Year Deductible*	
Lab & x-ray charges	*80% of Allowable Amount after Calendar Year Deductible*	
Non-Emergency Care (including Non-Emergency Care for Behavioral Health Services)		
Facility charges (excluding Certain Diagnostic Procedures)	*80% of Allowable Amount after $750 outpatient Hospital emergency room Copayment Amount (waived if admitted, and Inpatient Hospital Expenses will apply) after Calendar Year Deductible*	*60% of Allowable Amount after $750 outpatient Hospital emergency room Copayment Amount (waived if admitted, and Inpatient Hospital Expenses will apply) after Calendar Year Deductible*
Physician charges	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Lab & x-ray charges	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*

VI. Out-of-Area Services and Benefits

If you do not reside or work in your Employer's Plan Service Area, you are not eligible to enroll in the PPO Network Plan. You will be provided Traditional Medical Benefits by separate contract/certificate-booklet.

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. Additionally, the Allowable Amount for Out-of-Network Emergency Care and care provided by an Out-of-Network Provider when a Network Provider is not reasonably available to an insured will be no less than the amount required by Texas law and regulations.

VII. What Are My Financial Responsibilities?

You are entitled to coverage under the Contract provided you are eligible to enroll and you have completed an enrollment application form in accordance with Contract procedures. You are required to contribute toward the cost of your coverage by payment of the required premium. 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, Coinsurance Amounts, and any limited or non-covered services as described in the Contract.
- If you choose non-contracting Out-of-Network Providers, you will be responsible for billed charges above the BCBSTX Allowable Amount, any penalty amounts for failure to preauthorize required services, Deductibles and Coinsurance Amounts, and any limited or non-covered services. For Hospitals and Facility Other Providers, Physicians, Professional Other Providers, and any other provider not contracting with BCBSTX in Texas or any other Blue Cross and Blue Shield Plan outside of Texas the Allowable Amount will be the lesser of: (i) the Provider's billed charges, or; (ii) the BCBSTX non-contracting Allowable Amount. Except as otherwise provided in this section, the non-contracting Allowable Amount is developed from base Medicare Participating reimbursements adjusted by a predetermined factor established by BCBSTX. Such factor shall be not less than 75% and will exclude any Medicare adjustment(s) which is/are based on information on the claim.

  When a Medicare reimbursement rate is not available or is unable to be determined based on the information submitted on the claim, the Allowable Amount for non-contracting Providers will represent an average contract rate in aggregate for Network Providers adjusted by a predetermined factor established by BCBSTX. Such factor shall be not less than 75% and shall be updated not less than every two years.

  BCBSTX will utilize the same claim processing rules and/or edits that it utilizes in processing Network Provider claims for processing claims submitted by non-contracted Providers which may also alter the Allowable Amount for a particular service. In the event BCBSTX does not have any claim edits or rules, BCBSTX may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The Allowable Amount will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including, but not limited to, disproportionate share and graduate medical education payments.

  Notwithstanding the above, where applicable state or federal law requires another standard for a non-contracting claim, the Allowable Amount shall be the lessor of billed charge or the amount prescribed by law.

  The Allowable Amount for a non-contracting Out-of-Network Providers may be less the Provider's billed charges and if you receive services from a non-contracted Provider you will be responsible for the difference between the non-contracting Allowable Amount and the non-contracted Provider's billed charge, and this difference may be considerable.

  For Out-of-Network Emergency Care and care provided by an Out-of-Network Provider when a contracting provider is not reasonably available as defined by applicable law, the Allowable Amount will be the usual or customary amount as defined by Texas law or as prescribed under applicable law or regulations.
- To find out the BCBSTX non-contracting Allowable Amount for a particular service, you may call customer service at the number on the back of your BCBSTX Identification Card.

VIII. Limitations and Exclusions

The benefits provided under the medical portion of the Contract 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.
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, except any program which is a state or federal plan for medical assistance (i.e., Medicare or Medicaid); 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, except services or supplies for treatment of mental illness or mental retardation provided by a tax supported institution of the State of Texas.
7. Any services or supplies provided by a person who is related to the Participant by blood or marriage.
8. 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.

9. 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.
10. 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.
11. 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, except as provided in ***Extension Of Benefits***.
12. Any services or supplies provided for Dietary and Nutritional Services, except as may be provided under the Plan for:
    - 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**; or
    - ***Benefits for Certain Therapies for Children with Developmental Delays*** as described in **Special Provisions Expenses**; or
    - ***Benefits for Autism Spectrum Disorder*** as described in **Special Provisions Expenses.**
13. Any services or supplies provided for Custodial Care.
14. Any non-surgical (dental restorations, orthodontics, or physical therapy) or non-diagnostic services or supplies (oral appliances, oral splints, oral orthotics, devices, or prosthetics) provided for the treatment of the temporomandibular joint (including the jaw and craniomandibular joint) and all adjacent or related muscles and nerves.
15. Any items of Medical-Surgical Expense incurred for dental care and treatments, Covered Oral Surgery, or dental appliances, except as provided for in the ***Benefits for Dental Services*** provision in the **Special Provisions Expenses** portion of the Benefit Booklet.
16. 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 the Benefit Booklet.
17. Any services or supplies provided for:
    - Treatment of myopia and other errors of refraction, including refractive surgery; 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, except as may be provided in the Special Provisions Expenses portion of the Benefit Booklet; or
    - Restoration of loss or correction to an impaired speech or hearing function, including hearing aids, except as may be provided under the *Benefits for Speech and Hearing Services* and *Benefits for Autism Spectrum Disorder* provision in the Special Provisions Expenses portion of the Benefit Booklet.
18. 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, except as may be provided under the ***Benefits for Physical Medicine Services*** and ***Benefits for Autism Spectrum Disorder*** provision in the **Special Provisions Expenses** portion of the Benefit Booklet.
19. 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.
20. 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.
21. Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.
22. Any services or supplies provided for, in preparation for, or in conjunction with:
    - Sterilization reversal (male or female);
    - Sexual dysfunctions; and
    - In vitro fertilization; and
    - Promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct intra-peritoneal insemination, trans-uterine tubal insemination, gamete intra-fallopian transfer, pronuclear oocyte stage transfer, zygote intra-fallopian transfer, and tubal embryo transfer.
23. Any services or supplies in connection with routine foot care, including the removal of warts, corns, or calluses, the cutting and trimming of toenails, in the absence of diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency.
24. Any services or supplies in connection with foot care for flat feet, fallen arches, or chronic foot strain.

25. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
26. Supplies for smoking cessation programs and the treatment of nicotine addiction. With the exception of prescription and over-the-counter medications for tobacco cessation and tobacco cessation counseling covered in this Plan, supplies for smoking cessation programs and the treatment of nicotine addiction are excluded.
27. Any services or supplies provided for the following treatment modalities:
    - acupuncture;
    - intersegmental traction;
    - surface EMGs;
    - spinal manipulation under anesthesia; and
    - muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.

    NOTE: This exclusion does not apply to podiatric appliances when provided as Diabetic Equipment.
28. Any benefits in excess of any specified dollar, day/visit, or Calendar Year, maximums.
29. 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.
30. 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.
31. 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.
32. Donor expenses for a Participant in connection with an organ and tissue transplant if the recipient is not covered under this Plan.
33. Replacement Prosthetic Appliances when necessitated by misuse or loss by the Participant
34. Private duty nursing services
35. Any Covered Drugs for which benefits are available under the Pharmacy Benefits portion of the Plan.
36. Any non-prescription contraceptive medications or devices for male use.
37. Any services or supplies provided for reduction mammoplasty.
38. Any services or supplies provided for reduction of obesity or weight, including surgical procedures, even if the Participant has other health conditions which might be helped by a reduction of obesity or weight, except for healthy diet counseling and obesity screening/counseling as may be provided under **Preventive Services**.
39. Biofeedback except for an Acquired Brain Injury diagnosis or other behavior modification services.
40. Any related services to a non-covered service. Related services are:
    a. services in preparation for the non-covered service;
    b. services in connection with providing the non-covered service;
    c. hospitalization required to perform the non-covered service; or
    d. services that are usually provided following the non-covered service, such as follow-up care or therapy after surgery.
41. Any services or supplies not specifically defined as Eligible Expenses in this Plan.

The Pharmacy benefits are not available for:

1. Drugs which are not included on the Drug List.
2. Non-FDA approved drugs.
3. Drugs which do not by law require a Prescription Order, except as indicated under Preventive Care in PHARMACY BENEFITS, from a Provider or authorized Health Care Practitioner (except insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and select vaccinations administered through certain Participating Pharmacies as shown on your Schedule of Coverage); and Legend Drugs or covered devices for which no valid Prescription Order is obtained.
4. 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, including support garments and other non-medicinal substances, artificial appliances, or similar devices (except disposable hypodermic needles and syringes for self-administered injections and those devices listed as Diabetes Supplies). NOTE: Coverage for female contraceptive devices and the rental or purchase of manual or electric breast pumps is provided under the medical portion of this Plan.
5. Pharmaceutical aids such as excipients found in the USP-NF (United States Pharmacopeia- National Formulary), including but not limited to preservatives, solvents, ointment bases, and flavoring, coloring, diluting, emulsifying, and suspending agents.
6. Administration or injection of any drugs.

7. Vitamins (except those vitamins which by law require a Prescription Order and for which there is no non-prescription alternative or as indicated under Preventive Care in PHARMACY BENEFITS).
8. Drugs injected, ingested or applied in a Physician's or authorized Health Care Practitioner's office or during confinement while a patient is 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.
9. Covered Drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
10. Covered Drugs, devices, or other Pharmacy 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 the laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical assistance (Medicaid), or any prescription drug which may be properly obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law; provided, however, that the exclusions of this section shall not be applicable to any coverage held by the Participant for prescription drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
11. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery. Select vaccinations shown on your Schedule of Coverage, administered through certain Participating Pharmacies are an exception to this exclusion.
12. Covered Drugs for which the Pharmacy's usual retail price to the general public is less than or equal to the Participant's cost share determined under this Plan.
13. Any non-prescription contraceptive medications or devices for male use.
14. Oral and injectable infertility and fertility medications.
15. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
16. Fluoride supplements except as required by law.
17. 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.
18. Drugs dispensed in quantities in excess of the day supply amounts stipulated in your Schedule of Coverage or as shown under the Day Supply section of this Benefit Booklet, or refills of any prescriptions in excess of the number of refills specified by the Physician or authorized Health Care Practitioner or by law, or any drugs or medicines dispensed more than one year following the Prescription Order date.
19. Legend Drugs which are not approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation.
20. 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 intramuscular (in the muscle), unless approved by the FDA for self-administration, intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting. NOTE: This exception does not apply to dietary formula 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.
21. Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control.
22. Drugs, that the use or intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.
23. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Identification Card.
24. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under your Employer's group health care plan, or for which benefits have been exhausted.
25. 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.
26. Non-commercially available compounded medications, regardless of whether or not one or more ingredients in the compound requires a Prescription Order. (Non-commercially available compounded medications are those made by mixing or reconstituting ingredients in a manner or ratio that is inconsistent with United States Food and Drug Administration-approved indications provided by the ingredients' manufacturers.)
27. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.

28. Prescription Orders for which there is an over-the-counter product available with the same active ingredient(s) in the same strength, unless otherwise determined by the Plan.
29. Certain drug classes where there are over-the-counter alternatives available
30. Athletic performance enhancement drugs.
31. 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.
32. Allergy serum and allergy testing material.
33. Injectable drugs, except self-administered Specialty Drugs or those approved by the FDA for self-administration.
34. Prescription Orders which do not meet the required step therapy criteria.
35. Prescription Orders which do not meet the required prior authorization criteria.
36. Some drugs which are manufactured under multiple names and have many therapeutic equivalents. In such cases, BCBSTX may limit benefits to specific therapeutic equivalents. If you do not accept the therapeutic equivalents that are covered under your Plan, the drug purchased will not be covered under any benefit level. A list of brand or generic medications with lower cost therapeutics alternatives may exist.
37. Replacement of drugs or other items that have been lost, stolen, destroyed or misplaced.
38. Shipping, handling or delivery charges.
39. Institutional packs and drugs that are repackaged by anyone other than the original manufacturer.
40. Bulk powders.
41. Diagnostic agents (except for diabetic testing supplies or test strips as described in this Benefit Booklet).
42. Prescription Orders written by a member of your immediate family, or a self-prescribed Prescription Order.
43. Drugs determined by the Plan to have inferior efficacy or significant safety issues.

What Happens If I Don't Preauthorize Inpatient Admissions, Extended Care Expenses, Home Infusion Therapy or Outpatient Services*?*

Preauthorization is required for all inpatient Hospital Admissions, Extended Care Expense**,** Home Infusion Therapy**,** and all inpatient and the following outpatient treatments of Chemical Dependency, and Serious Mental Illness and Mental Health Care: Psychological testing, Neuropsychological testing, Electroconvulsive therapy, Repetitive transcranial magnetic stimulation, Applied behavior analysis Intensive outpatient Program, home hemodialysis, Molecular genetic testing, Outpatient Radiation Therapy Non-Emergency Fixed-Wing Air Ambulance transportation, specific outpatient procedures/services shown in the Preauthorization Requirements section of the Benefit Booklet Outpatient transplant evaluations, Dialysis obtained from an Out-of-Network Provider, Outpatient surgery received in an out-of-network Hospital or ambulatory surgical center.

When a Hospital Admission is preauthorized, a length-of-stay is assigned. The Contract provides a minimum length of stay in a Hospital for:

- Maternity Care: (1) 48 hours following an uncomplicated vaginal delivery and (2) 96 hours following an uncomplicated delivery by caesarean section.
- 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 of the treatment or service 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 in nature.
- You may be responsible for a penalty for failure to preauthorize inpatient Admissions for Out-of-Network hospital admissions. Inpatient treatment of Chemical Dependency, Serious Mental Illness, or Mental Health Care including partial hospitalization programs and treatment received at Residential Treatment Centers. You may be responsible for a penalty for failure to preauthorize Outpatient treatment of Extended Care Expense, Home Infusion Therapy, home hemodialysis, Non-Emergency Fixed-Wing Air Ambulance transportation, specific outpatient procedures/services shown in the Preauthorization Requirements section of the Benefit Booklet or outpatient surgery in an out-of-network Hospital or ambulatory surgical center..

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

In the event a Participant is under the care of a Network Provider at the time such Provider stops participating in the Network and at the time of the Network Provider's termination, the Participant has *special circumstances* such as a (1) disability, (2) acute condition,

(3) life-threatening illness, or (4) is past the 13th week of pregnancy and is receiving treatment in accordance with the dictates of medical prudence, BCBSTX will continue providing coverage for that Provider's services at the In-Network Benefit level.

Special circumstances means a condition such that the treating Physician or health care Provider reasonably believes that discontinuing care by the treating Physician or Provider could cause harm to the Participant. *Special circumstances* shall be identified by the treating Physician or health care Provider, who must request that the Participant be permitted to continue treatment under the Physician's or Provider's care and agree not to seek payment from the Participant of any amounts for which the Participant would not be responsible if the Physician or Provider were still a Network Provider.

The continuity of coverage under this subsection will not extend for more than ninety (90) days, or more than nine (9) months if the Participant has been diagnosed with a terminal illness, beyond the date the Provider's termination from the Network takes effect. However, for Participants past the 13th week of pregnancy at the time the Provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery.

XI. What If I Have a Complaint?

BCBSTX has established policies and procedures for you to voice your concerns or 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.

XII. How Do I Locate Network Providers?

A current list of Network Providers and a complete description of the preferred provider networks, 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 a Provider Directory. An updated directory will be available at least annually.

You may also call the BCBSTX Customer Service Helpline at: 1-800-521-2227 toll free or you may visit our web site at www.bcbstx.com to:

1. Identify your Plan Service Area
2. Receive information about Network Providers
3. Assist you in identifying a Preferred Provider (but specific Network Providers will not be recommended).

XIII. Plan Service Area

Your Plan Service Area is statewide.

XIV. Network Demographics

The following demographics describe the network as of March 2018, that your Texas Group Health Plan provides access to for the provision of Covered Services.

Region[A]	Insureds	Specialty	Participating Providers	Waiver and Access[B]
Region 1 - Panhandle	36,267	Internal Medicine	349	Yes
		Family/Gen. Practice	663	Yes
		Pediatrics	218	Yes
		Obstetrics and Gynecology	134	Yes
		Anesthesiology	154	Yes
		Psychiatry	61	Yes
		General Surgery	100	No

Region 2 - Northwest TX	25,658	Acute Care Hospitals	36	No
		Internal Medicine	270	No
		Family/Gen. Practice	406	No
		Pediatrics	64	Yes
		Obstetrics and Gynecology	53	No
		Anesthesiology	46	Yes
		Psychiatry	29	Yes
		General Surgery	40	No
Region 3 - Metroplex	286,049	Acute Care Hospitals	33	No
		Internal Medicine	3,701	No
		Family/Gen. Practice	2,731	No
		Pediatrics	1,600	No
		Obstetrics and Gynecology	928	No
		Anesthesiology	1,530	No
		Psychiatry	560	No
		General Surgery	532	No
Region 4 - Northeast TX	41,116	Acute Care Hospitals	101	No
		Internal Medicine	473	No
		Family/Gen. Practice	662	No
		Pediatrics	156	No
		Obstetrics and Gynecology	143	No
		Anesthesiology	132	No
		Psychiatry	58	No
		General Surgery	98	No
Region 5 - Southeast TX	24,289	Acute Care Hospitals	22	No
		Internal Medicine	224	No
		Family/Gen. Practice	373	No
		Pediatrics	61	Yes
		Obstetrics and Gynecology	60	No
		Anesthesiology	84	No
		Psychiatry	106	Yes
		General Surgery	43	No
Region 6 - Gulf Coast	251,733	Acute Care Hospitals	12	No
		Internal Medicine	2,489	No
		Family/Gen. Practice	2,302	No
		Pediatrics	2,073	No
		Obstetrics and Gynecology	921	No
		Anesthesiology	1,321	No
		Psychiatry	546	No
		General Surgery	537	No
Region 7 - Central TX	114,330	Acute Care Hospitals	70	No
		Internal Medicine	1,536	No
		Family/Gen. Practice	1,877	No
		Pediatrics	821	No
		Obstetrics and Gynecology	419	No

		Anesthesiology	441	No
		Psychiatry	367	No
		General Surgery	252	No
		Acute Care Hospitals	52	No
Region 8 - South Central TX	78,118	Internal Medicine	1,336	Yes
		Family/Gen. Practice	1,476	Yes
		Pediatrics	704	No
		Obstetrics and Gynecology	358	No
		Anesthesiology	691	No
		Psychiatry	301	Yes
		General Surgery	287	No
		Acute Care Hospitals	53	No
Region 9 - West TX	62,613	Internal Medicine	384	No
		Family/Gen. Practice	412	No
		Pediatrics	148	Yes
		Obstetrics and Gynecology	103	No
		Anesthesiology	101	Yes
		Psychiatry	100	Yes
		General Surgery	69	Yes
		Acute Care Hospitals	26	No
Region 10 - Far West TX	17,339	Internal Medicine	529	No
		Family/Gen. Practice	335	No
		Pediatrics	199	No
		Obstetrics and Gynecology	134	No
		Anesthesiology	140	No
		Psychiatry	144	No
		General Surgery	113	Yes
		Acute Care Hospitals	13	No
Region 11 - Rio Grande Valley	46,008	Internal Medicine	568	Yes
		Family/Gen. Practice	829	Yes
		Pediatrics	409	Yes
		Obstetrics and Gynecology	205	No
		Anesthesiology	225	No
		Psychiatry	69	No
		General Surgery	122	No
		Acute Care Hospitals	23	No

A – For a complete list of zip codes within each region, please see Geographic regions definitions in Title 28 of the Texas Administrative Code, section 3.3711. This information may be accessed at http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=28&pt=1&ch=3&sch=X&div=1&rl=Y

B - For additional information on the grant of waivers, please see www.tdi.texas.gov

Local Market Access Plans and Waivers

Waivers or local market access plans approved by the Texas Department of Insurance may be obtained by calling the Customer Service telephone number shown on the back of your Identification Card.

BlueCross BlueShield of Texas

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984

العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。 洽詢一位翻譯員, 請撥電話 號碼 855-710-6984.
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવા કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे है उसके, प्रश्न है, तो आपको अपनी भाषा मे निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें ।
日本語 Japanese	ご本人様、またはお客様の身の回りの方でも、ご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したり することができます。料金はかかりません。通訳とお話される場合、855-710-6984 までお電話ください。
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
ພາສາລາວ Laotian	ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກໍາລັງໄຫ້ການຊ່ວຍເຫຼືອມີຄໍາຖາມ, ທ່ານມີສິດຂໍເອົາການຊ່ວຍເຫຼືອ ແລະ ຂໍ ມູນເປັນພາສາຂອງທ່ານໄດ້ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອລົມກັບນາຍແປພາສາ, ໃຫ້ໂທຫາເບີ 855-710-6984.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił hodoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی،با شمار 855-710-6984 تماس حاصل نمایید.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị đang giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 855-710-6984.

BlueCross BlueShield of Texas

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

Texas Department of Insurance Notice

- You have the right to an adequate network of preferred providers (also known as "network providers").
  - If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.
  - If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network deductible and out-of-pocket maximum.

- You have the right, in most cases, to obtain estimates in advance:
  - from out-of-network providers of what they will charge for their services; and
  - from your insurer of what it will pay for the services.

- You may obtain a current directory of preferred providers at the following website: www.bcbstx.com or by calling the Customer Service number on the back of your ID card for assistance in finding available preferred providers. If the directory is materially inaccurate, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.

- If you are treated by a provider or hospital that is not a preferred provider, you may be billed for anything not paid by the insurer.

- If the amount you owe to an out-of-network hospital-based radiologist, anesthesiologist, pathologist, emergency department physician, neonatologist or assistant surgeon is greater than $500 (not including your copayment, coinsurance, and deductible responsibilities) for services received in a network hospital, you may be entitled to have the parties participate in a teleconference, and if the result is not to your satisfaction, in a mandatory mediation at no cost to you. You can learn more about mediation at the Texas Department of Insurance website: www.tdi.texas.gov/consumer/cpmmediation.html.