BENEFIT HIGHLIGHTS

BlueCross BlueShield of Texas

Blue Advantage Bronze HMO SM 833
Blue Advantage HMOSM Network

The following chart summarizes the coverage available under the offered HMO Plan. All Covered Services (except in emergencies) must be provided by or through the Member's Participating Primary Care Physician/Practitioner (PCP), who may refer them for further treatment by Providers in the applicable network of Participating Specialists and Hospitals. Female members may visit a participating OB/GYN physician in their PCP's provider network for diagnosis and treatment without a Referral from their PCP. Urgent Care, Retail Health Clinics and Virtual Visits do not require Primary Care Physician/Practitioner Referral. Some services may require Preauthorization by HMO. This summary should be reviewed along with the Limitations and Exclusions.

IMPORTANT NOTE: Copayment/Coinsurance shown below indicates the amount You are required to pay, are expressed as either a fixed dollar amount or a percentage of the Allowable Amount and will be applied for each occurrence unless otherwise indicated. Copayments/Coinsurance, Deductibles and out-of-pocket maximums may be adjusted for various reasons as permitted by applicable law.

Out-of-Pocket Maximums Per Calendar Year including Pharmacy Benefits	
Per Individual Member	$7,350
Per Family	$14,700
Deductibles Per Calendar Year including Pharmacy Benefits	
Per Individual Member	$7,350
Per Family	$14,700
Professional Services	
Primary Care Physician/Practitioner ("PCP") Office or Home Visit	100% of Allowable Amount, until Deductible is met.
Participating Specialist Physician ("Specialist") Office or Home Visit	100% of Allowable Amount, until Deductible is met. No Copayment/Coinsurance after Deductible and out-of-pocket maximum have been met.
Inpatient Hospital Services	
Inpatient Hospital Services, for each admission	100% of Allowable Amount, until Deductible is met. No Copayment/Coinsurance after Deductible and out-of-pocket maximum have been met.
Outpatient Facility Services	
Outpatient Surgery	100% of Allowable Amount, until Deductible is met.
-Radiation Therapy **-Dialysis** **-Urgent Care Facility Services**	100% of Allowable Amount, until Deductible is met. No Copayment/Coinsurance after Deductible and out-of-pocket maximum have been met.

Outpatient Infusion Therapy Services	
Routine Maintenance Drug – Hospital Setting	$500 Copay
Routine Maintenance Drug – Home, Office, Infusion Suite Setting	$50 Copay
Non- Maintenance Drug	100% of Allowable Amount, until Deductible is met.
Chemotherapy	100% of Allowable Amount, until Deductible is met. No Copayment/Coinsurance after Deductible and out-of-pocket maximum have been met.
Outpatient Laboratory and X-Ray Services	
Computerized Tomography (CT Scan), Computerized Tomography Angiography (CTA), Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET Scan), SPECT/Nuclear Cardiology studies, per procedure	100% of Allowable Amount, until Deductible is met.
Other X-Ray Services	100% of Allowable Amount, until Deductible is met.
Outpatient Lab	100% of Allowable Amount, until Deductible is met. No Copayment/Coinsurance after Deductible and out-of-pocket maximum have been met.
Rehabilitation Services and Habilitation Services	
Rehabilitation Services, Habilitation Services, and Therapies, per visit Limited to 35 visits per Calendar Year, including chiropractic services for Rehabilitation Services. Limited to 35 visits per Calendar Year, including chiropractic services for Habilitation Services.	100% of Allowable Amount until Deductible is met; unless otherwise covered under **Inpatient Hospital Services**. No Copayment/Coinsurance after Deductible and out-of-pocket maximum have been met.
Maternity Care and Family Planning Services	
Maternity Care	
Prenatal and Postnatal Visit – After the initial office visit, subsequent office visits are covered in full.	100% of Allowable Amount for PCP or Specialist, until Deductible is met.
Inpatient Hospital Services, for each admission	100% of Allowable Amount, until Deductible is met. No Copayment/Coinsurance after Deductible and out-of-pocket maximum have been met.

Family Planning Services:	
• Diagnostic counseling, consultations and planning services • Insertion or removal of intrauterine device (IUD), including cost of device • Diaphragm or cervical cap fitting, including cost of device • Insertion or removal of birth control device implanted under the skin, including cost of device • Injectable contraceptive drugs, including cost of drug	100% of Allowable Amount for PCP or Specialist, until Deductible is met - unless otherwise covered under Contraceptive Services and Supplies described in **Health Maintenance and Preventive Services**. No Copayment/Coinsurance after Deductible and out-of-pocket maximum have been met.
• Vasectomy	100% of Allowable Amount for Inpatient Hospital Service, until Deductible is met or 100%of Allowable Amount for outpatient surgery physician, until Deductible is met and 100% of Allowable Amount for Outpatient Surgery until Deductible is met, as applicable. No Copayment/Coinsurance after Deductible and out-of-pocket maximum have been met.
Infertility Services Diagnostic counseling, consultations, planning and treatment services	100% of Allowable Amount for PCP or Specialist, until Deductible is met. No Copayment/Coinsurance after Deductible and out-of-pocket maximum have been met.
Behavioral Health Services	
Outpatient Mental Health Care	100% of Allowable Amount for PCP or Specialist, until Deductible is met; other Covered Services paid same as any other physical illness.
Inpatient Mental Health Care	Any charges described in **Inpatient Hospital Services** will apply.
Serious Mental Illness	100% of Allowable Amount for PCP or Specialist, until Deductible is met; other Covered Services paid same as any other physical illness.
Chemical Dependency Services	100% of Allowable Amount for PCP or Specialist, until Deductible is met; other Covered Services paid same as any other physical illness. No Copayment/Coinsurance after Deductible and out-of-pocket maximum have been met.
Emergency Services	
Emergency Care	100% of Allowable Amount, until Deductible is met, waived if admitted. (If admitted, any charges described in **Inpatient Hospital Services** will apply.) No Copayment/Coinsurance after Deductible and out-of-pocket maximum have been met.

Urgent Care	
Urgent Care Services	100% of Allowable Amount, until Deductible is met. Any additional charges as described in **Outpatient Laboratory and X-Ray Services** may also apply. No Copayment/Coinsurance after Deductible and out-of-pocket maximum have been met.
Retail Health Clinics	
Retail Health Clinics	PCP amount described in **Professional Services**.
Virtual Visits	
Virtual Visits	100% of Allowable Amount, until Deductible is met. No Copayment/Coinsurance after Deductible and out-of-pocket maximum have been met.
Ambulance Services	
Ambulance Services	100% of Allowable Amount, until Deductible is met. No Copayment/Coinsurance after Deductible and out-of-pocket maximum have been met.
Extended Care Services	
Skilled Nursing Facility Services, for each day, up to 25 days per Calendar Year	100% of Allowable Amount, until Deductible is met.
Hospice Care, for each day	100% of Allowable Amount, until Deductible is met; unless otherwise covered under **Inpatient Hospital Services**.
Home Health Care, per visit, up to 60 visits per Calendar Year	100% of Allowable Amount, until Deductible is met. No Copayment/Coinsurance after Deductible and out-of-pocket maximum have been met.
Health Maintenance and Preventive Services	
Well child care through age 17	No Copay
Periodic health assessments for Members age 18 and older	No Copay
Immunizations	
• Childhood immunizations required by law for Members through age 6	No Copay
• Immunizations for Members over age 6	No Copay
Bone mass measurement for osteoporosis	No Copay

Well-woman exam, once every twelve months, includes, but not limited to, exam for cervical cancer (Pap smear)	No Copay
Screening mammogram for female Members age 35 and over and for female Members with other risk factors, once every twelve months	No Copay
• Outpatient facility or imaging centers	No Copay
Contraceptive Services and Supplies • Contraceptive education, counseling and certain female FDA approved contraceptive methods, female sterilization procedures and devices	No Copay
Breastfeeding Support, Counseling and Supplies • Electric breast pumps limited to one (1) per Calendar Year.	No Copay
Hearing Loss	
• Screening test from birth through 30 days	No Copay
• Follow-up care from birth through 24 months	No Copay
Rectal screening for the detection of colorectal cancer for Members age 50 and older:	
• Annual fecal occult blood test, once every twelve months	No Copay
• Flexible sigmoidoscopy with hemoccult of the stool, limited to 1 every 5 years	No Copay
• Colonoscopy, limited to 1 every 10 years	No Copay
Eye and ear screenings for Members through age 17, once every twelve months	100% of Allowable Amount for PCP or Specialist, until Deductible is met.
Eye and ear screening for Members age 18 and older, once every two years	100% of Allowable Amount for PCP or Specialist, until Deductible is met.
Note: Covered children to age 19 do have additional benefits as described in **PEDIATRIC VISION CARE BENEFITS**.	No Copayment/Coinsurance after Deductible and out-of-pocket maximum have been met.
Early detection test for cardiovascular disease, limited to 1 every 5 years	100% of Allowable Amount, until Deductible is met.
• Computer tomography (CT) scanning	100% of Allowable Amount, until Deductible is met.
• Ultrasonography	No Copayment/Coinsurance after Deductible and out-of-pocket maximum have been met.
Early detection test for ovarian cancer (CA125 blood test), once every twelve months	100% of Allowable Amount for PCP or Specialist, until Deductible is met. Any additional charges as described in **Outpatient Laboratory and X-Ray Services** may also apply. No Copayment/Coinsurance after Deductible and out-of-pocket maximum have been met.

Exam for prostate cancer, once every twelve months	100% of Allowable Amount for PCP or Specialist, until Deductible is met. Any additional charges as described in **Outpatient Laboratory and X-Ray Services** may also apply. No Copayment/Coinsurance after Deductible and out-of-pocket maximum have been met.
Dental Surgical Procedures	
Dental Surgical Procedures (limited Covered Services)	100% of Allowable Amount, for Inpatient Hospital Services, until Deductible is met or 100% of Allowable Amount for outpatient surgery physician, until Deductible is met and 100% of Allowable Amount for Outpatient Surgery, until Deductible is met, as applicable. No Copayment/Coinsurance after Deductible and out-of-pocket maximum have been met.
Cosmetic, Reconstructive or Plastic Surgery	
Cosmetic, Reconstructive or Plastic Surgery (limited Covered Services)	100% of Allowable Amount, for Inpatient Hospital Services, until Deductible is met or 100% of Allowable Amount for outpatient surgery physician, until Deductible is met and 100% of Allowable Amount for Outpatient Surgery, until Deductible is met, as applicable. No Copayment/Coinsurance after Deductible and out-of-pocket maximum have been met.
Allergy Care	
Testing and Evaluation **Injections** **Serum**	100% of Allowable Amount, until Deductible is met. No Copayment/Coinsurance after Deductible and out-of-pocket maximum have been met.
Diabetes Care	
Diabetes Self-Management Training, for each visit	100% of Allowable Amount for PCP or Specialist, until Deductible is met.
Diabetes Equipment	100% of Allowable Amount, until Deductible is met.
Diabetes Supplies Some Diabetes Supplies are only available utilizing pharmacy benefits, through a Participating Pharmacy. You must pay the applicable **PHARMACY BENEFITS** amount shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** and any applicable pricing differences.	100% of Allowable Amount, until Deductible is met. No Copayment/Coinsurance after Deductible and out-of-pocket maximum have been met.

Prosthetic Appliances and Orthotic Devices	
Prosthetic Appliances and Orthotic Devices	100% of Allowable Amount, until Deductible is met.
Cochlear Implants Limit one (1) per ear, with replacements as Medically Necessary or audiologically necessary.	100% of Allowable Amount, until Deductible is met. Any Outpatient Surgery charges as described in **Outpatient Facility Services** may also apply. No Copayment/Coinsurance after Deductible and out-of-pocket maximum have been met.
Durable Medical Equipment	
Durable Medical Equipment	100% of Allowable Amount, until Deductible is met. No Copayment/Coinsurance after Deductible and out-of-pocket maximum have been met.
Hearing Aids	
Hearing Aids Maximum benefit – one per ear, every 36 months	100% of Allowable Amount, until Deductible is met. No Copayment/Coinsurance after Deductible and out-of-pocket maximum have been met.
Speech and Hearing Services	
Speech and Hearing Services	Benefits paid same as any other physical illness
Telehealth and Telemedicine Services	
Telehealth and Telemedicine Medical Services	100% of Allowable Amount, until Deductible is met. No Copayment/Coinsurance after Deductible and out-of-pocket maximum have been met.

Pharmacy Benefits

		Copayment/Coinsurance (Prescription or Refill)
Preferred Participating Pharmacy Retail Pharmacy Benefit payment amounts are based on a 30-day supply, up to a 30-day supply. Extended Prescription Drug Supply Program (if allowed by the Prescription Order) – benefit payment amounts based on a 30-day supply, up to a 90-day supply.	Tier 1 Tier 2 Tier 3 Tier 4 Out-of-Area Drug	100% of Allowable Amount, until Deductible is met. No Copayment/Coinsurance after Deductible and out-of-pocket maximum have been met.
Participating Pharmacy Retail Pharmacy Benefit payment amounts are based on a 30-day supply, up to a 30-day supply.	Tier 1 Tier 2 Tier 3 Tier 4 Out-of-Area Drug	100% of Allowable Amount, until Deductible is met. No Copayment/Coinsurance after Deductible and out-of-pocket maximum have been met.
Mail-Order Program Extended Prescription Drug Supply Program (if allowed by the Prescription Order) – Benefit payment amounts are based on a 90 day supply, up to a 90-day supply only.	Tier 1 Tier 2 Tier 3 Tier 4	100% of Allowable Amount, until Deductible is met. No Copayment/Coinsurance after Deductible and out-of-pocket maximum have been met.
Specialty Pharmacy Program Benefit payment amounts are based on a 30-day supply, up to a 30-day supply only.	Tier 5 Tier 6	100% of Allowable Amount, until Deductible is met. No Copayment/Coinsurance after Deductible and out-of-pocket maximum have been met.
Select Vaccinations obtained through the Pharmacy Vaccine Network	$0 Copay	

For additional information regarding the applicable Drug List, please call customer service or visit the website at https://www.bcbstx.com/member/prescription-drug-plan-information/drug-lists.

The following refers to drugs as identified on the applicable Drug List.

Tier 1 includes mostly Preferred Generic Drugs and may contain some Brand Name Drugs.

Tier 2 includes mostly Non-Preferred Generic Drugs and may contain some Brand Name Drugs.
Tier 3 includes mostly Preferred Brand Name Drugs and may contain some Generic Drugs.
Tier 4 includes mostly Non-Preferred Brand Name Drugs and may contain some Generic Drugs.
Tier 5 includes mostly Preferred Specialty Drugs and may contain some Generic Drugs.
Tier 6 includes mostly Non-Preferred Specialty Drugs and may contain some Generic Drugs

LIMITATIONS AND EXCLUSIONS

The following is a list of services and supplies that are *generally* not covered or limited in coverage. Your plan may contain exceptions to this list based on the plan design purchased. Refer to the Certificate of Coverage for your specific provisions and limitations and exclusions. You will receive this document after you enroll.

1. Services or supplies of non-Participating Providers or self-referral to a Participating Provider, except:

   a. Emergency Care;
   b. when authorized by HMO or Your PCP; and
   c. female Members may directly access an Obstetrician/Gynecologist for: (1) well-woman exams; (2) obstetrical care; (3) care for all active gynecological conditions; and (4) diagnosis, treatment and referral for any disease or condition within the scope of the professional practice of the Obstetrician/Gynecologist.

2. Services or supplies which in the judgment of the PCP or HMO are not Medically Necessary and essential to the diagnosis or direct care and treatment of a sickness, injury, condition, disease or bodily malfunction as defined herein.

3. If a service is not covered, HMO will not cover any services related to it. 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.

4. Experimental/Investigational services and supplies. Denials based on Experimental/Investigational services and supplies are Adverse Determinations and are subject to the utilization review process, including reviews by an Independent Review Organization (IRO) as described in the **COMPLAINT AND APPEALS** section of the Certificate of Coverage.

5. Any charges resulting from the failure to keep a scheduled visit with a Participating Provider or for acquisition of medical records.

6. Special medical reports not directly related to treatment.

7. Examinations, testing, vaccinations or other services required by employers, insurers, schools, camps, courts, licensing authorities, other third parties or for personal travel.

8. Services or supplies provided by a person who is related to a Member by blood or marriage and self-administered services.

9. Services or supplies 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.

10. Benefits You are receiving through Medicare or for which You are eligible through entitlement programs of the federal, state, or local government, including but not limited to Medicaid and its successors.

11. Care for conditions that federal, state or local law requires to be treated in a public facility.

12. Appearances at court hearings and other legal proceedings, and any services relating to judicial or administrative proceedings or conducted as part of medical research.

13. 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.

14. Any services, supplies or drugs received by a Member outside of the United States, except for Emergency Care.

15. Transportation services except as described in **Ambulance Service**s, or when approved by HMO.

16. Personal or comfort items, including but not limited to televisions, telephones, guest beds, admission kits, maternity kits and newborn kits provided by a Hospital or other inpatient facility.

17. Private rooms unless Medically Necessary and authorized by the HMO. If a semi-private room is not available, HMO covers a private room until a semi-private room is available.

18. Any and all transplants of organs, cells, and other tissues, except as described in **Inpatient Hospital Services.** Services or supplies related to organ and tissue transplant or other procedures when You are the donor and the recipient is not a Member are not covered.

19. Services or supplies for Custodial Care.

20. Services or supplies furnished by an institution that is primarily a place of rest, a place for the aged or any similar institution.

21. Private duty nursing, except when determined to be Medically Necessary and ordered or authorized by the PCP.

22. Services or supplies for Dietary and Nutritional Services, including home testing kits, vitamins, dietary supplements and replacements, and special food items, except:

    a. an inpatient nutritional assessment program provided in and by a Hospital and approved by HMO;
    b. dietary formulas necessary for the treatment of phenylketonuria or other heritable diseases;
    c. as described in **Diabetes Care**;
    d. as described in **Autism Spectrum Disorde**r.

23. Services or supplies for Cosmetic, Reconstructive or Plastic Surgery, including breast reduction or augmentation (enlargement) surgery, even when Medically Necessary, except as described in **Cosmetic, Reconstructive or Plastic Surgery**.

24. Services or supplies provided primarily for:

    a. Environmental Sensitivity; or
    b. Clinical Ecology or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists; or
    c. inpatient allergy testing or treatment.

25. Services or supplies provided for, in preparation for, or in conjunction with the following, except as described in **Maternity Care and Family Planning Services**.

    a. sterilization reversal (male or female);
    b. treatment of sexual dysfunction including medications, penile prostheses and other surgery, and vascular or plethysmographic studies that are used only for diagnosing impotence;
    c. promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination super ovulation uterine capacitation enhancement, direct-intraperitoneal insemination, trans-uterine tubal insemination, gamete intrafallopian transfer, pronuclear oocyte stage transfer, zygote intrafallopian transfer and tubal embryo transfer;
    d. any services or supplies related to in vitro fertilization or other procedures when You are the donor and the recipient is not a Member;
    e. in vitro fertilization and fertility drugs, unless covered by a Rider.

26. Services or supplies in connection with routine foot care, including the removal of warts, corns, or calluses, or the cutting and trimming of toenails in the absence of diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency.

27. Services or supplies in connection with foot care for flat feet, fallen arches, or chronic foot strain.

28. Services or supplies for reduction of obesity or weight, including surgical procedures and prescription drugs, even if the Member 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**.

29. Services or supplies for, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.

30. Services or supplies for dental care, except as described in **Dental Surgical Procedures**.

31. Non-surgical or non-diagnostic services or supplies for treatment or related services to the temporomandibular (jaw) joint or jaw-related neuromuscular conditions with oral appliances, oral splints, oral orthotics, devices, 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 and all adjacent or related muscles and nerves. Medically Necessary diagnostic and/or surgical treatment is covered for conditions affecting the temporomandibular joint (including the jaw or craniomandibular joint) as a result of an accident, trauma, congenital defect, developmental defect or pathology, as described in **Dental Surgical Procedures**.

32. Alternative treatments such as acupuncture, acupressure, hypnotism, massage therapy and aroma therapy.

33. Services or supplies for:

    a. intersegmental traction;
    b. surface EMGs;
    c. spinal manipulation under anesthesia;
    d. muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.

34. Galvanic stimulators or TENS units.

35. Disposable or consumable outpatient supplies, such as syringes, needles, blood or urine testing supplies (except as used in the treatment of diabetes); sheaths, bags, elastic garments, stockings and bandages, garter belts, ostomy bags.

36. Prosthetic Appliances or orthotic devices not described in **Diabetes Care** or **Prosthetic Appliances and Orthotic Devices** including, but not limited to:

    a. orthodontic or other dental appliances or dentures;
    b. splints or bandages provided by a Physician in a non-Hospital setting or purchased over the counter for the support of strains and sprains;
    c. corrective orthopedic shoes, including those which are a separable part of a covered brace; specially-ordered, custom-made or built-up shoes and cast shoes; shoe inserts designed to support the arch or affect changes in the foot or foot alignment; arch supports; braces; splints or other foot care items.

37. The following psychological/neuropsychological testing and psychotherapy services:
    a. educational testing;
    b. employer/government mandated testing;
    c. testing to determine eligibility for disability benefits;
    d. testing for legal purposes (e.g., custody/placement evaluations, forensic evaluations, and court mandated testing);

e. testing for vocational purposes (e.g., interest inventories, work related inventories, and career development);
f. services directed at enhancing one's personality or lifestyle;
g. vocational or religious counseling;
h. activities primarily of an educational nature;
i. music or dance therapy;
j. bioenergetic therapy; or

38. Biofeedback (except for an Acquired Brain Injury diagnosis) or other behavior modification services.

39. Mental health services except as described in **Behavioral Health Services** or as may be provided under **Autism Spectrum Disorder.**

40. Residential Treatment Centers for Chemical Dependency that are not:

    a. affiliated with a Hospital under a contractual agreement with an established system for patient Referral;
    b. accredited as such a facility by the Joint Commission on Accreditation of Hospitals;
    c. licensed as a Chemical Dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or
    d. licensed, certified or approved as a Chemical Dependency treatment program or center by any other state agency having legal authority to so license, certify or approve.

41. Trauma or wilderness programs for behavioral health or Chemical Dependency treatment.

42. Replacement for loss, damage or functional defect of hearing aids. Batteries are not covered unless needed at the time of the initial placement of the hearing aid device(s).

43. Deluxe equipment such as motor driven wheelchairs and beds (unless determined to be Medically Necessary); comfort items; bedboards; bathtub lifts; over-bed tables; air purifiers; sauna baths; exercise equipment; stethoscopes and sphygmomanometers; Experimental and/or research items; and replacement, repairs or maintenance of the DME.

44. Over-the-counter supplies or medicines and prescription drugs and medications of any kind, except:

    a. as provided while confined as an inpatient;
    b. as provided under **Autism Spectrum Disorder**;
    c. as provided under **Diabetes Care**;
    d. contraceptive devices and FDA-approved over-the-counter contraceptives for women with a written prescription from a Participating Provider; or
    e. if covered under **PHARMACY BENEFITS**.

45. Male contraceptive devices, including over-the-counter contraceptive products such as condoms; female contraceptive devices, including over-the-counter contraceptive products such as spermicide, when not prescribed by a Participating Provider.

46. Any procedures, equipment, services, supplies, or charges for abortions except for abortions to terminate a pregnancy which, as certified by a Physician, places You in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed.

47. Self-administered drugs dispensed or administered by a Physician in his/her office.

48. Any services or supplies from more than one Provider on the same day(s) to the extent benefits were duplicated.

Pharmacy Benefits are not available for:

1. Drugs which are not included on the Drug List, unless specifically covered elsewhere in the Certificate of Coverage and/or such coverage is required in accordance with applicable law or regulatory guidance.

2. Non-FDA approved drugs.

3. Drugs which by law do not require a Prescription Order, except as indicated under **Preventive Care** in **PHARMACY BENEFITS**, from an authorized Health Care Practitioner and Legend Drugs or covered devices for which no valid Prescription Order is obtained. (Insulin, insulin analogs, insulin pens, prescriptive and nonprescriptive oral agents for controlling blood sugar levels, and select vaccinations administered through certain Participating Pharmacies shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** are covered.)

4. Prescription drugs if there is an over-the-counter product available with the same active ingredient(s) in the same strength, unless otherwise determined by HMO.

5. 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.

6. Drugs, that the use or intended use of would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.

7. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the identification card.

8. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction that is not covered under HMO, or for which benefits have been exhausted.

9. Drugs injected, ingested, or applied 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.

10. Drugs for which the Pharmacy's usual retail price to the general public is less than or equal to the Copayment.

11. Drugs purchased from a non-Participating Pharmacy in the Service Area.

12. Devices or Durable Medical Equipment (DME) such as but not limited to therapeutic devices, including support garments and other non- medicinal substances, even though such devices may require a Prescription Order. (Disposable hypodermic needles, syringes for self-administered injections and contraceptive devices are covered). However, You do have certain DME benefits available under the **Durable Medical Equipment** section in **COVERED SERVICES AND BENEFITS**. Coverage for female contraceptive devices and the rental (or, at HMO's option the purchase) of manual or electric breast pumps is provided as indicated under the **Health Maintenance and Preventives Services** section in **COVERED SERVICES AND BENEFITS**.

13. 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.

14. Male contraceptive devices, including over-the-counter contraceptive products such as condoms; female contraceptive devices, including over-the-counter contraceptive products such as spermicide when not prescribed by a Participating Provider.

15. Any special services provided by a Pharmacy, including but not limited to counseling and delivery. Select vaccinations shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** administered through certain Participating Pharmacies are an exception to this exclusion.

16. Drugs dispensed in quantities in excess of the day supply amounts indicated in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** or refills of any prescriptions in excess of the number of refills specified by the authorized Health Care Practitioner or by law, or any drugs or medicines dispensed more than one (1) year after the Prescription Order date.

17. Administration or injection of any drugs.

18. Injectable drugs except self-administered Specialty Drugs or those approved by the FDA for self-administration.

19. Legend Drugs which are not approved by the 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. 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.)

21. Fluids, solutions, nutrients or medications (including all additives and chemotherapy) used or intended to be used by intravenous or intramuscular injection (unless approved by the FDA for self- administration), intrathecal, intraarticular injection or gastrointestinal (enteral) infusion in the home setting.

22. 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**).

23. Allergy serum and allergy testing materials. However, You do have certain benefits available under **Allergy Care** in **COVERED SERVICES AND BENEFITS**.

24. Athletic performance enhancement drugs.

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. Any prescription antiseptic or fluoride mouthwashes, mouth rinses or topical oral solutions or preparations.

27. Fluoride suuplements except as required by law.

28. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.

29. Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss or dietary control.

30. Drugs to treat sexual dysfunction including but not limited to sildenafil citrate, phentolamine, apomorphine, and alprostadil in oral and topical form.

31. Drugs for the treatment of Infertility (oral and injectable).

32. Prescription Orders which do not meet the required step therapy criteria.

33. Prescription Orders which do not meet the required prior authorization criteria.

34. Some therapeutic equivalents are manufactured under multiple names. In some cases, HMO may limit benefits to only of the therapeutic equivalents available. If You do not accept the therapeutic equivalents that are covered under this Certificate, the drug purchased will not be covered under any benefit level.

35. Replacement of drugs or other items that have been lost, stolen, destroyed or misplaced.

36. Shipping, handling or delivery charges.

37. Certain drug classes where there is an over-the-counter alternative available.

38. Prescription Orders written by a member of Your immediate family, or a self-prescribed Prescription Order.

39. Institutional packs and drugs which are repackaged by anyone other than the original manufacturer.

40. Drugs determined by HMO to have inferior efficacy or significant safety issues.

41. Bulk powders.

42. Diagnostic agents (except for diabetic testing supplies or test strips as described in this Certificate).

43. Self-administered drugs dispensed or administered by a Physician in his/her office.

44. Drugs that are not considered Medically Necessary or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines.

RIDERS
and
AMENDMENTS

IN VITRO FERTILIZATION

This is a Rider to your Blue Cross and Blue Shield of Texas, A Division of Health Care Service Corporation HMO Certificate of Coverage. It is to be attached to and becomes part of the Benefit Highlights.

The **Benefit Highlights**, **Maternity Care and Family Planning Services**; section is amended to add the following provision:

In Vitro Fertilization, including Fertility Drugs	Benefits paid same as any other pregnancy-related illness.

The **Limitations and Exclusions;** section is amended to remove exclusion 25 and replace with the following:

25. Services or supplies provided for, in preparation for, or in conjunction with the following, except as described in **Maternity Care and Family Planning Services**.
    a. sterilization reversal (male or female);
    b. treatment of sexual dysfunction including medications, penile prostheses and other surgery, and vascular or plethysmographic studies that are used only for diagnosing impotence;
    c. promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination super ovulation uterine capacitation enhancement, direct-intraperitoneal insemination, trans-uterine tubal insemination, gamete intrafallopian transfer, pronuclear oocyte stage transfer, zygote intrafallopian transfer and tubal embryo transfer;
    d. any services or supplies related to in vitro fertilization or other procedures when You are the donor and the recipient is not a Member;
    e. services or supplies associated with surrogate ovum transplants.

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Certificate of Coverage to which this amendment is attached will remain in full force and effect.

Blue Cross and Blue Shield of Texas (BCBSTX)

President, Blue Cross and Blue Shield of Texas

NOTICES

NOTICE
Adverse Benefit Determinations

This Notice is to advise You that in addition to the processes outlined in **COMPLAINT AND APPEAL PROCEDURES** section of the **Certificate** and in the **Plan Description and Member Handbook,** you have the right to seek and obtain a review by HMO of any Adverse Benefit Determinations made by HMO in accordance with the benefits and procedures detailed in Your Certificate.

Review of Claim Determinations

Claim Determinations. When HMO receives a properly submitted claim, it has authority and discretion under the plan to interpret and determine benefits in accordance with the plan provisions. You have the right to seek and obtain a review by HMO of any determination of a claim, any determination of a request for preauthorization, or any other determination made by HMO in accordance with the benefits and procedures detailed in Your plan.

If a Claim is Denied or Not Paid in Full. If the claim is denied in whole or in part, You will receive a written notice from HMO with the following information, if applicable:

- The reasons for the determination;
- A reference to the benefit Plan provisions on which the determination is based, or the contractual, administrative or protocol basis for the determination;
- A description of additional information which may be necessary to perfect the claim and an explanation of why such material is necessary;
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- An explanation of HMO's internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of Your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal;
- In certain situations, a statement in non-English language(s) that written notice of claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by HMO;
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
- In the case of a denial of an urgent care clinical claim, a description of the expedited review procedure applicable to such claim. An urgent care clinical claim decision may be provided orally, so long as a written notice is furnished to the claimant within 3 days of oral notification; and
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

Timing of Required Notices and Extensions. Separate schedules apply to the timing of required notices and extensions, depending on the type of claim. There are three types of claims as defined below.

NOTICE
Adverse Benefit Determinations

- **Urgent Care Clinical Claim** is any pre-service claim that requires preauthorization, as described in this Certificate, for benefits for medical care or treatment with respect to which the application of regular time periods for making health claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment.
- **Pre-Service Claim** is any non-urgent request for benefits or a determination with respect to which the terms of the benefit Plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.
- **Post-Service Claim** is notification in a form acceptable to HMO that a service has been rendered or furnished to You. This notification must include full details of the service received, including Your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the claim charge, and any other information which HMO may request in connection with services rendered to You.

Urgent Care Clinical Claims*

Type of Notice or Extension	Timing
If Your claim is incomplete, HMO must notify You within:	**24 hours**
If You are notified that Your claim is incomplete, You must then provide completed claim information to HMO within:	**48 hours** after receiving notice
HMO must notify You of the claim determination (whether adverse or not):	
if the initial claim is complete as soon as possible (taking into account medical exigencies), but no later than:	**72 hours**
after receiving the completed claim (if the initial claim is incomplete), within:	**48 hours**

* You do not need to submit Urgent Care Clinical Claims in writing. You should call HMO at the toll-free number listed on the back of Your identification card as soon as possible to submit an Urgent Care Clinical Claim.

Pre-Service Claims

Type of Notice or Extension	Timing
If Your claim is filed improperly, HMO must notify You within:	**5 days**
If Your claim is incomplete, HMO must notify You within:	**15 days**
If You are notified that Your claim is incomplete, You must then provide completed claim information to HMO within:	**45 days** after receiving notice
HMO must notify You of the claim determination (whether adverse or not):	
if the initial claim is complete, within:	**15 days***

after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
If You require post-stabilization care after an Emergency within:	**the time appropriate to the circumstance not to exceed one hour after the time of request**

***** This period may be extended one time by HMO for up to 15 days, provided that HMO both (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies You, prior to the expiration of the initial 15−day period, of the circumstances requiring the extension of time and the date by which HMO expects to render a decision.

Post-Service Claims

Type of Notice or Extension	Timing
If Your claim is incomplete, HMO must notify You within:	**30 days**
If You are notified that Your claim is incomplete, You must then provide completed claim information to HMO within:	**45 days** after receiving notice
HMO must notify You of any adverse claim determination:	
if the initial claim is complete, within:	**30 days***
after receiving the completed claim (if the initial claim is incomplete), within:	**45 days**

*****This period may be extended one time by HMO for up to 15 days, provided that HMO both (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies You in writing, prior to the expiration of the initial 30−day period, of the circumstances requiring the extension of time and the date by which HMO expects to render a decision.

Concurrent Care. For benefit determinations relating to care that is being received at the same time as the determination, such notice will be provided no later than 24 hours after receipt of Your claim for benefits.

Note: If HMO is seeking to discontinue coverage of prescription drugs or intravenous infusions for which You are receiving health benefits under the plan, You will be notified no later than the 30th day before the date on which coverage will be discontinued. This notice will explain Your rights to expedited appeal and immediate review by an Independent Review Organization.

Claim Appeal Procedures

Claim Appeal Procedures – Definitions. An "Adverse Benefit Determination" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental/Investigational or not Medically Necessary or appropriate. If an ongoing course of treatment had been approved by HMO and HMO reduces or terminates such treatment (other than by amendment or termination of the Employer's benefit Plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A Rescission of coverage is also an Adverse Benefit Determination.

A "Final Internal Adverse Benefit Determination**"** means an Adverse Benefit Determination that has been upheld by HMO at the completion of HMO's internal review/appeal process.

Expedited Clinical Appeals. If Your situation meets the definition of an expedited clinical appeal, You may be entitled to an appeal on an expedited basis. An "expedited clinical appeal" is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care

provider, the denial of emergency care or continued hospitalization, or the discontinuance by HMO of prescription drugs or intravenous infusions for which You were receiving health benefits under the plan. Before authorization of benefits for an ongoing course of treatment/continued hospitalization is terminated or reduced, HMO will provide You with notice and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an expedited pre-service or concurrent clinical appeal, HMO will notify the party filing the appeal, as soon as possible, but in no event later than 24 hours after submission of the appeal, of all the information needed to review the appeal. HMO will render a decision on the appeal within 24 hours after it receives the requested information, but no later than 72 hours after the appeal has been received by HMO.

How to Appeal to an Adverse Benefit Determination. You have the right to seek and obtain a review of any determination of a claim, any determination of a request for preauthorization, or any other determination made by HMO in accordance with the benefits and procedures detailed in Your Plan. An appeal of an Adverse Benefit Determination may be filed by You or a person authorized to act on Your behalf. In some circumstances, a health care provider may appeal on his/her own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about You except to Your authorized representative. To obtain an Authorized Representative Form, You or Your representative may call HMO at the number on the back of Your identification card. If You believe HMO incorrectly denied all or part of Your benefits, You may have Your claim reviewed. HMO will review its decision in accordance with the following procedure:

- Within 180 days after You receive notice of an Adverse Benefit Determination, You may call or write to HMO to request a claim review. HMO will need to know the reasons why You do not agree with the Adverse Benefit Determination. Send Your request to:

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

- HMO will honor telephone requests for information; however, such inquiries will not constitute a request for review.
- In support of Your claim review, You have the option of presenting evidence and testimony to the HMO. You and Your authorized representative may ask to review Your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after You receive notice of an Adverse Benefit Determination or at any time during the claim review process.

  During the course of Your internal appeal(s), HMO will provide You or Your authorized representative (free of charge) with any new or additional evidence considered, relied upon or generated by HMO in connection with the appealed claim, as well as any new or additional rationale for a denial at the internal appeals stage. Such new or additional evidence or rationale will be provided to You or Your authorized representative as soon as possible and sufficiently in advance of the date a final decision on appeal is made in order to give You a reasonable opportunity to respond. HMO may extend the time period described in this Certificate for its final decision on appeal to provide You with a reasonable opportunity to respond to such new or additional evidence or rationale. If the initial benefit determination regarding the claim is based in whole or in part on a medical judgment, the appeal will be conducted by individuals associated with HMO and/or by external advisors, but who were not involved in making the initial denial of Your claim. No deference will be given to the initial Adverse Determination. Before You or Your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by the HMO.

- If You have any questions about the claims procedures or the review procedure, write to the HMO's Administrative Office or call the toll-free Customer Service Helpline number shown on Your identification card.

- If You have a claim for benefits which is denied or ignored, in whole or in part, and Your health plan is governed by the Employee Retirement Income Security Act (ERISA), You have the right to bring civil action under 502 (a) of ERISA.

NOTICE
Adverse Benefit Determinations

Timing of Appeal Determinations
HMO will render a determination of the non-urgent concurrent or pre-service appeal as soon as practical, but in no event more than 30 days after the appeal has been received by HMO.

HMO will render a determination of the post-service appeal as soon as practical, but in no event more than 60 days after the appeal has been received by HMO.

If You Need Assistance. If You have any questions about the claims procedures or the review procedure, write or call the HMO at 1-877-299-2377. The Customer Service Helpline is accessible from 8:00 A.M. to 8:00 P.M., Monday through Friday.

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

If You need assistance with the internal claims and appeals or the external review processes that are described below, You may call the number on the back of Your identification card for contact information. In addition, for questions about Your appeal rights or for assistance, You can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Notice of Appeal Determination

HMO will notify the party filing the appeal, You, and, if a clinical appeal, any health care provider who recommended the services involved in the appeal, orally of its determination followed-up by a written notice of the determination. The written notice to you and your authorized representative will include:

- The reasons for the determination;
- A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- An explanation of HMO's external review processes (and how to initiate an external review) and a statement of Your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on external appeal;
- In certain situations, a statement in non-English language(s) that written notice of claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by HMO;
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
- A description of the standard that was used in denying the claim and a discussion of the decision; and
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

If HMO denies Your appeal, in whole or in part or You do not receive timely decision, You may be able to request an external review of Your claim by an independent third party, who will review the denial and issue a final decision.

Note: You have the right to immediate review by an Independent Review Organization and do not have to comply with the internal appeal process in life-threatening or urgent care circumstances, if HMO has discontinued prescription drugs or intravenous infusions for which You were receiving health benefits under the plan, or if You do not receive a timely decision on Your appeal.

NOTICE
Adverse Benefit Determinations

How to Appeal a Final Adverse Determination to an Independent Review Organization (IRO)

External Review Criteria

External Review is available for Adverse Benefit Determinations and Final Adverse Benefit Determinations that involve rescission and determinations that involve medical judgment including, but not limited to, those based on requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or a covered benefit; determinations that a treatment is experimental or investigational; determinations whether you are entitled to a reasonable alternative standard for a reward under a wellness program; or a determination of compliance with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act.

Standard External Review

You or your authorized representative (as described above) may make a request for a standard external review or expedited external review of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination by an Independent Review Organization (IRO).

1. **Request for external review.** Within four months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination from the HMO, you or your authorized representative must file your request for standard external review.
2. **Preliminary review.** Within five business days following the date of receipt of the external review request, the HMO must complete a preliminary review of the request to determine whether:
    a. You are, or were, covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;

    b. The Adverse Benefit Determination or the Final Adverse Internal Benefit Determination does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination);

    c. You have exhausted the HMO's internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the **Exhaustion** section below for additional information and exhaustion of the internal appeal process; and

    d. You or your authorized representative have provided all the information and forms required to process an external review.

You will be notified within one business day after we complete the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the four-month external review request period (or 48 hours following receipt of the notice), whichever is later, to perfect the request for external review. If your claim is not eligible for external review, we will outline the reasons it is ineligible in the notice, and provide contact information for the Department of Labor's Employee Benefits Security Administration (toll-free number 1-866-444-EBSA (3272)) and or state consumer ombudsman as appropriate.

3. **Referral to Independent Review Organization (IRO).** When an eligible request for external review is completed within the time period allowed, the HMO will assign the matter to an IRO. The IRO assigned will be accredited by URAC or by similar nationally-recognized accrediting organization. Moreover, the HMO will ensure that the IRO is unbiased and independent. Accordingly, the HMO must contract with at least three IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO

may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The IRO must provide the following:

a. Utilization of legal experts where appropriate to make coverage determinations under the plan.

b. Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within 10 business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

c. Within five business days after the date of assignment of the IRO, the HMO must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the HMO to timely provide the documents and information must not delay the conduct of the external review. If the HMO fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within one business day after making the decision, the IRO must notify the HMO and you or your authorized representative.

d. Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within one business day forward the information to the HMO. Upon receipt of any such information, the HMO may reconsider the Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by the HMO must not delay the external review. The external review may be terminated as a result of the reconsideration only if the HMO decides, upon completion of its reconsideration, to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within one business day after making such a decision, the HMO must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the HMO.

e. Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the HMO's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

   (1) Your medical records;
   (2) The attending health care professional's recommendation;
   (3) Reports from appropriate health care professionals and other documents submitted by the HMO, you, or your treating provider;
   (4) The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
   (5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
   (6) Any applicable clinical review criteria developed and used by the HMO, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
   (7) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

f. Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the HMO and you or your authorized representative.

g. The notice of final external review decision will contain:

(1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

(2) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(3) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the HMO or you or your authorized representative;

(6) A statement that judicial review may be available to you or your authorized representative; and

(7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

h. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the HMO, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

4. **Reversal of plan's decision.** Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the HMO must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

1. **Request for expedited external review.** You may request for an expedited external review with the HMO at the time you receive:

a. An Adverse Benefit Determination, if the Adverse Benefit Determination involved a medical condition of yours for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

b. A Final Internal Adverse Benefit Determination, if the determination involved a medical condition of yours for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

2. **Preliminary review**. Immediately upon receipt of the request for expedited external review, the HMO must determine whether the request meets the reviewability requirements set forth in the **Standard External Review** section above. The HMO must immediately send you a notice of its eligibility determination that meets the requirements set forth in **Standard External Review** section above.

3. **Referral to Independent Review Organization (IRO).** Upon a determination that a request is eligible for external review following the preliminary review, the HMO will assign an IRO pursuant to the requirements set forth in the **Standard External Review** section above. The HMO must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final

Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the HMO's internal claims and appeals process.

4. **Notice of final external review decision.** The assigned IRO will provide notice of the final external review decision, in accordance with the requirements set forth in the **Standard External Review** section above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing verbal notice, the assigned IRO must provide written confirmation of the decision to the HMO and you or your authorized representative.

Exhaustion

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the Final Internal Adverse Benefit Determination. For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if the HMO waives the internal review process or the HMO has failed to comply with the internal claims and appeals process other than a de minimis failure. In the event you have been deemed to exhaust the internal review process due to the failure by the HMO to comply with the internal claims and appeals process other than a de minimis failure, you also have the right to pursue any available remedies under 502(a) of ERISA or under State law.

The internal review process will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the HMO demonstrates that the violation was for good cause or due to matters beyond the control of the HMO and that the violation occurred in the context of an ongoing, good faith exchange of information between you and the HMO.

External review may not be requested for an Adverse Benefit Determination involving a claim for benefits for a health care service that you have already received until the internal review process has been exhausted.

PLAN DESCRIPTION
AND
MEMBER HANDBOOK

Blue Cross and Blue Shield of Texas
(herein called “BCBSTX” or “HMO”)

This plan is offered by the following organization,
which operates under Chapter 843
of the Texas Insurance Code:

BLUE CROSS AND BLUE SHIELD OF TEXAS,
A DIVISION OF HEALTH CARE SERVICE CORPORATION
1001 E. Lookout Drive
Richardson, TX 75082

Plan Description and Member Handbook

The following is a brief summary of your benefits and describes your rights and responsibilities under this plan. This document may be delivered to you electronically. Any notices included with this document may be sent to you electronically by HMO, or Group by agreement between HMO and Group. Paper copies are available upon request. You can find more complete information about this plan in the Certificate of Coverage documents (COC) which you will receive after you enroll.

We want you to be satisfied with your new health care program. If you would like more information about the plan, a Customer Service representative will be happy to help you. Call Customer Service Monday through Friday from 7:30 a.m. to 6:00 p.m. CST at 1-877-299-2377. You may also write HMO at:

HMO Customer Service
P.O. Box 660044
Dallas, Texas 75266-0044

Again, thank you for considering us for your health care coverage.

If this plan is purchased through the Exchange (also known as health insurance marketplace), BCBSTX is not the agent for the Exchange and is not responsible for the Exchange. All information that you provide to the Exchange will be relied upon as accurate and complete. You must promptly notify the Exchange and BCBSTX of any changes to such information.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association

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MEDICALLY NECESSARY COVERED SERVICES AND BENEFITS

The COC contains specific information regarding your health care benefits, copayments, any other amounts due, limitations and exclusions. You will receive this document after you enroll. To obtain the most from your health care coverage, please take time to review your COC, Benefit Highlights and attachments carefully and keep them for reference. During enrollment, you will select a primary care physician (PCP) for yourself and one for each of your covered dependents. Your PCP can provide most of your health care needs. A PCP may be a family or general practitioner, Advanced Practice Nurse, Physician Assistant, internist, pediatrician or obstetrician-gynecologist (OB-GYN). Please see the "Receiving Care**"** section below for more information about PCPs.

Hospitalization

If you need to be hospitalized, your PCP or participating OB/GYN can arrange for your care at a local participating hospital. Your PCP or participating OB/GYN will make the necessary arrangements (including referrals) and keep you informed. HMO shall review the referral request and issue a determination indicating whether proposed services are preauthorized within 24 hours of the request by the PCP or participating OB/GYN. You may have to pay a copayment and any other applicable coinsurance or deductibles for some of these services, depending on your plan.

When you think you need hospital care, in non-emergency situations, first call your PCP. Special rules apply in emergency situations or in cases where you are out of the area (see the "Emergency Care" section below.)

Other Medical Services

In addition to PCPs, specialists, and hospitals, the network includes other health care professionals to meet your needs. If you need diagnostic testing, laboratory services or other health care services, your PCP or participating OB/GYN will coordinate your care or refer you to an appropriate setting. You may have to pay a copayment and any other applicable coinsurance or deductibles for some of these services, depending on your plan.

Preventive Care

Preventive care is a key part of your plan, which emphasizes staying healthy by covering:

- Well-child care, including immunizations
- Prenatal and postnatal care
- Hearing loss screenings through 24 months
- Periodic health assessments
- Eye and ear screenings
- Annual well-woman exams, including, but not limited to, a conventional Pap smear
- Annual screening mammograms for females age 35 and older or females with other risk factors
- Annual in home health assessment
- Bone mass measurement for osteoporosis
- Prostate cancer screening for males at least age 50, or at least age 40 with a family history of prostate cancer
- Colorectal cancer screening for persons 50 years of age and older
- Any other evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Task Force ("USPSTF") or as required by state law.

Behavioral Health Care

Your mental health benefits include outpatient and depending on your plan inpatient visits for crisis intervention and evaluation. Please refer to your COC for additional information. To access mental health services, call the designated behavioral health vendor listed on the back of your ID card.

Prescription Drugs

Depending on your plan, you may have coverage for prescription drugs. To find out which prescription drugs are covered under a plan, you can review the applicable drug list at https://www.bcbstx.com/member/prescription-drug-plan-information/drug-lists. You may also request a drug list exception. For information on how to request a drug list exception please refer to your Certificate of Coverage.

REMEMBER:

- Your PCP or participating OB/GYN will arrange for specialty care or hospitalization.
- Preventative care is an important part of your program to help you stay healthy. These services can be provided or arranged by your PCP.
- Usually a copayment and any applicable coinsurance or deductible is all you will be responsible for when you obtain services provided or arranged by your PCP.
- You won't have to file claims for services received from participating providers.

EMERGENCY CARE, AFTER HOURS CARE AND URGENT CARE

Medical Emergencies

Emergency care is defined as health care services provided in a participating or non-participating hospital emergency facility, 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 his or her 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, cause serious impairment to bodily function, cause serious dysfunction of any organ or part of the body, cause serious disfigurement or, in the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

In a medical emergency, seek care immediately. Present your ID card to the hospital emergency room or comparable facility. You or a family member should call your PCP within 48 hours or as soon as possible after receiving emergency care. This call is important so that your PCP can coordinate or provide any follow-up care required as a result of a medical emergency.

REMEMBER:

- In an emergency, seek care immediately.
- You or a family member should call your PCP within 48 hours or as soon as possible after receiving emergency care.

If post stabilization care is required after an emergency care condition has been treated and stabilized, the treating physician or provider will contact HMO or its designee, who must approve or deny such treatment within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case shall approval or denial exceed one hour from the time of the request.

After Hours Care

HMO participating providers have systems in place to respond to your needs when their business offices are closed. These systems may include the use of an answering service or a recorded telephone message informing patients how to access further care.

Urgent Care Services

Urgent care services are covered when rendered by a participating urgent care center provider for the immediate treatment of a medical condition that requires prompt medical attention but where a brief time lapse before receiving services will not endanger life or permanent health and does not require emergency care services. A PCP referral is not required.

Retail Health Clinics

Retail health clinics provide diagnosis and treatment of uncomplicated minor conditions in situations that can be handled without a traditional PCP office visit, urgent care visit or emergency care visit. A PCP referral is not required to obtain covered services.

Virtual Visits
Virtual visits provide you with access to virtual network providers that can provide diagnosis and treatment of non-emergency medical and behavioral health conditions in situations that can be handled without a traditional PCP office visit, behavioral health office visit, urgent care visit or emergency care visit. Covered services may be provided via a consultation with a licensed medical professional through interactive audio via telephone or interactive audio-video via online portal or mobile application. For information on accessing this service, you may access the website at www.bcbstx.com or contact customer service at the toll-free number on the back of your identification card. A PCP referral is not required to obtain covered services.

Note: not all medical or behavioral health conditions can be appropriately treated through virtual visits. The virtual network provider will identify any condition for which treatment by an in-person Provider is necessary.

Out-of-Area Services and Benefits

Emergency Services Outside the Service Area
In an emergency, go directly to the nearest hospital. If you are outside the service area and require medical care, you are covered for emergency services only.

Urgent Care Outside the Service Area
When you are traveling outside of Texas and you need urgent care that cannot be postponed until you return home, the BlueCard® Program gives you the ability to obtain health care services through a Blue Cross and Blue Shield-affiliated physician or hospital outside of Texas.

Follow these easy steps:
1. Locate a participating provider by calling BlueCard Access at 1-800-810-BLUE (2583) or visit the BlueCard Doctor and Hospital Finder website (www.bcbs.com).
2. Call your PCP for referrals and for care requiring preauthorization.
3. Schedule an appointment directly with the provider.
4. Present your ID card.
5. Pay any applicable copayments, coinsurance or deductible.
6. Discuss follow-up care with your PCP.

FACILITY BASED PHYSICIANS

Although health care services may be or have been provided to you at a health care facility that is a member of the provider network used by your health benefit plan, other professional services may be or have been provided at or through the facility by physicians and other health care practitioners who are not members of that network. You may be responsible for payment of all or part of the fees for those professional services that are not paid or covered by your health benefit plan. If you receive such a bill, please contact HMO.

YOUR FINANCIAL RESPONSIBILITIES

BCBSTX requires a premium from you (or your employer) as a condition of coverage. A copayment and any applicable coinsurance or deductible may be due at the time a participating provider renders service. Certain copayment amounts and any applicable coinsurance or deductible and the corresponding types of services are listed on your ID card. For a complete list, refer to the Schedule of Copayments and Benefit Limits in your COC. The copayment and any other coinsurance or deductible amount is

determined by your plan. Consumer Choice plans do not include all state mandated health insurance benefits which means these plans may include deductibles and benefit limits that are not included on other plans. Also, you will have to pay for services not covered by HMO.
HMO network physicians and providers have agreed to look only to HMO and not to its members for payment of covered services. Usually, you are expected to pay nothing more than a copayment and any applicable coinsurance or deductible to participating providers. You should not receive a bill for services received from participating providers. If this occurs, call Customer Service to help determine if the service is a covered benefit and/or to correct the problem.

LIMITATIONS AND EXCLUSIONS

Your COC contains specific information including limitations and exclusions. The Benefit Highlights also include a summary of limitation and exclusions.

PREAUTHORIZATION REQUIREMENTS, REFERRAL PROCEDURES AND OTHER REVIEW REQUIREMENTS

Except for emergency care, your PCP or OB/GYN must authorize all referrals in advance. When your PCP refers you for care, this helps ensure that you receive care that is medically necessary and appropriate. If your PCP or OB/GYN cannot render the services you require, then the PCP or OB/GYN will refer you to the provider(s) you need. Any referral services will be subject to all of the terms, conditions, limitations and exclusions of the HMO plan. Please see the **"**Receiving Care**"** section below for more information about PCPs.

Emergency care services for screening and stabilization do not require preauthorization. Routine requests for inpatient admissions are preauthorized by registered nurses who utilize a system of clinical protocols and criteria to determine the following:

- Medical necessity of the requested care;
- Appropriateness of the location and level of care;
- Appropriateness of the length of stay; and/or
- Assignment of the next anticipated review point.

Concurrent Review
HMO supports the review of requests for continued services including inpatient hospital admissions. Concurrent review is conducted both telephonically and via onsite review at selected facilities. Reviews are conducted by registered nurses and include the following:

- Evaluation for appropriateness (medical necessity/level of care/length of stay);
- Evaluation and coordination of discharge planning requirements;
- Referral to Case Management or Disease Management Programs; and/or
- Identification of potential quality of care issues.

Retrospective Review
HMO may conduct reviews after services have been provided to the patient. Retrospective review includes a medical necessity evaluation of the care/service provided to the member, and of physician compliance to the Utilization/Case Management Program Requirements.

Case Management Review
The Case Management Department facilitates a collaborative process to access, plan, implement, coordinate, monitor, and evaluate options and/or service to meet a member's health care needs through communication and available resources to promote appropriate, cost-effective outcomes.

CONTINUITY OF TREATMENT IN THE EVENT OF TERMINATION OF A NETWORK PROVIDER

If you receive notice that your provider is no longer participating with HMO, it is important to understand that there are special circumstances that allow the provider to continue treatment for a limited time. Except for reasons of medical competence or professional behavior, termination does not release HMO from the obligation to reimburse a provider who is treating you if you have a disability, acute condition, life-threatening illness, or a pregnancy which has passed the 13th week.

If your provider reasonably believes that discontinuing the care that he or she is providing may cause harm to you, he or she must identify the special circumstances to HMO and request that you be allowed to continue treatment. Continuity of treatment may last (i) for up to 90 days from the provider's termination date, (ii) for up to nine months in the case of a member who at the time of provider termination has been diagnosed with a terminal illness, or (iii) for a member who at the time of the termination is past the 13th week of pregnancy, through the delivery of the child, immediate postpartum care, and the follow-up checkup within the first six weeks of delivery.

COMPLAINT PROCEDURE: APPEAL OF ADVERSE DETERMINATION; INDEPENDENT REVIEW ORGANIZATION PROCESS; AND NON-RETALIATION

Claim or Benefit Reconsideration

If a claim or request for benefits is partially or completely denied, you will receive a written explanation of the reason for the denial and be entitled to a full review. If you wish to request a review or have a question regarding the explanation of benefits, call or write Customer Service at the telephone number or address on the back of your ID card. If you are still not satisfied, you may request an appeal of the decision or file a complaint. You may obtain a review of the denial by following the procedures set forth below and more fully in the Complaint and Appeal Procedures in the COC.

Complaints

There may be times when you find that you don't agree with a particular HMO policy or procedure or benefit decision, or you are not satisfied with some aspect of the treatment by a participating provider. We encourage you to communicate your dissatisfaction promptly and directly to the source of the problem.

The goal of Customer Service is to prevent small problems from becoming large issues. To express a complaint regarding any aspect of the HMO program, call or write Customer Service.

If an inquiry is not resolved promptly to your satisfaction, it will be handled according to the complaint procedure described below.

Complaint Procedure

A complaint is any dissatisfaction expressed orally or in writing to HMO regarding any aspect of our operation, such as plan administration; procedures related to review or appeal of an adverse determination; the denial, reduction, or termination of a service for reasons not related to medical necessity; the way a service is provided; or disenrollment decisions. A complaint is not a misunderstanding or problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to your satisfaction.

Also, a complaint does not include your oral or written dissatisfaction or disagreement with an adverse determination (a denial of care or service based on a lack of medical necessity or appropriateness of care).

Within five days of receiving your oral or written complaint, HMO will send you a letter acknowledging the complaint, together with a description of our complaint process and timeframes. If the complaint was received orally, we send a complaint form that you must fill out and return for prompt resolution.

After receiving your written complaint or the written complaint form, HMO will investigate your concerns and send you a letter outlining and explaining the resolution. The letter includes a statement of the specific medical

and contractual reasons for the resolution including any benefit exclusion, limitation or medical circumstance; additional information required to adjudicate a claim, if applicable, and the specialization of any provider consulted. The total time for acknowledging, investigating and resolving your written complaint will not exceed thirty calendar days from the date HMO receives your written complaint or complaint form.

If the complaint is not resolved to your satisfaction, you have the right to dispute the resolution by following the complaint appeals process. A full description of the complaint appeals process will accompany the complaint resolution.

Investigation and resolution of complaints concerning emergencies or denials of the continued hospitalization are concluded in accordance with the medical or dental immediacy of the case, not to exceed one business day from receipt of the complaint.

HMO is prohibited from retaliating against an individual because the individual has filed a complaint against or appealed a decision of HMO. Also, we are prohibited from retaliating against a physician or provider because the physician or provider has, on your behalf, reasonably filed a complaint against or appealed a decision of HMO.

Complaint Appeals to HMO
The complaint appeals process allows you to dispute the complaint resolution before a complaint appeal panel. Following receipt of your written request for a complaint appeal, you have the opportunity to dispute the complaint resolution in person, in writing, by telephone, or by other technological methods. HMO will send you an acknowledgement letter no later than five business days after the date of receipt of your written request for appeal.

The complaint appeal panel is an advisory committee composed of an equal number of HMO staff, physicians or other providers, and others covered by HMO. Participants of the complaint appeal panel will not have been involved in the previously disputed decisions related to the complaint. Experienced physicians or other providers review the case; the resolution recommended by the panel is independent of any prior physician or provider determinations. If you are disputing specialty care, the appeal panel must include a person who is a specialist in the field of care being disputed. Persons selected to participate on the complaint appeal panel are not HMO staff. The appeals process will not exceed thirty calendar days from the date HMO receives the written request for appeal.

No later than the fifth business day before the scheduled meeting of the panel, HMO will supply you or your designated representative with:

- Any documents to be presented to the panel by HMO staff;
- The specialization of any physicians or providers consulted during the investigation;
- The name and affiliation of each HMO representative on the panel; and
- The date and location of the hearing.

You are entitled to:

- Appear in person by conference call or other appropriate technology or through a representative, if the complainant is a minor or disabled, before the complaint appeal panel;
- Present written or oral information to the appeal panel;
- Present alternative expert testimony; and
- Request the presence of and question any person responsible for making the prior determination that resulted in the appeal.

You will receive a written decision of the complaint appeal. When appropriate, it includes specific medical determination, clinical basis, contractual criteria used to reach the final decision and the toll-free telephone number and address of the Texas Department of Insurance.

Upon request and free of charge, you are provided reasonable access to, and copies of all documents, records and other information relevant to the claim or appeal, including:

- Information relied upon in making the benefit determination;
- Information submitted, considered or generated in the course of making the benefit determination, whether or not it was relied upon in making the benefit determination;
- Descriptions of the administrative process and safeguards used in making the benefit determination;
- Records of any independent reviews conducted by HMO;
- Medical judgments, including determinations about whether a particular service is experimental, investigational or not medically necessary or appropriate; and
- Expert advice and consultation obtained by HMO in connection with the denied claim, whether or not the advice was relied upon in making the benefit determination.

Filing Complaints with the Texas Department of Insurance
Any person, including those who have attempted to resolve complaints through HMO's complaint process, who is dissatisfied with the resolution, may report their dissatisfaction to the Texas Department of Insurance, Consumer Protection (111-1A), P.O. Box 149091, Austin, Texas 78714-9091 or fax to (512) 490-1007.

There are three methods of filing a TDI complaint:
- via mail
- via fax
- via online at www.TDI.texas.gov

The Texas Department of Insurance will investigate complaints against HMO within sixty (60) days of receiving the complaint. The time necessary to complete an investigation may be extended if:
- additional information is needed;
- an on-site review is necessary;
- complainant, HMO, or the physician or provider does not provide all documentation necessary to complete the investigation; or
- other circumstances beyond the control of the Texas Department of Insurance occur.

Appeal of Adverse Determinations
An adverse determination is a determination made by HMO or a utilization review agent physician that health care services provided or proposed to be provided are experimental, investigational or not medically necessary. An adverse determination is not a denial of health care services due to the failure to request prospective or concurrent utilization review. In life-threatening or urgent care circumstances, if HMO has discontinued coverage of prescription drugs or intravenous infusions for which you were receiving health benefits under the Certificate, or if you do not receive a timely decision, you are entitled to an immediate appeal to an independent review Organization ("IRO") and are not required to comply with HMO's appeal of an adverse determination process. An IRO is an organization independent of the HMO which may perform a final administrative review of an Adverse Determination made by HMO.

HMO maintains an internal appeal system that provides reasonable procedures for the resolution of an oral or written appeal concerning dissatisfaction or disagreement with an adverse determination. The appeal of an adverse determination process is not part of the complaint process. You, your designated representative or your physician or provider may initiate an appeal of an adverse determination.

When services provided or proposed to be provided are deemed experimental, investigational or not medically necessary, HMO or a utilization review agent will regard the expression of dissatisfaction or disagreement as an appeal of an adverse determination.

Within five working days of your appeal request, HMO will send you a letter acknowledging the date of receipt of the appeal and a list of documents you must submit. For oral appeals, we will also send you a one-page appeal form for completion that must be returned to HMO. HMO will provide a review by a board certified physician or provider who has not already reviewed your case and who is of the same or

similar specialty as typically manages the medical condition, procedure or treatment under review. We have thirty days from your appeal request to provide you written notice of the appeal determination.

Note: If HMO is seeking to discontinue coverage of prescription drugs or intravenous infusions for which you are receiving health benefits under the COC, you will be notified no later than the 30th day before the date on which coverage will be discontinued.

You will receive a written decision of the appeal that will include dental, medical and contractual reasons for the resolution; clinical basis for the decision; specialization of provider consulted; notice of your right to have an independent review organization review the denial; and TDI's toll free telephone number and address.

Expedited Appeal of Adverse Determination Procedures
Investigation and resolution of appeals relating to ongoing emergencies or denials of continued hospital stays or the discontinuance by HMO of prescription drugs or intravenous infusions for which you were receiving health benefits under the Certificate, are referred directly to an expedited appeal process and will be concluded in accordance with the medical or dental immediacy of the case. In no event will the request for an expedited appeal exceed one business day from the date all information necessary to complete the appeal request is received or three calendar days of the appeal request, whichever is sooner. HMO will provide a review by a board certified physician or provider who has not already reviewed your case and who is of the same or similar specialty as typically manages the medical condition, procedure or treatment under review. That physician or provider may interview you and will render a decision on the appeal. The initial notice of the decision may be made orally with written notice of the determination following within three days.

Appeals Process to Independent Review Organization
An independent review organization is an organization independent of HMO that may perform a final administrative review of an adverse determination made by us.
In a circumstance involving a life-threatening or urgent care circumstances, if HMO has discontinued coverage of prescription drugs or intravenous infusions for which you were receiving health benefits under the Certificate, or if you do not receive a timely decision, you are entitled to an immediate appeal to an independent review organization rather than going through HMO's appeal of an adverse determination process.
The independent review organization process is not part of the complaint process, but is available only for appeals of adverse determination.
You may request a review of an appeal of an adverse determination by the independent review organization. HMO will adhere to the following guidelines/criteria:

- Provide you, your designated representative, or your provider of record, information on how to appeal the denial of an adverse determination to an independent review organization;
- Provide this information at the initial adverse determination and the denial of the appeal;
- Provide the appropriate form to complete;
- You, a designated representative, or your provider of record must complete the form and return it to HMO to begin the independent review process;
- In life-threatening or urgent care situations, or if HMO has discontinued coverage of prescription drugs or intravenous infusions for which you were receiving health benefits under the Certificate, you, your designated representative, or provider of record, may contact HMO by telephone to request the review;
- Submit medical records, names of providers and any documentation pertinent to the adverse determination to the independent review organization;
- Comply with the determination by the independent review organization; and
- Pay for the independent review.

Upon request and free of charge you are provided reasonable access to, and copies of all documents, records and other information relevant to the claim or appeal, including:

- Information relied upon in making the benefit determination;
- Information submitted, considered or generated in the course of making the benefit determination, whether or not it was relied upon in making the benefit determination;
- Descriptions of the administrative process and safeguards used in making the benefit determination;
- Records of any independent reviews conducted by HMO;
- Medical judgments, including determinations about whether a particular service is experimental, investigational or not medically necessary or appropriate; and
- Expert advice and consultation obtained by HMO in connection with the denied claim, whether or not the advice was relied upon in making the benefit determination.

The appeal process does not prohibit you from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or relief available under law, if exhausting the procedures of HMO's process for appeal and review places your health in serious jeopardy.

NETWORK PROVIDERS

To find out more about HMO contracting providers, refer to the website at https://www.bcbstx.com/find-a-doctor-or-hospital for Provider Finder®, an Internet-based provider directory. It has important information about the locations and availability of providers, restrictions on accessibility and referrals to specialists, and information about limited provider networks. You may also request a hard copy or electronic copy of the provider directory, which is updated quarterly, by calling or writing Customer Service. The directories can also be found at https://www.bcbstx.com/find-a-doctor-or-hospital. Upon admission to an inpatient facility, (e.g. hospital or skilled nursing facility), a participating physician other than your primary care physician may direct and oversee your care.

Your (PCP) will be the one you call when you need medical advice, when you are sick and when you need preventive care such as immunizations.

Your PCP will play a key role in the delivery of your health care. The network to which your PCP belongs will provide or arrange for all of your care, so make sure that your PCP's network includes the specialists and hospitals that you prefer.

If your PCP changes networks, you will be notified and will receive an updated ID card. You and your covered dependents may select the same or a different provider network, and the same or a different PCP within the network.

DIRECT ACCESS FOR OBSTETRICIAN/GYNECOLOGIST (OB/GYN) CARE

ATTENTION FEMALE MEMBERS: Your HMO plan provides direct access to participating OB/GYNs for gynecologic and obstetric conditions, including annual well woman exams and maternity care, without first obtaining a referral from a PCP or calling HMO. Your PCP or participating OB/GYN will establish a referral for you for any required obstetric/gynecologic specialty care.

HMO has opted not to limit your selection of OB/GYN to your PCP's provider network. It is not required that you select an OB/GYN; you may choose to receive your OB/GYN services from your PCP.

If you need help in locating a participating OB/GYN in your area, refer to the online provider directory (an Internet-based provider directory available on our website at https://www.bcbstx.com/find-a-doctor-or-hospital), or to your provider directory, or call Customer Service at the telephone number on the back of your ID care for assistance.

SERVICE AREA

For a map of the HMO service area, refer to the website at www.bcbstx.com for Provider Finder, an Internet-based provider directory, or request a hard copy or electronic copy of the provider directory by calling Customer Service.

GENERAL INFORMATION

Identification (ID) Card

Once enrolled, you and each of your covered dependents will receive an ID card. Please take a moment to check the following information on the card for accuracy, and call Customer Service if changes are needed.

- Identification number
- Coverage effective date
- Your and/or your covered dependents' names
- Group number
- Primary care physician (or "PCP") name
- PCP telephone number

Your ID card also shows certain copayments and any other amounts due for services that are part of the plan selected.

The back of your ID card includes the toll-free Customer Service telephone number.

Be sure to take your ID card with you when you seek health care. It has important information on it that your PCP or other health care professional will need to know. Always present your ID card to the medical office staff, so they can verify eligibility and collect the appropriate copayment and any other amounts due.

If your ID card is lost or stolen, call Customer Service immediately and a new ID card will be sent to you. Or you may go to the website at www.bcbstx.com, and print a temporary ID card or order a replacement under the Blue Access for Members section. You will also receive an updated ID card if you change your PCP, or if your PCP changes to another network

REMEMBER:

- Your COC contains important details about your health care benefits. Please review them carefully. Contact Customer Service if you have questions about your plan.
- Your provider directory gives you a complete listing of participating providers in your area. Contact Customer Service if you need assistance in locating a PCP in your area.
- Take your ID card with you when you seek care. It has important information your provider needs to know.

RECEIVING CARE

Your Primary Care Physician (PCP)

We encourage you to make an appointment with your PCP before you need health care so that you can establish yourself as a patient. One of the advantages of establishing a physician/patient relationship with your PCP is that your PCP becomes familiar with you and your medical history, which helps make sure you receive the care that is right for you.

It is very important to visit or contact your PCP first when seeking medical care. Your PCP will either treat you or refer you for specialty care. Your PCP will also coordinate any required hospital admissions.

REMEMBER:
Always see your PCP first when you need health care. Services received from any provider without a referral from your PCP will not be covered, except in emergency situations or for OB/GYN services provided by a participating OB/GYN in your network, as described below.

Changing PCPs
Changing your PCP is easy. Simply use the online provider directory at https://www.bcbstx.com/find-a-doctor-or-hospital, refer to your provider directory, or call Customer Service for assistance in selecting a new PCP in your area.

Sometimes a PCP may not be accepting new patients. When selecting a new PCP, you may call Customer Service or the PCP's office and ask about availability. If the PCP is unavailable, Provider Finder or Customer Service can help you find another physician in your area.

Once you've made your decision, either call Customer Service or complete a change form and submit it to the Membership Department, P.O. Box 655730, Dallas, Texas 75265-5730. You may also request the transfer of your medical records from your previous PCP to the newly selected physician.

PCP changes become effective the first day of the month following HMO's receipt and approval of your request. You will receive an updated ID card that shows your new PCP's name and phone number. If you need health care but have not received your new ID card with your new PCP's name, call Customer Service to verify that your request has been processed. You may also go to the website at www.bcbstx.com, and print a temporary ID card under the Blue Access for Members section.

Making Appointments
You may make appointments for periodic health assessments at a time convenient for you.

If the nature of an illness warrants an urgent appointment, your PCP can generally fit you into his or her schedule within a reasonable period of time. If your PCP cannot fit you in, he or she may direct you to a designated back-up physician. If you need assistance, you may call Customer Service at the telephone number on the back of your ID card.

If you need to change or cancel an appointment, be sure to call your PCP as soon as you can. When you visit your PCP's office for covered services, you will pay only a copayment and any other applicable coinsurance or deductibles for the office visit. There are no claims to file. If you need the care of a specialist, your PCP will refer you and will handle any preauthorization requirements for you.

REMEMBER:
- Have your health care provided or arranged by your PCP.
- For obstetric or gynecologic conditions, you may directly access a participating OB/GYN (in the same provider network as your PCP).
- Contact Customer Service for assistance in changing your PCP.
- It is important to schedule an appointment with your PCP as soon as you can. Contact Customer Service if your PCP cannot fit you in.

Telehealth and Telemedicine Medical Services
Telehealth and Telemedicine Medical Services are covered as defined below and may require Preauthorization.

Telehealth Service means a health service, other than a Telemedicine Medical Service, delivered by a health professional licensed, certified, or otherwise entitled to practice in Texas and acting within the scope of the health professional's license, certification, or entitlement to a

patient at a different physical location than the health professional using telecommunications or information technology.

Telemedicine Medical Services means a health care service delivered by a Physician licensed in Texas, or a health professional acting under the delegation and supervision of Physician licensed in Texas, and acting within the scope of the Physician's or health professional's license to a patient at a different physical location than the Physician or health professional using telecommunication or information technology.

ADDITIONAL INFORMATION

Status Changes

Your records are very important to us. Incorrect records can delay membership verification or medical care, create problems in continuing coverage for a dependent, and possibly cost you money. To keep your coverage up to date, see your employer for specific instructions about submitting forms to notify us of any changes. If this plan is purchased through the Exchange you must notify the Exchange within 30 days of any changes that will affect eligibility. Completed forms must be received by HMO within 31 days from the date of any change listed below:

- Birth of a child;
- Adoption or becoming a party in a suit for adoption, or legal guardianship;
- Change of dependency status of a child;
- Court-ordered dependents;
- Loss of other health coverage;
- Marriage;
- Divorce;
- Death;
- Change of address; and
- Change of telephone number.

Coverage will be automatic for subscriber or subscriber's spouse's newborn child for the first thirty-one (31) days following the date of birth. Coverage will continue beyond the thirty-one (31) days only if the child is an eligible dependent and You notify HMO (verbally or in writing) or submit an enrollment application/change form to HMO timely and make or agree to make any additional premium payments. Note: If this plan is purchased through the Exchange, application must be made to the Exchange within 30 days and you must make or agree to make any additional Premium payments in accordance with this Certificate.

Duplication of Coverage and Coordination of Benefits

If you or your dependents are covered by more than one health benefit plan, you may have duplicate coverage. Each covered dependent will then have "primary" and "secondary" coverage. At the time of enrollment, you were asked to provide information about your other health benefit plan. Please notify Customer Service of any change in your duplicate coverage.

Injuries and sometimes illnesses may be covered by other types of insurance such as auto, homeowners or workers' compensation. Please call Customer Service in cases such as these for information on what steps to take.

It is important that you provide this information to us to allow coordination of payment of your claims to ensure that claims are not paid twice. This helps keep your health care costs down.

Continuation of Benefits

Under the Consolidated Omnibus Budget Reconciliation Act (federal legislation called COBRA), many employers offer a continuation of group coverage if you become ineligible for group membership. Ask

your employer if this coverage is available to you. You also may be able to continue your coverage under State Continuation guidelines, as explained in your COC.

REMEMBER:
- Notify us within 31 days of a change to your eligibility. If this plan is purchased through the Exchange, notify the Exchange within 30 days of any changes that will affect eligibility.
- Be sure to indicate any other health coverage you have, or contact Customer Service with this information.
- You may be eligible to continue your membership. Please review the guidelines above to see if you are elgibile.

New Medical Technology
HMO keeps abreast of medical breakthroughs, experimental treatments and newly approved medication. The medical policy department evaluates new technologies, medical procedures, drugs and devices for potential inclusion in the benefit packages we offer. Clinical literature and accepted medical practice standards are assessed thoroughly with ongoing reviews and determinations made by our Medical Policy Group

YOUR RIGHTS AND RESPONSIBILITIES

You have certain rights and responsibilities when receiving health care services and should expect the best possible care available. We have provided the following information, so you can be an informed customer and active participant in your plan.

Your Rights
You have the right to:

- Select or change your PCP and know the qualifications, titles and responsibilities of the professionals responsible for your health care;
- Receive prompt and appropriate treatment for physical or emotional disorders and participate with your providers in decisions regarding your care;
- Be treated with dignity, compassion and respect for your privacy;
- Have a candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage;
- Have all medical and other information held confidential unless disclosure is required by law or authorized in writing by you;
- Be provided with information about:
  - HMO;
  - Health care benefits;
  - Copayments, copayment limitations, and/or other charges;
  - Service access;
  - Changes and/or termination in benefits and participating providers;
  - Exclusions and limitations;
- Express opinions, concerns, and complaints in a constructive manner or appeal regarding any aspect of the HMO;
- Receive timely resolution of complaints or appeals through Customer Service and the complaint procedure;
- Have access to review by an Independent Review Organization;
- Refuse treatment and be informed of the medical consequences that may be a result of your decision; and
- Make recommendations regarding your HMO rights and responsibilities policies.

Your Responsibilities
You have the responsibility to:

- Meet all eligibility requirements;
- Identify yourself by presenting your ID card and pay the copayment and any other applicable amount due at the time of service for network benefits;
- Establish a physician/patient relationship with your PCP and seek your PCP's medical advice/referral for network services prior to receiving medical care, unless it is an emergency situation or services are performed by your HMO participating OB/GYN;
- Understand the medications you are taking and receive proper instructions on how to take them;
- Communicate complete and accurate medical information to health care providers;
- Call in advance to schedule appointments with network providers and notify them prior to canceling or rescheduling appointments;
- Ask questions and follow instructions and guidelines given by providers to achieve and maintain good health;
- Discuss disagreements and/or misunderstandings regarding treatment from providers;
- Notify your PCP or HMO within 48 hours or as soon as reasonably possible after receiving emergency care services;
- Provide, to the extent possible, information that HMO needs in order to administer your benefit plan, including changes in your family status, address and phone numbers ;
- Read your COC for information about HMO benefits, limitations, and exclusions; and
- Understand your health conditions, and participate to the degree possible in the development of treatment goals mutually agreed upon between you and your provider.

CONFIDENTIALITY AND ACCESS TO RECORDS

We are required by federal and state law to maintain the privacy of your protected health information. "Protected health information" (PHI) is information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. With limited exceptions, your medical records may not be disclosed to others, including your employer, without your written consent. You, or an individual acting on your behalf, may request medical records for the purpose of providing care or resolving disputes related to coverage, reimbursement, or complaints.

Routine consent signed at the time of enrollment permits us to release information for purposes of quality assessment and measurement, treatment, coordination of care, accreditation, billing and other uses. Identifiable information is minimized and protected from inappropriate disclosure. Information provided to employer groups is aggregated to protect the identification of any individual.

You have a right to specifically approve the release of information beyond the uses identified in the routine consent that you sign upon enrollment and, at other times, as needed for worker's compensation claims, auto insurance claims, marketing or data used for research studies.

You may give us written authorization to use your PHI or to disclose it to another person only for the purpose you designate. PHI may not be disclosed to your spouse or family without written authorization from you or an authorized representative. Information regarding children under 18 years of age may be released to a parent or legal guardian. If an adult is incapacitated, a legally appointed guardian may act on their behalf. Unless you give us written authorization, we cannot use or disclose your PHI for any reason except those described in the HIPAA Notice.

Participating providers must comply with applicable HIPAA laws, professional standards and policies regarding the confidential treatment of medical information, including security measures to control access to confidential information maintained in computer systems. Access to electronic files containing information is to be protected and restricted to employees who have a business-related need to know. Oral, written and electronic personal health information across the organization will be kept confidential in accordance with applicable law.

Blue Cross Blue Shield of Texas understands the importance of confidentiality and respects your right to privacy. A summary of our privacy practices is available on the BCBSTX website at www.bcbstx.com/privacy.htm or you may call Customer Service at the telephone number on the back of your ID card to obtain a paper copy.

CUSTOMER SERVICE

Questions

If you have questions about your benefits, Customer Service representatives are available to help you at the telephone number on the back of your ID card. Customer Service can also help if you want to change your PCP. They will have an up-to-date list of participating providers in your area.

Customer Service can also assist you with special communications needs. If your first language is not English, you can ask to speak to a bilingual staff member (English or Spanish). Some written materials (including this Plan Description and Member Handbook) are available in Spanish. Members may also ask for access to a telephone-based translation service to assist with other languages.

BCBSTX provides TDD/TYY services and language assistance for incoming callers for deaf, hard-of-hearing and speech-disabled members. Members can utilize their TeleTypewriter (TTY) or Telecommunication Device (TDD) to access a teletype operator.

If you are not satisfied with service you have received, HMO has a formal complaint process you can follow to advise us of issues related to quality of care or service. We monitor the care you receive and follow through on all complaints and inquiries, because your satisfaction is important to us.

NOTICE

OUT-OF-NETWORK PHYSICIANS AND PROVIDERS

This notice is to advise you of your rights regarding services from out-of-network physicians and providers. Out-of-network physicians and providers are not part of HMO's network of participating providers.

A health maintenance organization (HMO) plan provides no benefits for services you receive from out-of-network physicians or providers, with specific exceptions as described in your Certificate of Coverage and below.

- You have the right to an adequate network of in-network physicians and providers (known as *network physicians and providers*).
- If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance at: www.tdi.texas.gov/consumer/complfrm.html.
- If your HMO approves a referral for out-of-network services because no network physician or provider is available, or if you have received out-of-network emergency care, the HMO must, in most cases, resolve the out-of-network physician's or provider's bill so that you only have to pay any applicable in-network copayment, coinsurance, and deductible amounts.
- You may obtain a current directory of network physicians and providers at the following website: https://www.bcbstx.com/find-a-doctor-or-hospital or by calling 1-877-299-2377 for assistance in finding available network physicians and providers. If you relied on materially inaccurate directory information, you may be entitled to have a claim by an out-of-network physician or provider paid as if it were from a network physician or provider, if you present a copy of the inaccurate directory information to the HMO, dated not more than 30 days before you received the service.

BLUE CROSS AND BLUE SHIELD OF TEXAS
A DIVISION OF HEALTH CARE SERVICE CORPORATION
(herein called "BCBSTX" or "HMO")

This is an amendment to your Plan Description and Member Handbook. It is to be attached to and becomes part of the Plan Description and Member Handbook. This amendment may be delivered to you electronically, but a paper copy of this amendment is available on request.

The **Plan Description and Member Handbook, Network Providers section** is amended to add the following information:

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

Network	Enrollees	Specialty	Participating Providers	Access
Blue Advantage HMO Network	399,813	Internal Medicine	6,149	Yes
		Family/Gen. Practice	8,058	Yes
		Pediatrics	2,995	Yes
		Obstetrics and Gynecology	2,157	Yes
		Anesthesiology	3,333	Yes
		Psychiatry	1	Yes
		General Surgery	1,178	Yes
		Acute Care Hospitals	212	Yes

For additional information regarding network adequacy please call the customer service telephone number shown on the back of your identification card or visit the website at https://www.bcbstx.com.

Changes in state or federal law or regulations, or interpretations thereof, may change the terms and conditions of coverage. Except as changed by this Amendment, all terms, conditions, limitations and exclusions of the Member Handbook and Plan Description to which this Amendment is attached will remain in full force and effect.

Blue Cross and Blue Shield of Texas (BCBSTX)

By:
President, Blue Cross and Blue Shield of Texas