BlueCross BlueShield of Texas

Blue Essentials Access Silver HMO SM802

Blue Essentials HMO SM 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 a Participating Provider. 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	$7,900
Per Family	$15,800
Deductibles Per Calendar Year	
Per Individual Member	$3,000
Per Family	$9,000
Professional Services	
Primary Care Physician/Practitioner ("PCP") Office or Home Visit	$40 Copay
Participating Specialist Physician ("Specialist") Office or Home Visit	$80 Copay
Inpatient Hospital Services	
Inpatient Hospital Services, for each admission	$250 Copay, plus 30% Coinsurance after Deductible
Outpatient Facility Services	
Outpatient Surgery	$200 Copay, plus 30% Coinsurance after Deductible
Radiation Therapy **Dialysis** **Urgent Care Facility Services**	30% Coinsurance after Deductible

Outpatient Infusion Therapy Services	
Routine Maintenance Drug – Hospital Setting Routine	$500 Copay
Maintenance Drug – Home, Office, Infusion Suite Setting	$50 Copay
Non-Maintenance Drug	30% Coinsurance after Deductible
Chemotherapy	30% Coinsurance after Deductible

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	$200 Copay, plus 30% Coinsurance after Deductible
Other X-Ray Services	30% Coinsurance after Deductible
Outpatient Lab	30% Coinsurance after Deductible

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.	30% Coinsurance after Deductible; unless otherwise covered under **Inpatient Hospital Services**.

Maternity Care and Family Planning Services

Maternity Care	
Prenatal and Postnatal Visit – Copay is applied to the first office visit only. Subsequent office visits are covered in full.	$40 Copay for PCP or $80 Copay for Specialist.
Inpatient Hospital Services, for each admission	$250 Copay, plus 30% Coinsurance after Deductible
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	$40 Copay for PCP or $80 Copay for Specialist; unless otherwise covered under Contraceptive Services and Supplies described in **Health Maintenance and Preventive Services**.
• Vasectomy	$250 Copay, plus 30% Coinsurance for Inpatient Hospital Services after Deductible or 30% Coinsurance for outpatient surgery physician and $200 Copay, plus 30% Coinsurance for Outpatient Surgery after Deductible, as applicable.
Infertility Services	
• Diagnostic counseling, consultations, planning and treatment services	$40 Copay for PCP or $80 Copay for Specialist

Behavioral Health Services

Outpatient Mental Health Care	$40 Copay for PCP office or home visit, 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	$40 Copay for PCP office or home visit, other Covered Services paid same as any other physical illness.
Chemical Dependency Services	$40 Copay for PCP office or home visit, other Covered Services paid same as any other physical illness.

Emergency Services

Emergency Care	$500 Copay, plus 30% Coinsurance after Deductible, waived if admitted. (If admitted, any charges described in **Inpatient Hospital Services** will apply.)

Urgent Care	
Urgent Care - Services	$40 Copay Any additional charges as described in **Outpatient Laboratory and X-Ray Services** may also apply.
Retail Health Clinics	
Retail Health Clinics	PCP amount described in **Professional Services**.
Virtual Visits	
Virtual Visits	$40 Copay
Ambulance Services	
Ambulance Services	30% Coinsurance after Deductible
Extended Care Services	
Skilled Nursing Facility Services, for each day, up to 25 days per Calendar Year	30% Coinsurance after Deductible
Hospice Care, for each day	30% Coinsurance after Deductible; unless otherwise covered under **Inpatient Hospital Services**.
Home Health Care, per visit, up to 60 visits per Calendar Year	30% Coinsurance after Deductible
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 • Immunizations for Members over age 6	 No Copay 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 • Outpatient facility or imaging centers	No Copay 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	$40 Copay for PCP or $80 Copay for Specialist
Eye and ear screening for Members age 18 and older, once every two years Note: Covered children to age 19 do have additional benefits as described in **PEDIATRIC VISION CARE BENEFITS**.	$40 Copay for PCP or $80 Copay for Specialist
Early detection test for cardiovascular disease, limited to 1 every 5 years	
• Computer tomography (CT) scanning	$200 Copay, plus 30% Coinsurance after Deductible
• Ultrasonography	30% Coinsurance after Deductible
Early detection test for ovarian cancer (CA125 blood test), once every twelve months	$40 Copay for PCP or $80 Copay for Specialist. Any additional charges as described in **Outpatient Laboratory and X-Ray Services** may also apply.
Exam for prostate cancer, once every twelve months	$40 Copay for PCP or $80 Copay for Specialist. Any additional charges as described in **Outpatient Laboratory and X-Ray Services** may also apply.

Dental Surgical Procedures

Dental Surgical Procedures (limited Covered Services)	$250 Copay, plus 30% Coinsurance for Inpatient Hospital Services after Deductible, or 30% Coinsurance for outpatient surgery physician after Deductible and $200 Copay, plus 30% Coinsurance for Outpatient Surgery after Deductible, as applicable.

Cosmetic, Reconstructive or Plastic Surgery	
Cosmetic, Reconstructive or Plastic Surgery (limited Covered Services)	$250 Copay, plus 30% Coinsurance for Inpatient Hospital Services after Deductible, or 30% Coinsurance for outpatient surgery physician after Deductible and $200 Copay, plus 30% Coinsurance for Outpatient Surgery after Deductible, as applicable.
Allergy Care	
Testing and Evaluation **Injections** **Serum**	30% Coinsurance after Deductible
Diabetes Care	
Diabetes Self-Management Training, for each visit	$40 Copay for PCP or $80 Copay for Specialist
Diabetes Equipment	30% Coinsurance after Deductible
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.	30% Coinsurance after Deductible
Prosthetic Appliances and Orthotic Devices	
Prosthetic Appliances and Orthotic Devices	30% Coinsurance after Deductible
Cochlear Implants Limit one (1) per ear, with replacements as Medically Necessary or audiologically necessary.	30% Coinsurance after Deductible. Any Outpatient Surgery charges as described in **Outpatient Facility Services** may also apply.
Durable Medical Equipment	
Durable Medical Equipment	30% Coinsurance after Deductible
Hearing Aids	
Hearing Aids Maximum benefit – one per ear, every 36 months	30% Coinsurance after Deductible
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	$40 Copay

Pharmacy Benefits

		Copayment/Coinsurance (Prescription or Refill)
Preferred Participating Pharmacy Retail Pharmacy One Copayment amount per 30-day supply, up to a 30-day supply. Extended Prescription Drug Supply Program (if allowed by the Prescription Order) – one Copayment amount per 30-day supply, up to a 90-day supply.	Tier 1 Tier 2 Tier 3 Tier 4 Out-of-Area Drug	$0 Copay $10 Copay $50 Copay $100 Copay $100 Copay
Participating Pharmacy Retail Pharmacy One Copayment amount per 30-day supply, up to a 30-day supply only	Tier 1 Tier 2 Tier 3 Tier 4 Out-of-Area Drug	$10 Copay $20 Copay $70 Copay $120 Copay $120 Copay
Mail-Order Program Extended Prescription Drug Supply Program (if allowed by the Prescription Order) - One Copayment amount per 90-day supply, up to a 90-day supply only.	Tier 1 Tier 2 Tier 3 Tier 4	$0 Copay $30 Copay $150 Copay $300 Copay
Specialty Pharmacy Program One Copayment amount per 30-day supply, up to a 30-day supply only.	Tier 5 Tier 6	$150 Copay $250 Copay
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 except:
   a. Emergency Care and
   b. when authorized by HMO.

2. Services or supplies which in the judgment of a qualified Participating Provider 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 their 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 a qualified Participating Provider.

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 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 supplements 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 one 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 drugs 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-adminstered 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