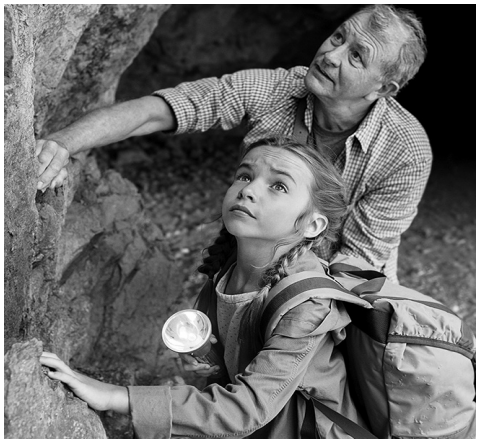
Administered by:

BlueCross BlueShield of Texas






Your Health Care Benefits Program
Blue Balance Funded

A Message to Employees:

Your employer offers this **plan** to you has an employment benefit. The **benefits** provided are intended to assist you with many of your health care expenses for **medically necessary** services and supplies. Coverage under this **plan** is provided regardless of your race, color, national origin, disability, age, sex, gender identity or sexual orientation. There are provisions throughout this plan that affect your health care coverage. It is important to read the **plan**, to be aware of your **benefits** and requirements.

This **plan** was designed to provide affordable coverable and meet your family's health care needs by providing access to a comprehensive network of:

- **Hospitals**
- **Primary Care Physicians**
- **Specialist**
- Other qualified **participating providers**

This **plan** is Blue Cross and Blue Shield of Texas, a Division of Health Care services corporation. We provide administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Please note: Bolded words are defined terms and can be found in the **GLOSSARY** section.

Read Your Benefit Booklet Carefully

THIS BENEFIT BOOKLET REPLACES, IN ITS ENTIRETY, ALL PREVIOUSLY ISSUED BENEFIT BOOKLETS.

Claim Administrator
PO BOX 660247
Dallas, TX 75266-0247
1-877-299-2377

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QUICK REFERENCE

Where to Find the Answer	
Provider Directory	www.bcbstx.com
Prescription Drug List	www.bcbstx.com
Prior Authorization List	www.bcbstx.com
Preventive Services	https://www.bcbstx.com/provider/clinical/clinical-resources/preventive-care
• Customer Service • Prior Authorization • Inpatient Admissions • Appeals • Claim Forms • Prescription Drug • Mail-order Services • Pharmacy Locator	See **CUSTOMER SERVICE** section in this benefit booklet for contact information such as phone numbers, websites and mailing addresses where available
Definitions	See **GLOSSARY** section Defined terms are in bold in your booklet
Your cost share information for **covered services**	See **SUMMARY OF BENEFITS** section Cost shares for medical and **pharmacy** services are listed separately in this section.

SUMMARY OF BENEFITS

This is your **SUMMARY OF BENEFITS**. It shows your **cost share** including **deductible** amounts, **copayment** amounts and **coinsurance** amounts and how they apply to the **covered services** you receive under this **plan**. The information below summarizes your **cost share** and any limits that may apply to **covered services**. You may contact Customer Service at the telephone number on the back of your member **identification card** for any questions or additional information.

All Covered Services (except in emergencies) must be provided by or through your **participating provider**. Some services may require **prior authorization**.

How cost sharing works:

- The **deductible** amounts and copayment amounts listed in the charts below show the amounts you pay for covered services.
- **Coinsurance** amounts, if any, listed in the charts below are the percentage of the allowable amount you pay. You may have to satisfy deductible amount(s), copayment amount(s) and/or coinsurance amount(s) before you receive services.
- All **copayment** and **coinsurance** costs shown in the charts below are after your **deductible** has been met, if a **deductible** applies.
- Your **benefit period** is a period of one year beginning on January 1 of each year. When you first enroll under this **plan**, your coverage begins on the date shown above and ends on the first day of the month the following year. For example 01/01/2026 - 12/31/2026.

Blue Balance Funded℠

Benefit Period	Calendar year

Deductible	**In-Network Providers and Pharmacies You Pay**
Individual	$3,000
Family	$9,000
• Per calendar year deductible amounts include pharmacy benefits • Three month deductible carryover applies	

Out-of-Pocket Maximum	**In-Network Providers and Pharmacies You Pay**
Individual	$7,350
Tier Family	$14,700
• Out-of-pocket maximum includes pharmacy benefits	

Please review the **COVERED SERVICES** section of your booklet for additional information about the **covered services** listed below.

Acupuncture

Description	In-Network You Pay
Acupuncture	Not Covered

Allergy Care

Description	In-Network You Pay
Allergy Testing and Evaluations	30% Coinsurance after deductible
Allergy Injections	30% Coinsurance after deductible
Allergy Serum	30% Coinsurance after deductible

Ambulance Services

Description	In-Network You Pay
Air Ambulance	30% Coinsurance after deductible
Ground Ambulance	30% Coinsurance after deductible
• For OON Air Ambulance: member shall not be liable for any amount over the in-network cost share. Member will be held harmless if balance billed	

Autism and Autism Spectrum Disorder Services

Description	In-Network You Pay
Autism and Autism Spectrum Disorder	Covered based on type of service and where it is received

Behavioral Health Services (Mental Health and Substance Use Disorder)

Description	In-Network You Pay
Inpatient Facility Services	30% Coinsurance after deductible
Inpatient Physician Services	30% Coinsurance after deductible
Outpatient Facility Services	30% Coinsurance after deductible
Outpatient Physician Services	30% Coinsurance after deductible
Office Visit	$50 Copay
• A referral is not required for an in-network HMO outpatient behavior health services.	

Chiropractic Care

Description	In-Network You Pay
Chiropractic Care	30% Coinsurance after deductible
Limits	No maximum

Cosmetic, Reconstructive or Plastic Surgery

Description	In-Network You Pay
Cosmetic, Reconstructive or Plastic Surgery (Limited Covered Services)	30% Coinsurance after deductible

Dental Surgical Procedures

Description	In-Network You Pay
Dental Surgical Procedures (Limited Covered Services)	Covered based on type of service and where it is received

Diabetes Care

Description	In-Network You Pay
Diabetes Self-Management Training	30% Coinsurance after deductible
Diabetes Equipment	30% Coinsurance after deductible
Diabetes Supplies	30% Coinsurance after deductible
• 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.	

Durable Medical Equipment (DME)

Description	In-Network You Pay
Durable Medical Equipment	30% Coinsurance after deductible

Emergency Services

Description	In-Network You Pay
Emergency Care Facility Charges	$500 per occurrence deductible then 30% coinsurance after deductible ER copay waived if admitted
Emergency Care Physician Charges	30% Coinsurance after deductible
• If admitted, any charges described in inpatient hospital services will apply. • You must notify your PCP within forty-eight (48) hours of receiving emergency care, or as soon as possible without being medically harmful or injurious to you. • Non-emergency care when traveling outside of the US is not in benefit.	

Gender Affirming Care

Description	In-Network You Pay
Gender Affirming Care	30% Coinsurance after deductible
The following are not **covered services**:	

• Treatment this is deemed experimental/investigational

Hearing Aids and Audiological Services

Description	In-Network You Pay
Hearing Aids	30% Coinsurance after deductible
Limits	Limited to one hearing aid per ear each 36 month period

Home Health Care

Description	In-Network You Pay
Home Health Care	30% Coinsurance after deductible
Limits	No Maximum
• Preauthorization required • Private duty nursing is covered when medically necessary	

Hospice Care

Description	In-Network You Pay
Hospice Inpatient Services	No coinsurance
Hospice At Home Services	No coinsurance
• Private Duty Nursing is covered when medically necessary • Hospice care that is provided in a hospital will include charges as described in the **COVERED SERVICES** section of your benefit booklet	

Infertility Services

Description	In-Network You Pay
Infertility Treatments	30% Coinsurance after deductible
Artificial Insemination	30% Coinsurance after deductible
In-Vitro Fertilization	Not Covered
The following are not **covered services**: • Cost of sperm	

Infusion Therapy

Description	In-Network You Pay
Office Visit, In Your Home and Infusion Suite	$50 copay
In an Outpatient Setting	$500 copay
• NOTE: Outpatient infusion site of care does NOT apply to H S A products/plans. • Specific targeted outpatient Infusion drugs require prior authorization (PA is not dependent on plan design with ISOC benefit differential), before the therapy services are administered. If approved, the SoC benefit will apply. If denied, infusion drugs PLUS infusion therapy services will be denied.	

Inpatient Hospital Services

Description	In-Network You Pay
Inpatient Facility Services	30% Coinsurance after deductible
Inpatient Physician Services	30% Coinsurance after deductible
• Certain services will require prior authorization • All usual hospital services and supplies, including semiprivate room, intensive care, and coronary care units • Includes treatment of behavioral health services	

Maternity Services

Description	In-Network You Pay
Maternity Care	Covered based on type of service and where it is received
Maternity Related Newborn Care	Covered based on type of service and where it is received
Maternity for Dependents	Covered
Prior Authorization	Inpatient prior authorization not required for the following length of stays: 48 hours following an uncomplicated vaginal delivery 96 hours following an uncomplicated delivery by caesarean section
Maternity care is globally billed meaning: • Physician and Specialist Services office visit or consultation benefit located in this SUMMARY OF BENEFITS applies to initial prenatal visit (per pregnancy) to an in-network provider.	

Occupational Therapy Services

Description	In-Network You Pay
Occupational Therapy Inpatient Rehab	30% Coinsurance after deductible
Occupational Therapy Outpatient Rehab	30% Coinsurance after deductible
Limits	No maximum
• Preauthorization required for inpatient rehabilitation. • Benefits for autism spectrum disorder will not apply towards and are not subject to any occupational therapy services visits maximum.	

Outpatient Hospital Services

Description	In-Network You Pay
Outpatient Facility Services	30% Coinsurance after deductible
Outpatient Physician Services	30% Coinsurance after deductible

Pharmacy Services

For information on prescription drugs benefit and cost share please refer to your **SUMMARY OF BENEFITS FOR PHARMACY BENEFITS** directly following this **SUMMARY OF BENEFITS**.

Physical Therapy Services

Description	In-Network You Pay
Physical Therapy Inpatient Rehab	30% Coinsurance after deductible
Physical Therapy Outpatient Rehab	30% Coinsurance after deductible
Limits	No maximum
• Preauthorization required for inpatient rehabilitation. • Benefits for autism spectrum disorder will not apply towards and are not subject to any physical therapy services visits maximum.	

Physician and Specialist Services

Description	In-Network You Pay
Primary Care Office Visit or Consultation	$50 Copay
Retail Health Clinic Visit	$50 Copay
Specialty (Specialist) Office Visit or Consultation	$100 Copay
Telehealth & Telemedicine Services **Primary Care Consultation**	$50 Copay
Telehealth & Telemedicine Services **Primary Care Consultation for Behavioral Health**	$50 Copay
Telehealth & Telemedicine Services **Specialty Consultation**	$100 Copay
Virtual Visits	$50 Copay
Certain Diagnostic Procedures & Imaging Services (MRI, CT Scan, PET Scan)	30% Coinsurance after deductible
Certain Diagnostic Procedures & Imaging Services (Lab, X-Ray & Other Diagnostic Services in Physician Office)	30% Coinsurance after deductible
Certain Diagnostic Procedures & Imaging Services (Lab, X-Ray & Other Diagnostic Services in Facility)	30% Coinsurance after deductible
Surgical Procedures Performed in a Physician's Office	30% Coinsurance after deductible

- Copays applicable only to covered services which are subject to the office visit copayment. For services which are not subject to the office visit copayment, this percentage amount is reduced to coinsurance and benefit period deductible.
- Cost shares for covered services provided through telemedicine visits will be the same as if provided in-person, except where otherwise noted
- $0 Cost-Share Contrast Breast MRI Service

Preventive Care Services

Description	In-Network You Pay
Preventive Care Services	No charge
• Some services may require prior authorization and may be subject to copayment/coinsurance, deductible or dollar maximums.	

Private Duty Nursing

Description	In-Network You Pay
Private Duty Nursing	30% Coinsurance after deductible
• Private duty nursing is covered when medically necessary.	

Skilled Nursing Facility

Description	In-Network You Pay
Skilled Nursing Facility	30% Coinsurance after deductible
Limits	60 day per benefit period
• Preauthorization required • Private Duty Nursing is covered when medically necessary	

Speech Therapy

Description	In-Network You Pay
Office Visit	30% Coinsurance after deductible
In an Outpatient Setting	30% Coinsurance after deductible
Limits	No maximum
• Preauthorization required for inpatient rehabilitation. • Benefits for autism spectrum disorder will not apply towards and are not subject to any speech therapy services visits maximum.	

Surgery

Description	In-Network You Pay
Physician & Facility Services	Covered based on type of service and where it is received

Transplants Services (Organ and Tissue Transplants)

Description	In-Network You Pay
Organ and Tissue Transplants	30% Coinsurance after deductible
Travel and lodging	Not covered

• Prior authorization is required for any organ or tissue transplant. Prior authorization is required even if the patient is already in a hospital under another prior authorization.

Urgent Care

Description	In-Network You Pay
Urgent Care Center Visit	$75 Copay
• Any additional charges as described in outpatient laboratory and x-ray services may also apply.	

Weight Loss Services

Description	In-Network You Pay
Weight Loss Services	30% Coinsurance after deductible

Wigs

Description	In-Network You Pay
Wigs	30% Coinsurance after deductible
Limits	$300 maximum benefit for purchase of one (1) wig needed as a result of current chemotherapy or radiation treatment for cancer.

Note: For **members** with a chronic, complex, rare, or life-threatening medical condition, **covered drugs** that will be administered by a **provider** in a **physician's** office may be obtained from a non-**participating pharmacy** by the **provider**, after the **provider** has determined that disease progression, patient harm, or death is probable, or where the **provider** has concerns about patient adherence or timely delivery. These services are covered under the medical benefit and the cost-sharing requirements will be the same as if they were obtained from a **participating pharmacy**.

SUMMARY OF BENEFITS
for
PHARMACY BENEFITS

Retail Pharmacy Cost Share

Retail Pharmacy Program	Preferred Participating Pharmacy You Pay	Non-Preferred Pharmacy You Pay
Tier 1 **Generic Drugs (Preferred)**	No copay	$10 Copay
Tier 2 **Generic Drugs (Non-Preferred)**	$10 Copay	$20 Copay
Tier 3 **Brand Name Drugs (Preferred)**	$50 Copay	$70 Copay
Tier 4 **Brand Name Drugs (Non-Preferred)**	$100 Copay	$120 Copay
Out-of-Area Drug	$100 Copay	$120 Copay

- In addition to any copayments and/or coinsurance amounts, you are also responsible for any charges which exceed the allowable amounts
- If you receive a brand name drug when a generic drug is available, you may incur additional costs. Refer to the **PHARMACY BENEFITS** section of your benefit booklet for details.
- Extended prescription drug supply program (if allowed by the prescription order)
- One copayment per 30-day supply, no more than a 30-day supply

Mail-Order Pharmacy Program

Mail-Order Pharmacy Program	Participating Mail-Order Pharmacy You Pay	Any Pharmacy other than the Participating Mail-Order Pharmacy You Pay
Tier 1 **Generic Drugs (Preferred)**	No copay	Not Covered
Tier 2 **Generic Drugs (Non-Preferred)**	$30 Copay	Not Covered
Tier 3 **Brand Name Drugs (Preferred)**	$150 Copay	Not Covered
Tier 4 **Brand Name Drugs (Non-Preferred)**	$300 Copay	Not Covered

- Extended prescription drug supply program (if allowed by the prescription order)
- In addition to any copayments and/or coinsurance amounts, you are also responsible for any charges which exceed the allowable amounts
- If you receive a brand name drug when a generic drug is available, you may incur additional costs. Refer to the **PHARMACY BENEFITS** section of your benefit booklet for details.
- Up to 90-day supply
- Cost share will be based on day supply (1-30-day supply, 31-60-day supply, 61-90-day supply) dispensed

Specialty Pharmacy Program

Specialty Pharmacy Program	Preferred Participating Pharmacy You Pay	Participating Pharmacy You Pay
Tier 5 **Specialty Drugs (Preferred)**	$150 Copay	$150 Copay
Tier 6 **Specialty Drugs (Non-Preferred)**	$250 Copay	$250 Copay

- In addition to any copayments and/or coinsurance amounts, you are also responsible for any charges which exceed the allowable amounts
- One copayment amount per 30 day supply- limited to a 30 day supply.
- Some Specialty Drugs have FDA approved dosing regimens exceeding the 30-day supply limits and may be allowed greater than a 30-day supply, if allowed by your plan benefits. Cost share will be based on a day supply (1-30-day supply, 31-60-day supply, 61-90 day supply) dispensed.

Vaccines

Select Vaccines Obtained through Pharmacies	Pharmacy Vaccine Network Pharmacy You pay	Other Pharmacy You pay
	Covered Vaccine(s) - $0 Copay	Not covered

- Each participating pharmacy that has contracted with BCBSTX to provide this service may have age, scheduling, or other requirements that will apply, so you are encouraged to contact them in advance.
- Childhood immunizations subject to state regulations are not available under this pharmacy benefit. Refer to your BCBSTX medical coverage for benefits available for childhood immunizations

- Diabetes supplies are covered as described in **Pharmacy Benefits**. All provisions listed in **Pharmacy Benefits** will apply, including copayments/coinsurance, deductibles, and any pricing differences.
- The copayment for insulin included in the drug list will not exceed $25 per prescription for a 30-day supply, regardless of the amount or type of insulin needed to fill the prescription.
- Certain covered drugs may be available at no cost through a **participating pharmacy** for the following categories of medication: severe allergic reactions, hypoglycemia, opioid overdoses, and nitrates. For further information, call the number on the back of your identification card.
- For additional information regarding the applicable drug list, please call customer service or visit the website at https://www.bcbstx.com.
- Select covered drugs, determined by the plan, may be covered with no member cost share, to make these medications more affordable to members.

CUSTOMER SERVICE

Medical Benefits	Call	Website
Customer Service Helpline	See telephone number on the back of your identification card	www.bcbstx.com BCBSTX Provider Directory Wellness Other Online Services and Information
Prior Authorization	See telephone number on the back of your identification card	
Inpatient Admissions	See telephone number on the back of your identification card	

Self-Service Member Portal **Blue Access for Members (BAM)**	**Website**
Provider Directory	www.bcbstx.com
Identification Card	www.bcbstx.com

For Medical Appeals **Send via mail**	**Mailing Address:**
for Non-Behavioral Health	Blue Cross and Blue Shield of Texas Appeals Division PO Box 660044 Dallas, TX 75266-0044
for Behavioral Health/Mental Health/Substance Use Disorder Treatment	Blue Cross and Blue Shield of Texas Appeals Division PO Box 660044 Dallas, TX 75266-0044

BLUECARD® NATIONWIDE/WORLDWIDE COVERAGE PROGRAM

1-800-810-BLUE (2583) – http://provider.bcbs.com

MDLIVE®

1-888-684-4233

Prescription Drug Benefits	Call	Website	Mailing Address
Pharmacy Benefit Manager (PBM) Prime Therapeutics	See Pharmacy customer service telephone number on the back of your identification card	www.bcbstx.com	Prime Therapeutics LLC PO Box 25136 Lehigh Valley, PA 18002-5136

Where to Mail Completed Claim Forms:

For Medical Claims	Prescription Drug Claims
Blue Cross and Blue Shield of Texas Claims Division PO Box 660044 Dallas, TX 75266-0044	Prime Therapeutics LLC PO Box 25136 Lehigh Valley, PA 18002-5136

INTRODUCTION

This is your health insurance benefit booklet. It describes your **covered services**, what they are and how you obtain them.

The defined terms are in bold and are defined in the **GLOSSARY**.

The terms "you", "your", "**participant**" and "member" are used in reference to the **employee** or **subscriber**.

The term "us", "we", and "our" is used to describe the BlueCross and BlueShield (BCBS) plan that is the **claim administrator.**

In-Network Benefits

To receive **in-network benefits** as shown under your **SUMMARY OF BENEFITS (SOB)**, you must choose **providers** within the network (except for emergencies). We have established a network of **physicians**, **providers**, **specialists**, **hospitals**, and other health care facilities that may offer care and **covered services** to you and your **dependents.** They are listed in our **provider** directory. For help in finding a **participating provider** you can view our **provider** directory by visiting our website at www.bcbstx.com.

When you choose an **participating provider**, the **provider** will bill us, not you, for services provided.

Out-of-Network Benefits

If you choose a **non-participating provider**, only **out-of-network benefits** will be available. If you go to a **provider** outside the network, then **benefits** will be paid at the **out-of-network** benefit level. You may have to pay in full and then submit a claim to us for reimbursement.

Your Insurance Identification Card

Show your **identification card** each time you receive services from a **provider**. We will mail you your **identification card**. If you haven't received it before you need **covered services**, or if you lose it, you can print a temporary card on the member website at www.bcbstx.com/member. Only members on your **plan** can use your **identification card**.

About Your SUMMARY OF BENEFITS

Your **SUMMARY OF BENEFITS** shows the out-of-pocket costs you are responsible for when you receive **covered services.** It may also show benefit limitations or other useful information that apply to your **plan**.

Out-of-pocket costs include things like **deductibles**, **copayments** and **coinsurance**. Limitations include things like maximum age, visits, days, hours, and admissions.

Your **SUMMARY OF BENEFITS** will also show any total maximum out-of-pocket limit(s) that may apply.

You are responsible for paying your part of the cost sharing. You are also responsible for costs not covered by us.

See **HOW THE PLAN WORKS** below and your **SUMMARY OF BENEFITS** for more information.

What Medical Necessity/Medically Necessary Means

You will see the terms **medical necessity** or **medically necessary** in your benefit booklet. The **GLOSSARY** defines it but resources like **Customer Service** or Blue Access for Members℠ (BAM) can get help with questions on if specific services meet the requirements to be considered **medically necessary** or meet **medical necessity**.

Your **plan** pays for its share of the costs for **covered services** when these requirements are met:

- The service is **medically necessary** and/or meets **medical necessity** requirements
- For **in-network benefits**, you get the service from a **participating provider**

Your **provider** or you get **prior authorization** on services when required

WHO GETS BENEFITS

No eligibility rules or variations in **premium** will be imposed based on your health status, medical condition, claims experience, receipt of care, medical history, genetic information, evidence of insurability, disability, or other **health status related factor**. **Benefits** under this **plan** are provided regardless of your race, color, national origin, disability age, sex, gender identity, sexual orientation, political affiliation, or expression. This **plan** does not require documentation certifying a COVID-19 vaccination or documentation of post-transmission recovery. Variations in the administration, processes or **benefits** of this **plan** are based on clinically indicated, reasonable medical management practices, or are part of permitted wellness incentive; disincentives and/or other programs do not constitute discrimination.

Eligibility Requirements

The **eligibility date** is the date you or your **dependents** qualify to be covered under this **plan**.

Employee Eligibility

You are eligible for coverage under this benefit booklet when you satisfy the following:

- Reside, live, or work in the **service area**
- Meet the **group** criteria of an eligible **employee**
- Satisfy any probationary or **waiting period** requirements established by **group**

Dependent Eligibility

If you apply for coverage, you may include your **dependents**. Eligible **dependents** must:

- Reside in the **service area** or permanently reside with a **subscriber** who works in the **service area**
- Meet the group criteria of an eligible **dependent**
- Your spouse or domestic partner. Domestic partner coverage is available at your **employer's** discretion (Note: domestic partner coverage is at your employer's discretion. Contact your **employer** for information on domestic partner coverage)
- **Dependent** child that is under age 26
- **Dependent** child must be a dependent on your federal income tax at the time of the application for coverage
- A **dependent** child includes:
    - Adopted child or child placed for adoption (including a child for whom you, your spouse or your domestic partner is a party in legal action in which the adoption of the child is sought)
    - Eligible foster child
    - Natural child
    - Stepchild
    - You or your spouse or domestic partner is a court-appointed legal guardian.

Dependent child that you are responsible for economic support and maintenance by reason of mental retardation or physical handicap. You must provide us with the **dependent** child's statement of disability form. The disability form must include a medical certification of disability. This should be done within 31 days of the date of such medical certification. We may require this on a yearly basis. If a court order for coverage to be provided for a spouse or minor child under your **plan.** If a there is request for enrollment, it shall be made within 31 days after court order.

Loss of Eligibility

You must notify us within 31 days of any changes that will affect your or your **dependents** eligibility.

Applying for Coverage

You and eligible **dependents** can apply for coverage during the following time periods by contacting your employer:

- During the **open enrollment period**
- At special enrollment periods during the year
- During the initial enrollment period

Everyone included for **coverage** must be listed on the **enrollment application / change form**. No proof of insurability required.

Open Enrollment Period

Your **group** will designate an **open enrollment period** during which you may apply for or change coverage for you and your eligible **dependents**. A **group open enrollment period** will be held at least annually.
The **effective date of coverage** is the first day of the month after the **open enrollment period**. The date can different if specified and agreed upon by the **group** and the **claim administrator**.

Special Enrollment Period

You may apply for or change coverage for yourself and your eligible **dependents** during the following qualifying events:

- You gain a **dependent** through birth, adoption, legal guardianship or placement of a foster child
- You gain a **dependent** through marriage, establishment of a **domestic partnership** or court ordered coverage
- You or your dependent lose other health insurance coverage or COBRA continuation of coverage

Other Special Enrollment Periods

You may apply for or change coverage for yourself and your eligible dependents during the following qualifying events:

- You get a divorce or end a **domestic partnership**
- The month your **child** reaches 26 years of age
- You lose coverage under your **plan** as specified under the **Termination of Coverage** section of this benefit booklet

Late Enrollment

If your application is not received within 31 days from the **eligibility date**, you will be considered a **late enrollee**. You will become eligible to apply for coverage during your **employer**'s next **open enrollment period**. Your coverage will become effective on the **contract date**.

When Coverage Begins

Coverage begins after you have applied for coverage for yourself and your eligible **dependents**. The **effective date** is the date coverage begins. It may be different from the **eligibility date**.

Medicaid or Child Health Plan Special Enrollment Coverage

Coverage begins no later than the first of the month if you apply within 60 days of the following qualifying event:

- You or your **dependent** lose eligibility for coverage under a Medicaid **plan** or a state **child** health **plan** under Title XXI of the Social Security Act
- You or your **dependent** become eligible for assistance under such Medicaid plan or state **child** health plan

Loss of Other Health Insurance Special Enrollment Coverage

Coverage begins no later than the first of the month if you apply within 31 days of any of the following qualifying events:

- You and your **dependent** lose other health insurance coverage or COBRA continuation coverage.

The special enrollment period for loss of the other health insurance coverage is available to you and your **dependent** who meet the following requirements:

- You and your **dependent** were covered under other health insurance coverage or COBRA continuation coverage when you were first eligible to enroll for this coverage.
- You and your **dependent** lost the other health insurance coverage due to:
    - Legal separation
    - Divorce or the end of a domestic partnership
    - Death of your spouse or your domestic partner
    - Termination of employment or reduction of hours
    - COBRA continuation coverage is terminated
    - Incurring a claim that would meet or exceed a lifetime limit on all **benefits** under prior **health plan** coverage.
    - The **prior health plan** no longer offering any **benefits** to the class of similarly situated individuals that include you and your **dependent(s)**
    - If coverage was through a health maintenance organization (HMO). You or your **dependent(s)** no longer residing or working in the service area of the HMO and no other benefit option is available.
    - Termination of contribution toward the **premium** made by the former **employer**.
    - Expiration of the continuation of coverage period of the Prior Health Benefit Plan under Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, or under the continuation provisions of the Texas Insurance Code.
- You and your **dependent** did not lose coverage due to failure to pay **premiums** or fraud.
- If it was required, you state in writing that you and your **dependent** were covered by other health insurance or COBRA continuation coverage as reason for declining enrollment in this coverage.

If all conditions described above are not met, you will be considered a **late enrollee**. The **effective date of coverage** under this subsection is the day after prior coverage terminated.

Health Insurance Premium Payment (HIPP) Reimbursement Program

You will be eligible to enroll if you:

- Receive medical assistance under the Texas Medicaid Program or CHIP and if you are a participant in Texas HIPP Reimbursement Program. You may enroll with no enrollment period restrictions.
- Are not eligible unless a family member is enrolled, then both you and the family member may enroll.

- The effective date of coverage is on the first day of the month after we receive the following:
- Written notice from the Texas Health and Human Services Commission.
- Enrollment forms and applicable **premium** payments within 60 days after the date the individual becomes eligible to participate.

In addition to the **GLOSSARY** section of this benefit booklet, the following definitions apply to **WHO GETS BENEFITS** section:

- **Effective Date of Coverage** means the commencement date of coverage under this **plan**.
- **Health Status Related Factor** means:
  - Health status
  - Medical condition, including both physical and mental health
  - Claims experience
  - Receipt of health care
  - Medical history
  - Genetic information
  - Evidence of insurability, including conditions arising out of acts of family violence
  - Disability
- **Late Enrollee** means any employee or dependent eligible for enrollment who requests enrollment in an **employer's health benefit plan**:
  - After the expiration of the initial enrollment period established under the terms of the first **plan** for which that **participant** was eligible through the **employer**
  - At the expiration of an **open enrollment period**
  - After the expiration of a special enrollment period
- **Group Open Enrollment Period** means the 31-day period preceding the next contract date during which **employees** and **dependents** may enroll for coverage.
- **Waiting Period** means a period established by an **employer** that must pass before a potential enrollee is eligible for covered benefits. No such **waiting period** may exceed 90-days unless permitted by applicable law. If your group **waiting period** exceeds the time period permitted by applicable law, we reserve the right to begin your coverage on a date that we believe is within the required period. Regardless of whether we exercise that right, your **group** is always responsible for your **waiting period**. If you have questions about your **waiting period**, please contact your **group**.

  Note: Retiree coverage is available at your **employer's** discretion. Contact your **employer** for information on retiree coverage.

HOW THE PLAN WORKS

Your **SUMMARY OF BENEFITS** lists what you pay for each type of **covered service**. In general, this is how your **benefits** work:

- You pay the **deductible** when it applies. Then we, the plan and you, the **participant**, share the expense. Your share is called a **copayment** or a **coinsurance** amount
- Then we, the plan, pays the entire expense after you reach your **out-of-pocket maximum**
- Expenses in this general rule means the eligible charge or maximum allowance for services received from a **participating provider**.

Allowable Amount

The **allowable amount** is the maximum amount determined we will pay for:

- Service
- Supply
- Procedure

The **allowable amount** is based on the **participating provider** contract and the payment methodology in:

- Date of service
- Diagnostic related grouping (DRG)
- Capitation
- Relative value
- Fee schedule
- Per diem or other

Deductibles

Benefits under your **plan** will be available after you meet your **deductible(s)** as shown on your **SUMMARY OF BENEFITS**.

How Individual Deductibles Work:

- **Benefits** will be available after your individual deductible amount, shown under your **SUMMARY OF BENEFITS,** have been met.

How family **deductibles** work:

- If a single-family member reaches the individual **deductible** shown under your **SUMMARY OF BENEFITS,** they will be eligible for **benefits** and do not have to wait for other family members to meet their **deductible.** This is known as an embedded family **deductible.**
- A family member may not apply more than the individual **deductible** amount toward the family **deductible** amount.
- Should two or more members of your family ever receive **covered services** due to injuries received in the same accident, only one program **deductible** will be applied against those **covered services**.

Copayments/Coinsurance

Some of the care and treatment you receive under the **plan** will require that a **copayment** be paid at the time you receive the services. Refer to your **SUMMARY OF BENEFITS** for your **copayments.**

Out-of-Pocket Maximum

The **out-of-pocket maximum** is the total amount of **deductibles**, **copayments** and/or **coinsurance** which must be satisfied during your **benefit period** for all **covered services** and for **covered drugs** received from **participating providers** your **plan** will begin to cover all expenses at 100% for the remainder of the **calendar year**.

How Individual Out-of-Pocket Maximums Work

When you have met the **out-of-pocket maximum** specified in your **SUMMARY OF BENEFITS**, no additional **deductible**, **copayment** and/or **coinsurance** will be required for **covered services** and/or **covered drugs** you receive during the remainder of your **calendar year.**

How Family Out-of-Pocket Maximums Work

If you have family coverage and your family's out-of-pocket payments during the **benefit period** equals the family **out-of- pocket maximum** shown under the **SUMMARY OF BENEFITS** then for the rest of the **benefit period**, all family members will have **benefits** for **covered services** and**/**or **covered drugs** (except for those charges specifically excluded below) paid by us at 100%.

Only services that are performed, prescribed, directed, or authorized in advance by the **Primary Care Physician** (**PCP**) or BCBS are covered **benefits** under this **plan** except for:

- Emergency Care
- Participating Urgent Care
- Virtual Visits
- Retail Health Clinics
- **Covered services** provided to female, who may directly access an Obstetrician/Gynecologist in the same **limited provider network** as their **PCP** for:
    - Well woman exams
    - Obstetrical care
    - Care for all active gynecological conditions; diagnosis and treatment
    - **Referral** for any disease or condition within the scope of the professional practice of the Obstetrician/Gynecologist

PCPs in a **limited provider network** will be identified in **our provider** directory. You can call Customer Service at the toll-free telephone number on the back of your **identification card**.

BCBS and **participating providers** do not have any financial responsibility for any services you seek or receive from a **non-participating provider** or facility. Unless both your **PCP** and BCBS have made prior **referral** authorization arrangements.

Continuity of Care

If you are under the care of a **participating provider** who stops participating in **HMO's** network, (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or for fraud), we will continue coverage for that **provider's covered services** if you have one of the following special circumstances:

- You are undergoing a course of treatment for a serious and complex condition.
- You are undergoing institutional or inpatient care.
- You are scheduled to undergo non-elective surgery from the **provider** (including receipt of post-operative care from such **provider** with respect to such surgery).
- You are pregnant or undergoing a course of treatment for the pregnancy.
- You are terminally ill.

The continuity of coverage under this subsection shall continue until the treatment is complete but shall no extend for more than ninety (90) days, or more than nine (9) months if you have been diagnosed with a terminal illness, beyond the date the provider's termination from the network takes effect. If you are pregnant and past the thirteenth (13^{th}) week of pregnancy at the time the provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery.

Selecting a PCP

You must choose a **PCP** when you enroll. You and your enrolled **dependents** must choose a **PCP** from HMO's directory of **participating providers** to receive **covered services**. If the **subscriber** has an enrolled **dependent** that is incapable of selecting a **PCP**, the **subscriber** should select a **PCP** on their behalf. We may assign a **PCP** if one has not been selected. **Benefits** will be limited to **emergency care** until a **PCP** is selected or assigned.
A **referral** from a **PCP** is not needed for female **participants** to select an Obstetrician/Gynecologist (OB/GYN) in your **PCP's** network for:

- Gynecological and obstetric conditions
- Annual well woman exam
- Maternity care

Inpatient Care by Non-PCP

A **physician** other than your **PCP** may direct and oversee your care in the following inpatient settings:

- **Participating hospital**
- **Skilled nursing facility**
- Other **participating** facility

Upon your discharge from inpatient care, you must:

- Return to the care of your **PCP.**
- Have your **PCP** coordinate care that may be **medically necessary.**

Limited Provider Network

What does it mean if your **PCP** is part of a **limited provider network**:

- You may only be referred to **participating providers** associated with the same **limited provider network.**
- Your choice of **PCP**'s may affect the **participating providers** available.

- You can be referred to **participating providers** not associated with that group or **limited provider network** only for **covered services** that are not available within the group or **limited provider network.**
- You may be required to choose an OB/GYN who belongs to the same **limited provider network** as your **PCP**. Female **participant's** right to directly access an OB/GYN will not infringe upon.

Participants who have been diagnosed with a chronic, disabling or life-threatening illness may request approval to choose a **participating specialist** as a **PCP**. Using a **specialist** as **PCP** process is described below.

Specialist as a PCP

If you have been diagnosed with a chronic, disabling, or life-threatening illness, you may request approval to choose a **participating specialist** as your **PCP**. The process to choose a **participating specialist** as your **PCP**:

- Contact Customer Service at toll-free telephone number on your **identification card**.
- Submit information for approval from **HMO medical director** to choose a **participating specialist** as your **PCP**.
- The **medical director** will require both you and the **participating specialist** interested in serving as your **PCP** to sign a certification of medical need, to submit along with all supporting documentation.
- The **participating specialist** must meet **HMO's** requirements for **PCP participation** and accept the coordination of all your healthcare needs.

If your request is denied, you may appeal the decision. If your request is approved, the **specialist's** designation as your **PCP** will not be effective retroactively.

Your PCP

Your **PCP** coordinates your medical care, as appropriate, either by providing treatment or by issuing **referrals** to **specialists**. Except for **emergency care**/medical emergencies or certain direct-access **specialist benefits** described in this **plan**. Only those services which are provided by or referred by your **PCP** will be covered. It is your responsibility to discuss all medical care with your **PCP.**

If your **PCP** performs or recommends a course of treatment for you that includes services that are not **covered services**, the entire cost will be your responsibility.

Changing Your PCP

You may change your **PCP** by:

- Call the Customer Service toll-free telephone number listed on your **identification card.**
- Request a change form.

P**CP** change is effective on the first day of month following the **claim administrator's** receipt and approval of the request.

Availability of Participating Provider

We cannot guarantee the availability or continued participation of a **particular provider**. The **participating provider** may accept a limited number of patients. If the initial selected **PCP** cannot accept more patients, you will be able to select another **PCP**. You must then cooperate with the us to select another **PCP**.

Termination of Participating Provider

If a **participating provider** termination is imminent, we will provide advance notice to **participants** receiving care. Special circumstances may render you eligible to continue receiving treatment from a **participating provider** after the effective date of termination. Which is fully described in **Continuity of Care** below.

Out-of-Network Services

You may obtain **covered services** from providers who are not part of **HMO's** network:

- You or your **dependents** are receiving **emergency care.**
- Court-ordered **dependents** living outside of **service area** may use **non-participating providers.**

Post-stabilization care from inpatient hospital services you must:

- Contact us within 48 hours of receiving **emergency care** or as soon as possible without being medically harmful to the **subscriber**.
- We will review **medical necessity** and **participating provider** availability of inpatient hospital services.

Benefits at the non-**participating hospital** will not be covered if:

- We determine the inpatient hospital services are not **medically necessary.**
- You do not notify us within 48 hours.
- There was a **participating provider** available.
- If **covered services** are not available from **participating providers** within access requirements then:
    - We will allow a **referral** by your **PCP** to a **non-participating provider.**
- We have to approve the **referral.**
- If your **PCP** is in a **limited provider network.**
    - We will first consider **participating providers** in the **PCP's limited provider network**.
    - We will review the entire network when the **covered service** is not available in the **limited provider network.**

To receive **covered services** not available in **limited provider network**, the following apply:

- You will not be required to change your **PCP** or **specialist.**
- The request must be from a **participating provider.**
- Reasonably requested documentation must be received by the **claim administrator**.
- The **referral** will not to exceed five business days, based on the circumstances and your condition.
- If we approve the **referral** to a **non-participating provider**, we will reimburse the non-**participating provider**. The reimbursement will be at the customary or agreed rate. You are responsible for **copayment/coinsurance** and any **deductibles**.
- Before we deny a referral, we will:
    - Conduct a review by the same or similar specialty type of **provider.**

Instances you will be unable to choose a **participating provider, such as:**

- When you receive service from a **non-participating** facility-based **provider.**
- When you receive services from **non-participating** laboratory or diagnostic imaging facility in connection with care from your **participating provider.**
- In these instances, your services may be covered, and you would not be responsible for any amounts beyond your **copayment/coinsurance** and any **deductibles.**
- Contact us if you receive a bill from an out-of-network **provider** in these instances.

Provider Communication

The claim administrator will not prohibit, attempt to prohibit or discourage any **provider** from discussing or communicating to you, or your authorized representative information or opinions regarding:

- Your healthcare
- The health benefit plan
- The **provider**'s contract with the HMO has terminated
- The provider will no longer be providing services under the HMO

Your Responsibilities

- You shall complete and submit to BCBS an application, forms or statements we request. You agree that all information contained in the application, form, and statement submitted to us regarding enrollment under this **plan** correct and complete to the best of your knowledge.
- You shall notify us immediately of any change of address for you or any or your dependents.
- You understand that we are acting in reliance upon all information you provide to BCBS.
- By electing coverage pursuant to this **plan**, or accepting hereunder, you represent that all information provided is true and accurate and agree to all terms, conditions, and provisions under this **plan**.
- You will need to abide by the rules and regulations of each provider from which benefits are provided.

Refusal to Accept Treatment

You may, for personal reasons, refuse to accept procedures or treatment by a **participating provider**. **Participating providers** shall use their best efforts to render all necessary and appropriate **professional services** in a manner compatible with your wishes. These efforts shall be consistent with **participating provider's** judgment as to the requirements of proper medical practice. If you refuse to follow a recommended treatment or procedure, and the **participating provider** informed you of their belief that no professionally acceptable alternative exists, neither BCBS nor any **participating provider** shall have any further responsibility to provide care for the condition under treatment.

Failure to Render Payments

If we receive your stipulated payment, you are entitled to health services covered only for the **contract month** for received payment. You will be responsible for the cost of services rendered to you during the **grace period** of the **contract month** in the event that payments are not made by **group**. If payment is not received by the **contract month** due date, then you will be terminated at the end of the **grace period** of the **contract month**.

Change in Payments

We reservice the right to change the schedule of payments upon 60 days written notice to group when:

- Upon each **anniversary date** of this **plan**.

- A law or regulation change which increases our risk under this **plan**.

Member Claims Refund

You are not expected to make payments, other than required **copayments**/**coinsurance** and **deductibles**, for any benefits provided under this **plan**. However, if you make a payment, you may send us a claim for reimbursement. The instructions for a claim for reimbursement are in the chart below. Please visit the website at www.bcbstx.com or call customer service at the toll-free number on the back on the back of your identification card to obtain a medical claim form or a prescription reimbursement claim form.

Claim For Reimbursement	Requirement	Deadline
Notice of Claim (Written proof of a payment to the BCBS)	You must notify the us within 90 days from after a covered expense was incurred.	If you do not notify us within 90 days, you must show that it was not reasonably possible to give notice and that notice was given as soon as reasonably possible. A claim may not be given later than 1 year a covered expense was incurred, except for prescription drug claims which must be given within 90 days of the date of purchase. Written proof of a payment to us within one (1) year of occurrence.
Receipt of Your written notice	We will acknowledge your claim and begin any necessary investigation.	Within 15 days
Additional information from you	We may request additional information from you to complete your claim.	Within 15 business days of receipt of a completed claim. However, we may notify you why additional time is needed to investigate your claim.
Completed claim and additional time		Within 45 days after the additional time notification is given to you, BCBS will give a decision.
We will notify you that we will pay a claim or part of a claim		Within 5 business days

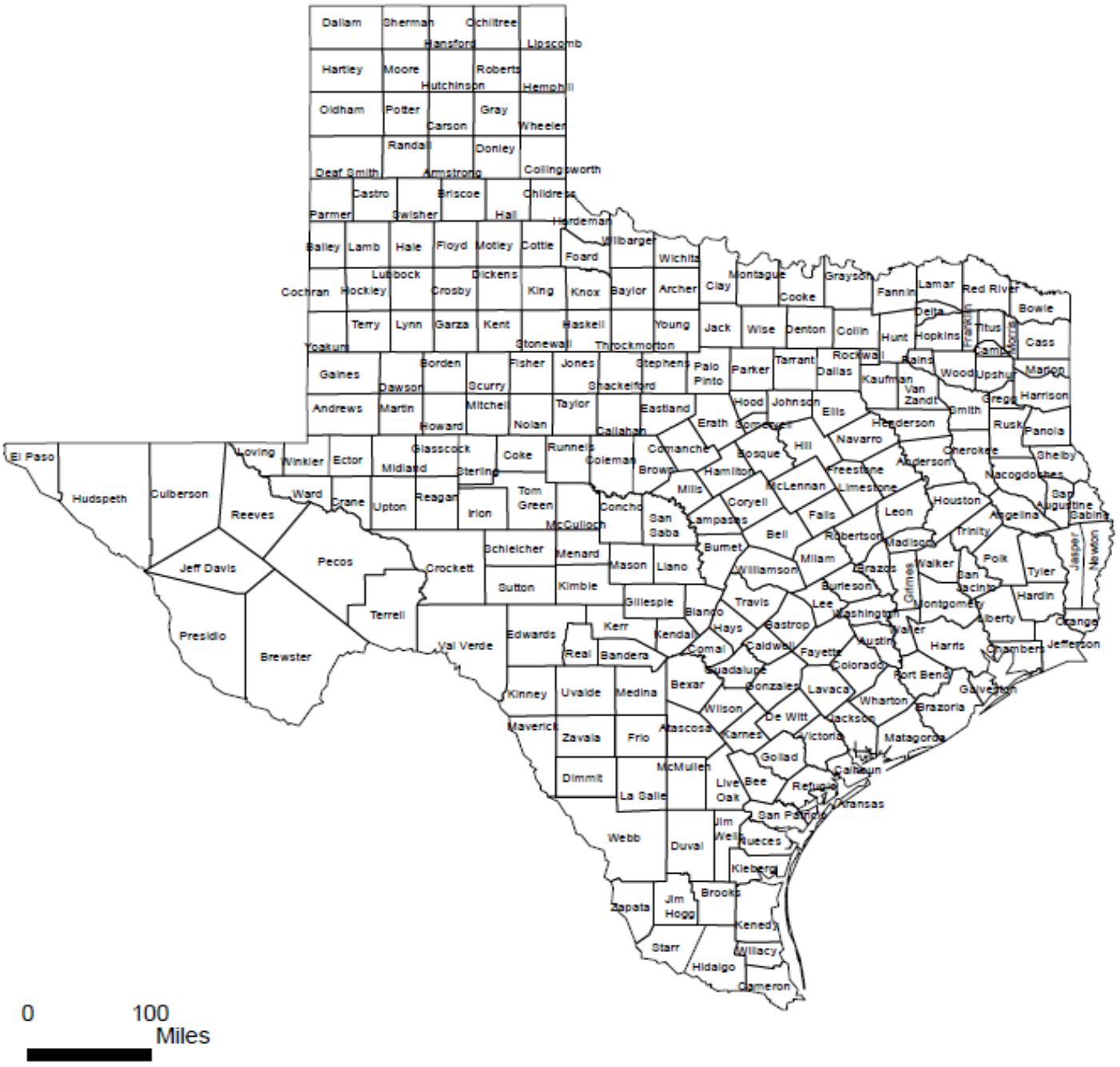
In addition to the **GLOSSARY** section of this benefit booklet, the following definitions apply to this section:

- **Contract Month** means the period of each succeeding month beginning on the **group agreement** effective date.
- **Grace Period** means a 30-day period after all but the first due date, during which period may be paid to us without lapse of coverage occurring. If payment is not received within thirty (30) days, coverage will be terminated after the 30th day and you will be liable for the cost of services received during the **grace period**.
- **Life threatening** means a disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- **Medical Director** means a **physician** who is responsible for monitoring the provision of **covered services** to **participants**.
- **Plan Anniversary Date** means the day, month, and year of the 12-month period following the **plan effective date** and corresponding date in each year thereafter for as long as this **benefit booklet** is in force.

SERVICE AREA

Service Area

The Service Area covered by this Certificate includes the 254 counties on the map below and listed on the next page.



Anderson
Andrews
Angelina
Aransas
Archer
Armstrong
Atascosa
Austin
Bailey
Bandera
Bastrop
Baylor
Bee
Bell
Bexar
Blanco
Borden
Bosque
Bowie
Brazoria
Brazos
Brewster
Briscoe
Brooks
Brown
Burleson
Burnet
Caldwell
Calhoun
Callahan
Cameron
Camp
Carson
Cass
Castro
Chambers
Cherokee
Childress
Clay
Cochran
Coke
Coleman
Collin
Collingsworth
Colorado
Comal
Comanche
Concho
Cooke
Coryell
Cottle
Crane
Crockett
Crosby
Culberson
Dallam
Dallas
Dawson
De Witt
Deaf Smith
Delta
Denton
Dickens
Dimmit
Donley
Duval
Eastland
Ector
Edwards
El Paso
Ellis
Erath
Falls
Fannin
Fayette
Fisher
Floyd
Foard
Fort Bend
Franklin
Freestone
Frio
Gaines
Galveston
Garza
Gillespie
Glasscock
Goliad
Gonzales
Gray
Grayson
Gregg
Grimes
Guadalupe
Hale
Hall
Hamilton
Hansford
Hardeman
Hardin
Harris
Harrison
Hartley
Haskell
Hays
Hemphill
Henderson
Hidalgo
Hill
Hockley
Hood
Hopkins
Houston
Howard
Hudspeth
Hunt
Hutchinson
Irion
Jack
Jackson
Jasper
Jeff Davis
Jefferson
Jim Hogg
Jim Wells
Johnson
Jones
Karnes
Kaufman
Kendall
Kenedy
Kent
Kerr
Kimble
King
Kinney
Kleberg
Knox
La Salle
Lamar
Lamb
Lampasas
Lavaca
Lee
Leon
Liberty
Limestone
Lipscomb
Live Oak
Llano
Loving
Lubbock
Lynn
Madison
Marion
Martin
Mason
Matagorda
Maverick
McCulloch
McLennan
McMullen
Medina
Menard
Midland
Milam
Mills
Mitchell
Montague
Montgomery
Moore
Morris
Motley
Nacogdoches
Navarro
Newton
Nolan
Nueces
Ochiltree
Oldham
Orange
Palo Pinto
Panola
Parker
Parmer
Pecos
Polk
Potter
Presidio
Rains
Randall
Reagan
Real
Red River
Reeves
Refugio
Roberts
Robertson
Rockwall
Runnels
Rusk
Sabine
San Augustine
San Jacinto
San Patricio
San Saba
Schleicher
Scurry
Shackelford
Shelby
Sherman
Smith
Somervell
Starr
Stephens
Sterling
Stonewall
Sutton
Swisher
Tarrant
Taylor
Terrell
Terry
Throckmorton
Titus
Tom Green
Travis
Trinity
Tyler
Upshur
Upton
Uvalde
Val Verde
Van Zandt
Victoria
Walker
Waller
Ward
Washington
Webb
Wharton
Wheeler
Wichita
Wilbarger
Willacy
Williamson
Wilson
Winkler
Wise
Wood
Yoakum
Young
Zapata
Zavala

COVERED SERVICES

This section describes **covered services** for which your **plan** pays **benefits** for you and your eligible dependents. **Covered services** must also meet the criteria for **medically necessary**. Some services may require **prior authorization**. This requires the provider to get approval from BCBS for certain covered services. Please refer to **prior authorization** under the **HOW THE PLAN WORKS** and **UTILIZATION MANAGEMENT** sections or contact Customer Service by calling the number on the back of your **identification card** or visiting the Blue Access for Members℠ **(BAM) website**.

Some services may be **covered services** but are not listed in your booklet. For assistance determining if a service will be covered you may call the number on the back of your insurance **identification card**.

Covered services appear alphabetically.

Acquired Brain Injury

Covered services include:

- Cognitive communication therapy
- Cognitive rehabilitation therapy
- Neurobehavioral testing
- Neurocognitive therapy and rehabilitation
- Neurobehavioral treatment
- Neuropsychological testing
- Neuropsychological treatment
- Neurophysiological testing
- Neurophysiological treatment
- Psychophysiological testing
- Psychophysiological treatment
- Neurofeedback therapy
- Remediation
- Post-acute transition services and community reintegration services, including:
    - Outpatient day treatment services or
    - Any other post-acute care treatment services

  if necessary, as a result of and related to an **acquired brain injury**

Treatment may be provided at:

- A **hospital**, an acute or post-acute rehabilitation hospital
- An assisted living facility or any other facility at which appropriate services or therapies may be provided

To ensure that appropriate post-acute care treatment is provided, this **plan** includes coverage for reasonable expenses related to periodic re-evaluation of the care of a covered **participant** who:

- Has incurred an **acquired brain injury**

- Has been unresponsive to treatment
- Becomes responsive to treatment at a later date

Treatment goals for services may include:

- The maintenance of functioning or
- The prevention of or slowing of further deterioration

Acquired Brain Injury means a neurological insult to the brain, which is not:

- Hereditary
- Congenital, or
- Degenerative

The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of:

- Physical functioning
- Sensory processing
- Cognition, or
- Psychosocial behavior

Allergy Care

Covered services include:

- Allergy testing and treatment provided or arranged by a **PCP.**

Ambulance Services

Covered services include:

- **Emergency Care** by means of ground ambulance service or air ambulance services to the nearest **hospital** equipped and staffed for treatment of a **participant's** condition.
- **Non-Emergency care**, by means of ground ambulance services or air services, when **medically necessary** and one of the following conditions is met:
    - Authorized by a **PCP**
    - Authorized by us, to or from a facility equipped and staffed for treatment of a **participant's** condition.

Non-emergency care air ambulance services are only covered when terrain, distance, your physical condition, or other circumstances require the use of air ambulance services rather than ground ambulance services.

Ambulance services includes, but is not limited to, transportation from one **hospital** to another **hospital** and from a **hospital** to a rehabilitation facility or **skilled nursing facility**. A **participant's** condition must be such that any other form of transportation would be medically contraindicated.

The following are not **covered services**:

- Transportation services except as described above in the ambulance services section, or when approved by BCBS.

Autism Spectrum Disorder

Covered services include:

- Psychiatric care, including diagnostic services
- Psychological assessments and treatments
- Habilitative or rehabilitative treatments

Screenings at 18 and 24 months

- Therapeutic care, including behavioral speech, occupational and physical therapies that provide treatment in the following areas:
    - Self-care and feeding
    - Pragmatic, receptive, and expressive language
    - Cognitive functioning
    - Applied behavior analysis (ABA) intervention and modification
    - Motor planning
    - Sensory processing
    - Drugs or nutritional supplements used to address symptoms of **autism spectrum disorder**

Services provided for **autism spectrum disorder** will not apply to any benefit maximum indicated on your **SCHEDULE OF BENEFITS**.

Your **physician** or **behavioral health practitioner** must prescribe these services in a recommended treatment plan. Individuals providing treatment prescribed under this plan must be a **provider** who meets at least one of the following criteria:

- Is licensed, certified, or registered by an appropriate agency of Texas
- Has professional credentials that are recognized and accepted by an appropriate agency of the United States
- Is certified as a provider under the TRICARE military health system

You can also receive treatment from individuals acting under the supervision of a **provider** described above.

The following are not **covered services**:

- Magnetoencephalography
- Elimination diets
- Music, vision, art, animal, touch, or massage therapies

Autism spectrum disorder means a **neurobiological disorder** that includes autism, Asperger's syndrome, or pervasive developmental disorder not otherwise specified.

A **neurobiological disorder** means an illness of the nervous system caused by genetic, metabolic, or other biological factors.

Behavioral Health

Covered Services includes:

- **Benefits** and coverage for **behavioral health** services provided under the same terms and conditions applicable to this **plan's** medical and surgical **benefits** and coverage.

We will not impose quantitative or nonquantitative treatment limitations on **benefits** for **behavioral health** services that are generally more restrictive than treatment limitations imposed on coverage of **benefits** for medical or surgical services.

Mental Health Condition

Covered services that require **prior authorization** include:

- Office visits with a **physician, behavioral health administrator**, psychiatrist, psychologist, social worker, or licensed professional counselor
- Outpatient diagnostic evaluation, treatment, and crisis intervention
- Inpatient mental health care
- **Residential treatment center** or **crisis stabilization unit** when a member meets one of the following criteria:
    - Has an acute condition that substantially impairs thought, perception of reality, emotional process or judgement.
    - Has grossly impaired behavior as manifested by recent disturbed behavior, which would otherwise necessitate confinement.
- **Mental health condition** treatment when rendered by a **participating provider**, which includes a **psychiatric day treatment facility**

Crisis Stabilization Unit or Facility means an institution which is appropriately licensed and accredited as a **crisis stabilization unit or facility** for the provision of **mental health condition** services to persons who are displaying a moderate to severe acute demonstrable psychiatric crisis.

Psychiatric Day Treatment Facility means an institution that is appropriately licensed and accredited by the Joint Commission on Accreditation of Healthcare Organizations as a **psychiatric day treatment facility** for the provision of **mental health condition** services to **participant** for periods of time not to exceed eight hours in any 24-hour period. Any treatment in such facility must be certified in writing by the attending **physician** to be in lieu of hospitalization.

Residential Treatment Center means a facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a level of security, supervision, and structure medically necessary to meet the needs of patients served or to be served by such facility. Residential treatment centers must be licensed by the appropriate state and local authority as a Residential Treatment Facility or its equivalent under the laws or regulations of such locality and/or must be accredited by a national accrediting body as a **residential treatment center** or its equivalent. Accepted accrediting bodies are The Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), Accreditation Association for Ambulatory Healthcare (AAAHC), Council on Accreditation of Services for Families and Children Inc. (COA), or National Integrated Accreditation of Healthcare Organizations (NIAHOSM). This includes any specialized licensing that may be applicable given the services to be provided or population to be served. As they do not provide the level of care, security, or supervision appropriate of a Residential Treatment Center, the following shall not be included in the definition of Residential Treatment Center:

- Half-way houses
- Supervised living

- Group homes
- Wilderness programs
- Boarding houses
- Other facilities that provide primarily a supportive/custodial environment and/or primarily address long term social needs, even if counseling is provided in such facilities.

To qualify as a **residential treatment center**, patients must be medically monitored with 24-hour medical professional availability and on-site nursing care and supervision for at least one shift a day with on call availability for the other shifts.

Residential Treatment Center for Children and Adolescents means a childcare institution that provides residential care and treatment for emotionally disturbed children and adolescents and that is accredited as a **residential treatment center** by the Council on Accreditation, the Joint Commission on Accreditation of Healthcare Organizations or the American Association of Psychiatric Services for Children.

Mental health condition means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

- Bipolar disorders (hypomanic, manic, depressive, and mixed)
- Depression in childhood and adolescence
- Major depressive disorders (single episode or recurrent)
- Obsessive-compulsive disorders
- Paranoid and other psychotic disorders
- Schizo-affective disorders (bipolar and depressive)
- Schizophrenia

Substance Use Disorder

Covered services, which may require **prior authorization**, include:

- Treatment for **substance use disorder**
- Inpatient **benefits** must be provided in a **substance use disorder center**

The following are not **covered services**:

- Mental health services except described above or under **Autism Spectrum Disorder**
- **Residential treatment centers** for substance use disorder that are not:
    - Affiliated with a **hospital** under a contractual agreement with an established system for patient **referral.**
    - Accredited as such a facility by the Joint Commission on Accreditation of Hospitals
    - Licensed as a **substance use disorder** treatment program by the Texas Commission on Alcohol and Drug Abuse
    - Licensed, certified, or approved as a **substance use disorder** treatment program or center by any other state agency having legal authority to so license, certify, or approve
- Trauma or wilderness programs
- Inpatient mental services that are provided:
    - **Non-participating provider**
    - Non-participating **mental health condition** facility

    - **Crisis Stabilization unit**
    - **Residential treatment center** for children and adolescents
- Inpatient mental health services for the following diagnosed conditions:
    - Alzheimer's disease
    - Intractable personality disorders
    - Mental retardation
    - Educational testing
    - Any testing required by school system
    - Psychiatric therapy on court order, condition of parole, probation or/and chronic organic brain syndrome

Substance use disorder means the abuse of or psychological or physical dependence on or addiction to alcohol or a **controlled substance.**

Substance use disorder Treatment Center means a facility that provides a program for the treatment of **substance use disorder** pursuant to a written treatment **plan** approved by us or its designated **behavioral health** administrator. The facility must be:

- Affiliated with a **hospital** under a contractual agreement with an established system for patient **referral**
- Accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations
- Licensed, certified or approved as a **substance use disorder** treatment program or center by an agency of the state of Texas having legal authority to so license, certify or approve
- If outside Texas, licensed, certified or approved as a **substance use disorder** treatment program or center by the appropriate agency of the state in which it is located having the legal authority to so license, certify or approve.

Biomarker Testing

Covered services includes:

- Diagnosis
- Treatment
- Appropriate management
- Ongoing monitoring of your disease or condition to guide treatment when the test is supported by medical and scientific evidence, including:
    - A labeled indication for a test approved or cleared by the FDA
    - An indicated test for a drug approved by the FDA
    - A national coverage determination made by CMS or a local coverage determination made by a Medicare administrative contractor
    - Nationally recognized clinical practice guidelines
    - Consensus statements

Biomarker means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to the specific therapeutic intervention. Includes gene mutations and protein expression.

Biomarker Testing means the analysis of a patient's tissue, blood, or other biospecimen for the presence of a **biomarker**. The term includes single-analyte tests, multiplex panel tests and whole genome sequencing.

Certain Therapies for Children with Developmental Delays

Covered services for children with **developmental delays** include:

- Occupational therapy evaluations and services
- Physical therapy evaluations and service
- Speech therapy evaluations and services
- Dietary or nutritional evaluations

The therapy should follow an **individualized family service plan**, submitted to us prior to the start of services, and when the **individualized family service plan** is altered.

After the age of 3, when services under the **individualized family service plan** are ended, other services covered under this **plan** will be available. Any limitations and exclusions, and benefit maximums will apply to those services.

Developmental Delay means a significant variation in normal development as measured by appropriate diagnostic tools and procedures, in one or more of the following areas:

- Cognitive development
- Physical development
- Communication development
- Social or emotional development
- Adaptive development

Individualized Family Service Plan means an initial and ongoing treatment **plan** developed by the Texas Interagency Council on Early Childhood Intervention.

Clinical Trials

Covered services include:

- **Routine patient care costs**, as defined below, that are provided in connection with participation in an **approved clinical trial**.
- Services must be provided or arranged by a **PCP**.

Related services are:

- Services in preparation for the non-covered service
- Services in connection with providing the non-covered service
- Hospitalization required to perform the non-covered service
- Services that are usually provided following the non-covered service, such as follow up care or therapy after surgery.

The following are **not covered services**:

- Services that are a part of the subject matter of a clinical trial
- Services that are customarily paid for by the research institution conducting the clinical trial

Approved clinical trial means a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition.

Routine patient costs means the cost for all covered items and services provided in this benefit booklet that are normally covered for you if you are not enrolled in a clinical trial.

Clinician-Administered Drugs

For **members** with a chronic, complex, rare, or life-threatening medical condition. Covered Drugs that will be administered by a **provider** in a **physician's** office may be obtained from a non-**participating pharmacy** by the **provider**, after the **provider** has determined that disease progression, patient harm, or death is probable, or where the **provider** has concerns about patient adherence or timely delivery. These services are covered under the medical benefit and the cost-sharing requirements will be the same as if they were obtained from **participating pharmacy**.

Contraceptive/Birth Control Services

Covered services include contraceptive services such as:

- Contraceptive counseling
- Examinations, procedures and medical services related to contraceptives
- FDA approved prescription drugs and devices Note: prescription contraceptive drugs may be covered under your **PHARMACY BENEFITS.**
- **Covered services** may also include female sterilization procedures for women with reproductive capacity and contraceptive service **benefits.**

Cosmetic, Reconstructive, or Plastic Surgery

Covered services which may require **prior authorization**, are limited to the following:

- Correction of defects caused by an accidental injury
- Mammaplasty reduction
- Reconstructive surgery following cancer surgery
- Reconstructive surgery following a mastectomy
    - Surgery on the other breast to make it symmetrical with the reconstructed breast
    - Prostheses
    - Treatment of physical complications at all stages of the mastectomy, including lymphedemas 48-hours of inpatient care following a mastectomy
    - 24-hours of inpatient care following a lymph node dissection for treatment of breast cancer
- Correction of a congenital defect, development deformity, functional impairment or craniofacial disfigurement and abnormalities

The following are **not covered services**:

- Any services and/or surgery including enlargement surgery. Even if the services and/or surgery are medically necessary.

Cosmetic, Reconstructive or Plastic Surgery means surgery that can be expected or is intended to improve:

- Physical appearance
- Performed for psychological purposes
- Restores form but does not correct or materially restore a bodily function

Reconstructive Surgery for Craniofacial Abnormalities means surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections or disease.

Dental Surgical Procedures

Covered services, which may require **prior authorization** include:

- Limited oral surgical procedures when prescribed by a **PCP** and performed in either setting:
    - A **participating provider's** office
    - An inpatient setting
    - An outpatient setting

The following are covered oral surgical procedures:

- Treatment for accidental injury, injury resulting from domestic violence, or a medical condition to **sound natural adult teeth**, the jaw bones, or surrounding tissues, not caused by biting or chewing.
- Treatment or correction of a non-dental physiological condition which has resulted in severe functional impairment.
- Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Diagnostic and surgical treatment of conditions affecting the temporomandibular joint (including the jaw or craniomandibular joint) as a result of an accident, a trauma, a congenital defect, a developmental defect, or a pathology.
- Removal of complete bony impacted teeth.

For **medically necessary** dental services to be covered in a **hospita**l or surgery center your **provider** must certify that the dental care you receive could not be performed in the dentist's office due to a physical, mental, or medical condition.

The following are **not covered services**:

- Routine dental care
- Standard dental treatments
- Dental appliances

Sound Natural Adult Teeth means teeth that are free of active or chronic clinical decay, have at least 50% bony support, are functional in the arch, and have not been excessively weakened by multiple dental procedures.

This plan provides coverage for medically necessary general anesthesia in connection with dental services.

Diabetic Equipment, Supplies and Self-Management

Covered services, which may require prior authorization, include any of the following for the treatment of type I, type II, or gestational diabetes (prescribed by a physician or other provider):

- Diabetes self-management training in an inpatient or outpatient setting which enables you to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications
- Visits for re-education and refresher training
- Medical nutrition therapy relating to diet, caloric intake and diabetes management

When the following diabetes equipment and supplies are obtained, you may be required to pay the full amount of the bill and submit a reimbursement claim form to us, with itemized receipts. Visit the website at www.bcbstx.com to obtain a medical claim form. If you choose to purchase diabetes supplies utilizing pharmacy **benefits**, you must pay the applicable **PHARMACY BENEFITS copayment/coinsurance** and any **deductibles**. No claim forms are required.

Equipment, but are not limited to:

- Blood glucose monitors
- Insulin pumps and necessary accessories
- Insulin infusion devices
- Podiatric appliance (including up to two pairs of therapeutic footwear per **calendar year**)

Supplies, but are not limited to:

- **Prescription orders** for insulin and insulin analog preparations
- Prescriptive and nonprescriptive oral agents for controlling blood sugar levels
- Glucose meter solution
- Visual reading and urine test strips and tablets that test for glucose, ketones and protein
- Test strips specified for use with a corresponding blood glucose monitor
- Lancets and lancet devices
- Injection aids, including devices used to assist with insulin injection and needleless systems
- Glucagon emergency kits
- Insulin syringes

Covered services also include:

- Repairs and necessary maintenance of insulin pumps if not covered by manufacturer's warranty or purchase agreement
- Rental fees for pumps during repair and maintenance of insulin pumps
- New or improved treatment, equipment or supplies that become available, and must be:
    - Approved by the United States Food and Drug Administration
    - **Medically necessary** and appropriate
    - Prescribed by your **physicia**n or other **provider**

The following are covered **only** under the **PHARMACY BENEFITS** portion of your plan:

- Insulin and insulin analogs preparations
- Insulin pens
- Insulin syringes and needles
- Injection devices
- Glucagon emergency kits
- Lancets and lancet devices
- Glucose meter solution
- Test strips specified for use with a corresponding blood glucose monitor
- Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein
- Glucose meter solution
- Prescriptive and nonprescriptive oral agents for controlling blood sugar levels

Durable Medical Equipment (DME)

Covered services, which may require **prior authorization** include:

- The rental and/or purchase of DME through a participating DME provider with a written prescription for your therapeutic use. We will determine whether the DME is rented or purchased and retains the option to recover the DME upon cancellation or termination of your coverage.
- DME is only covered at initial placement and when standard replacements are needed due to physical growth. Participants under 18 years of age and must be consistent with the Medicare DME Manual.

The following are covered equipment examples:

- Bedside commodes
- Crutches, walkers, standard wheelchairs
- Hospital beds
- Orthopedic tractions
- Oxygen tanks
- Suction machines

The following are examples of non-covered equipment:

- Home spirometers or telespirometers

Medical Supplies

The following medical or disposable supplies prescribed by a **physician** include, but are not limited to:

- Urinary catheters
- Wound care or dressing supplies given by a **provider** during treatment for covered health services
- Medical-grade compression stockings when considered **medically necessary**. The stockings must be prescribed by a **physician**, individually measured and fitted to the patient
- Ostomy supplies:
    - Pouches, face plates, and belts
    - Irrigation sleeves, bags, and ostomy irrigation catheters

    - Skin barriers
    - Deodorants, filters, lubricants, tape, appliance cleaners, adhesive and adhesive remover
- Disposable supplies necessary for the effective use of durable medical equipment and diabetic supplies

The following are not **covered services**:

- Medical supplies including but not limited to:
    - Compression stockings
    - Ace bandages
    - Wound care or dressing supplies
    - Prescribed or non-prescribed medical and disposable supplies that can be purchased over the counter

Those not covered services does not apply to:

- Ostomy bags and related supplies
- Disposable supplies necessary for the effective use of durable medical equipment for which **benefits** are provided
- Urinary catheters, wound care or dressing supplies given by a **provider** during treatment for covered services
- Medical grade compression stockings when considered medically necessary. The stockings must be prescribed by a **physician**, individually measured and fitted to the patient
- Covered diabetic supplies
- Batteries, tubing, nasal cannulas, connectors and masks except when used with durable medical equipment

Emergency Services

Covered services include:

- **Emergency medical care** when you receive **covered services** that meet the definition of **Emergency Care** (see **Glossary**) and services.

Emergency care includes:

- Treatment
- Stabilization of an emergency medical condition
- Originated in a **hospita**l emergency facility or comparable facility where you are receiving **emergency care** from a **participating** or **non-participating provider**
    - Based on your signs and symptom at time of treatment
    - Is **emergency care** received within **service are**a or out-of-area

Emergency Care services are subject to the **copayment/coinsurance** and per occurrence **deductible**. If you are admitted as an inpatient directly from the emergency room, in which case you pay the inpatient **hospital** amount.

If post stabilization care is required in a **non-participating hospital** after an **emergency care** condition that originated in a **hospital** emergency facility or in a **participating comparable facility** (as defined in this

paragraph), has been treated and stabilized, the treating **physician** or **provider** may contact us or its designee. **Prior authorization** is not required for post-stabilization care in a **non-participating hospital**.

Comparable Facility means:

- Any stationary or mobile facility, including, but not limited to, Level V Trauma Facilities, and rural health clinics, that have licensed or certified, or both licensed and certified, personnel and equipment to provide Advanced Cardiac Life Support consistent with American Heart Association and American Trauma Society standards of care, and a free-standing emergency medical care facility as that term is defined under Insurance Code §843.002
- **Emergency Care** related to mental illness, a mental health facility that can provide 24-hour residential and psychiatric services and that is:
    - A facility operated by the Texas Department of State Health Services
    - A private mental **hospital** licensed by the Texas Department of State Health Services
    - A community center as defined by Texas Health and Safety Code §534.001 (concerning Establishment)
    - A facility operated by a community center or other entity the Texas Department of State Health Services designates to provide mental health services
    - An identifiable part of a general **hospital** in which diagnosis, treatment, and care for persons with mental illness is provided, and that is licensed by the Texas Department of State Health Services
    - A **hospital** operated by a federal agency

Regardless of other provisions under this **plan** to the contrary, for **emergency care** rendered by **providers** who are not part of our network of **participating providers** (**non-participating provider**) or otherwise contracted with BCBS. We shall fully reimburse such providers at its:

- Usual and customary rate
- Agreed-upon rate
- Not to exceed billed charges

This amount is calculated excluding any in-network **copayment/coinsurance** and any **deductibles** imposed with respect to a **participant**.

Emergency Care Out-of-Area Services

Only **emergency care** services as described above are covered. Continuing or follow-up treatment for accidental injury or **emergency care** is limited to care required before you can return to the **service area** without medically harmful or injurious consequences.

You may be entitled to protection from balance billing if you receive **out-of-area emergency care**. If you received services because you believed that failing to get care placed your health or the health of a spouse, child, or unborn child in danger, but you have questions about whether your claim was processed as **emergency care** or questions about a balance bill. Please call the toll-free telephone number on the back of your ID card.

Fertility Preservation Services

Benefits for **fertility preservation services** will be provided when a **medically necessary** treatment may directly or indirectly cause **iatrogenic infertility**.

Covered services include standard procedures to preserve fertility consistent with:

- Established medical practices
- Professional guidelines published by either:
    - American Society of Clinical Oncology
    - American Society for Reproductive Medicine

Fertility Preservation Services means the collection and preservation of sperm, unfertilized oocytes, and ovarian tissue; and does not include the storage of such unfertilized genetic materials.

Iatrogenic Infertility means an impairment of fertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment, affecting reproductive organs or processes.

Gender Affirming Services

Covered services include:

- Certain services and supplies for gender affirming treatment (sometimes called gender reassignment).

Gender affirming services must be **medically necessary** for the treatment of gender dysphoria.

We cover **medically necessary**, sex-specific **covered services** regardless of identified gender.

Gender Transition Procedure or Treatment

Covered services include:

- Coverage for related adverse consequences and side effects.
- Necessary annual testing and screening.
- Coverage for procedures to manage, reverse, reconstruct from, or recover from the **gender transition**.

Hearing Aids and Audiological Services

Covered Services and equipment, which may require **prior authorization**:

- Prescribed electronic hearing aids installed in accordance with a **prescription** written during a covered hearing exam
- Any related services necessary to access, select, and adjust or fit a hearing aid

Hearing aids are limited to 1 per ear every thirty-six (36) months.

The following are **not covered services**:

- Replacement of a hearing aid that is lost, stolen or broken
- Replacement parts or repairs for a hearing aid
- Batteries or cords

Hearing aid means any wearable, non-disposable instrument or device designed to make up for impaired hearing including the parts, attachments or accessories.

Hearing Exams

Covered services include:

- A hearing exam for the evaluation of hearing impairment, hard of hearing or hearing loss.

Hearing exam must be performed by a hearing specialist such as an audiologist

Hearing Implants

Covered services include:

- One cochlear implant, including an external speech processor and controller, per impaired ear
- Habilitation and rehabilitation services
- Fitting and dispensing services
- The provision of ear molds as necessary to maintain optimal fit
- Treatment related to the maintenance of your cochlear implants

Implant components may be replaced as audiologically necessary or **medically necessary.**

Home Health Care

Covered services include:

- Care in the home by health care professionals who are **participating providers**

Visits include but are not limited to:

- Home health aide services
- Physical, occupational, speech, and respiratory therapy services by licensed therapists
- Professional services of a registered nurse or licensed practical nurse

Services must be provided or arranged by a **PCP**.

Hospice Care

Covered services include:

- Inpatient, outpatient or **hospice** facility agency services
- In-home services which are part of a **plan** of care
- Physical, speech, and respiratory therapy services by licensed therapists
- Homemaker and counseling services routinely provided by the hospice agency, including bereavement counseling.

Hospice care may be covered when:

- You have a terminal illness with a life expectancy of one year or less, as certified by your attending **physician.**
- You no longer benefit from standard medical care or have chosen to receive **hospice care** rather than other standard care.

The following are **not covered services**:

- Home delivered meals
- Transportation services

- **Custodial care**

Hospice Care means an integrated set of services designed to provide palliative and supportive care for terminally ill patients.

Infertility Treatment

Covered services, which may require **prior authorization**, include:

- Services rendered in connection with a diagnosis and/or treatment of **infertility**.
- Once the infertility workup and testing have been completed, subsequent workups and testing will require approval of our **medical director**
- Artificial insemination for treatment of **infertility** (cost of sperm is not covered)

The following are **not covered services**:

- Drugs for the treatment of **infertility**

Infusion Therapy

Covered services that may require **prior authorization** and arrange by your **PCP** include:

- Infusion and injectable therapy

Non-maintenance outpatient **infusion therapy** services will be covered the same as any other illness. Some outpatient **infusion therapy services** for routine maintenance drugs have been identified as capable of being safely administered in a lower level of care, outside of a **hospital**.

Your out-of-pocket expenses may be lower when **Covered Services** are provided in:

- **Infusion suite**
- Home setting
- Office

Infusion Suite means a place of treatment that is an alternative to **hospital** and clinic-based infusion settings where specialty medications can be infused.

Infusion Therapy means the administration of medication through a needle or catheter. It is prescribed when a patient's condition is so severe that it cannot be treated effectively by oral medications. Typically, it means that a drug is administered intravenously, but the term also may refer to situations where drugs are provided through other non-oral routes, such as intramuscular injections and epidural routes (into the membranes surrounding the spinal cord). **Infusion therapy** in most cases requires health care professional services for the safe and effective administration of the medication.

Inpatient Hospital Services

Inpatient hospital services, except **emergency care** and treatment of breast cancer, must be arranged by your **PCP**.

Covered services that require **prior authorization** include:

- Inpatient care received in a **hospital** setting including:

    - Bed, board and general nursing care when you are in a semi-private room or **medically necessar**y private room authorized by a **PCP**.
    - Short-term rehabilitation therapy services
    - Special duty and private duty nursing when **medically necessary** authorized or ordered by a **PCP.**
    - Special diets and meals when **medically necessary** authorized or ordered by a **PCP.**
    - Use of intensive care or cardiac care units and related services when **medically necessary** and authorized or ordered by a **PCP.**
- Ancillary services such as:
    - Anesthesia and oxygen services
    - Laboratory, x-ray, and other diagnostic services
    - Operating, delivery, and treatment rooms
    - Radiation therapy, inhalation therapy, and chemotherapy
    - Whole blood and blood plasma, blood processing, and administration
- Drugs, medications, biologicals, and their administration
- Treatment of breast cancer (no **prior authorization** required) for a minimum of:
    - 48 hours following a mastectomy
    - 24 hours following a lymph node dissection

The following are **not covered services**:

- Personal or comfort items provided by a **hospital** or other inpatient facility, including, but not limited to:
    - Televisions and telephones
    - Guest beds
    - Admission kits, maternity kits, and newborn kits
- Private rooms unless **medically necessary** and authorized by BCBS. If a semi-private room is not available, we will cover a private room until a semi-private room is available.

Maternity Care

Covered services include:

- Inpatient care for the mother/birthing parent and newborn **child** in a health care facility for a minimum of:
    - 48 hours following an uncomplicated vaginal delivery
    - 96 hours following an uncomplicated delivery by caesarean section
- Treatment for complications of pregnancy

If the mother/birthing parent or newborn is discharged before the minimum hours of coverage, your **plan** provides coverage for postdelivery care for the mother/birthing parent and newborn. **Postdelivery care** may be provided at the mother's/birthing parent's home, a health care **provider's** office, or a health care facility.

Charges for well-baby nursery care, including the initial examination and administration of a newborn screening test (which includes the test kit required by the state of Texas) during the mother's/birthing parent **hospital**

admission for the delivery will be considered inpatient **hospital services** and will be subject to the benefit provisions and benefit maximums.

Maternity Care means care, and services provided for treatment of the condition of pregnancy, other than complications of pregnancy.

Postdelivery Care means postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments. The term includes:

- Parent education
- Assistance and training in breast-feeding and bottle feeding
- The performance of any necessary and appropriate clinical tests

Complications of Pregnancy means conditions, requiring **hospital** confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as:

- Acute nephritis
- Nephrosis
- Cardiac Decompensation
- Missed miscarriage
- Similar medical and surgical conditions of comparable severity

Complications of pregnancy do not include:

- False labor
- Occasional spotting
- **Provider** prescribed rest during the period of pregnancy
- Morning sickness
- Hyperemesis gravidarum
- Pre-eclampsia
- **Similar** conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy or non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.

The following are **not covered services**:

- For or related to the planned delivery of a newborn **child** at home, or in any setting other than a **hospital**, licensed birthing center or other facility licensed to provide such services
- **Ductal** lavage of the mammary ducts
- **Cervicovaginal** fluid for amniotic fluid protein during pregnancy, which might be ordered in people suspected to have fluid leaking from around the baby (premature ruptured membranes)

Medical Benefit Therapeutic Alternatives

Certain prescription drugs administered by a health care professional have therapeutic equivalents or therapeutic alternatives that are used to treat the same condition. Benefits may be limited to only certain therapeutic equivalents or therapeutic alternatives. However, benefits may be provided for the therapeutic

equivalents or therapeutic alternatives that are not otherwise covered under your benefit, if an exception is granted.

You may contact Customer Service at the toll-free telephone number on the back of your **identification card**, or visit www.bcbstx.com/find-care/medical-rx for more information about covered therapeutic equivalents or therapeutic alternatives. To request an exception, you, your prescribing health care **provider**, or your authorized representative, can call the toll-free telephone number on the back of your **identification card**.

Therapeutic equivalents or therapeutic alternatives may be covered through your prescription drug benefit, depending on your benefit plan.

Nutritional Support

Covered services include:

- Dietary formulas needed for the treatment of phenylketonuria or other heritable diseases
- Amino based formulas, regardless of the formula delivery method, used for diagnosis and treatment of:
- Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins
    - Severe food protein-induced enterocolitis syndromes
    - Eosinophilic disorders, as evidenced by the results of biopsy
    - Disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract

A prescription from your **physician** is required.

Orally Administered Anticancer Drug

Covered services include:

Orally administered anticancer drug that is used to kill or slow the growth of cancerous cells.

Organ Tissue and Transplants

Covered services that require **prior authorization** include:

- Transplant surgery, services, and treatment related to organ or tissue transplant provided by a **physician** and or **hospital** for you, your dependents, and the donor.

Covered services and supplies related to transplant surgery include, but are not limited to:

- Chemotherapy
- Complications arising from transplant
- Laboratory testing
- Prescription drugs
- Procurement of organs or tissues from a living or deceased donor
- Radiation therapy
- X-rays

The following organ and tissue transplants are covered:

- Bone marrow
- Corneal
- Heart
- Kidney
- Liver
- Lung
- Pancreas
- Peripheral stem cell transplants

The following criteria must be met for coverage:

- The transplant procedure is not **experimental/investigational** in nature
- Donated human organs or tissue or a United States Food and Drug Administration approved artificial device are used
- The **participant** meets all of the criteria established by us in pertinent written medical policies
- The **participant** meets all of the protocols established by the **hospital** in which the transplant is performed

Benefits will be determined on the same basis as any other sickness when the transplant procedure is considered **medically necessary** and meets all the conditions cited above. **Benefits** will be available for:

- A recipient who is a member covered under BCBS
- A donor who is a member covered under BCBS
- A donor who is not a member covered under BCBS

Covered services and supplies include those provided for the:

- Donor search and acceptability testing of potential live donors
- Evaluation of organs or tissues including, but not limited to, the determination of tissue matches
- Removal of organs or tissues from living or deceased donors
- Transportation and short-term storage of donated organs or tissues

The following are not **Covered Services**:

- Living and/or travel expenses of the recipient or a live donor
- Expenses related to maintenance of life of a donor for purposes of organ or tissue donation
- Purchase of the organ or tissue other than payment for **covered Services** and supplies identified above
- Organ or tissue (xenograft) obtained from another species
- If the transplant operation is performed in China or another country known to have participated in forced organ harvesting
- The human organ to be transplanted was procured by a sale or donation originating in China or another country known to have participated in forced organ harvesting

Orthotic and Prosthetic

Covered services include:

- Leg, arm, back, neck, or other body braces
- A prosthetic device that your provider orders and fits (including external breast prostheses after mastectomy)
- Adjustments, repair and subsequent replacements due to wear or change in your physical condition

We will cover the same type of devices that are covered by Medicare.

The following are **not covered services**:

- Test sockets for prosthetic
- Waterproof/water resistant prosthetics
- Carbon fiber running foot/blade
- Trusses, corsets, and other support items
- Repair and replacement due to misuse or loss

Osteoporosis

Covered services include medically accepted bone mass measurement for the following purposes:

- Detection of low bone mass
- Determine your risk of osteoporosis and fractures associated with osteoporosis

In order to be eligible to receive these services, you must meet one of the following criteria:

- You are a postmenopausal participant not receiving estrogen replacement therapy
- You have:
    - Vertebral abnormalities
    - Primary hyperthyroidism
    - A history of bone fractures
- You are:
    - Receiving long-term glucocorticoid therapy
    - Being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy

Outpatient Facility Services

Covered services that may require **prior authorization** include:

- Services provided through a **participating hospital** outpatient department, or a free-standing facility, must be prescribed by a **PCP** include:
    - Dialysis
    - Infusion Therapy (including chemotherapy)
    - Outpatient surgery
    - Radiation therapy

Outpatient Diagnostic Services

Covered services, which may require **prior authorization**, included:

- Tests, scans, and procedures specifically designed to detect and monitor a condition or disease

The following are covered diagnostic and diagnostic imaging service examples:

- X-ray and x-ray therapy
- Chemotherapy
- Fluoroscopy
- Electrocardiograms
- Laboratory tests
- Therapeutic radiology

Services must be ordered, authorized, or arranged by a **PCP** and provided through a **participating facility**.

Prostate Cancer Detection Tests

Covered services include:

- An annual medically recognized diagnostic, physical examination for the detection of prostate cancer
- A prostate-specific antigen test used for the detection of prostate cancer for each **participant** who is at least:
    - 50 years of age and asymptomatic
    - 40 years of age and has a family history of prostate cancer or another prostate cancer risk factor

Ovarian and prostate cancer detection test may require **prior authorization** and may be subject to **copayment/coinsurance, deductible** or dollar maximums.

Rehabilitation Services

Covered services, which may require **prior authorization**, include:

- Occupational therapy
- Physical therapy
- Speech therapy

Services are covered in the following settings:

- Home Health care visits
- Hospital as in inpatient
- Outpatient facility
- **Provider'**s office

Rehabilitation services must be **medically necessary** and meet or exceed your treatment prescribed by your **PCP** or **specialist**.

For a physically disabled person, treatment goals may include:

- Maintenance of functioning
- Prevention
- Slowing of further deterioration

Retail Health Clinics

Covered services include:

- Diagnosis and treatment of uncomplicated minor conditions in situations that can be handled without:
  - Traditional **PCP** office visit
  - Urgent care visit
  - Emergency care visit

PCP referral is not required to obtain **Covered Services**.

Retail Health Clinic means a **participating provider** that provides treatment of uncomplicated minor illnesses.

Retail health clinics are typically located in retail stores and are typically staffed by advanced practice nurses or physician assistants.

Skilled Nursing Facility Services

Covered services include **skilled nursing facility** services.

Skilled nursing facility care includes:

- Bed, board and general nursing care
- Ancillary services (such as drugs and surgical dressings or supplies)
- Physical, occupational, speech, and respiratory therapy services by licensed therapists

The following are **not covered services**:

- Continued skilled nursing visits if you no longer improve from treatment.
- Care in the home is not available or the home is unsuitable for such care.
- For **custodial care**, or care for someone's convenience.

Skilled Nursing Facility means a facility primarily engaged in providing **skilled nursing services** and other therapeutic services and which is:

- Licensed in accordance with state law (where the state law provides for licensing of such facility)
- Medicare or Medicaid eligible as a supplier of skilled inpatient nursing care

Telehealth and, Teledentistry, Telemedicine Services

Covered services include:

- **Telehealth services**
- **Telemedicine medical services**
- **Teledentistry dental services**

Teledentistry Dental Service means a health service delivered by a dentist, or a health professional acting under the delegation and supervision of a dentist, acting within the scope of the dentist's or health professional's license or certification to a patient at a different physical location that the dentist or health professional using telecommunications or information technology.

Telehealth Service means a health service, other than a **telemedicine medical service** or a **teledentistry dental 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 Service means a health care service delivered by a **physician** or **behavioral health provider** licensed in Texas, or a health professional acting under the delegation and supervision of a **physician** or **behavioral health provider** 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 that the **physician** or health professional using telecommunications or information technology.

Urgent Care

Covered services include:

Services and supplies to treat an urgent condition at an urgent care center. Services will not endanger life, permanent health and does not require emergency care services. A **PCP referral** is not required. Additional charges for outpatient diagnostic services or outpatient facility services may apply.

Virtual Visits

Covered services include:

- The diagnosis and treatment of certain non-emergency medical and **behavioral health** conditions or illnesses when a virtual provider determines that your diagnosis and treatment can be done without an in-person office visit for:
    - Primary care
    - Convenient care
    - Emergency room care
    - **Behavioral health** care
    - Urgent care

Not all medical or **behavioral health** conditions can be treated by virtual visit. Your virtual provider will identify any condition for which treatment should be performed by an in-person **provider**.

PREVENTIVE CARE

Preventive **covered services** are intended to help keep you healthy, supporting you in achieving your best health through early detection. In addition to the **covered services** in this benefit booklet, all preventive **covered services** will be considered **medically necessary covered services** and will not be subject to any **deductible**, **coinsurance**, **copayment** and/or **benefit** maximum when such services are received from a **participating provider** or **participating pharmacy.** Preventive care services from out-of-network providers may be subject to **deductible**, **copayment** and/or **coinsurance**, except for certain state or federally mandated **benefits** (example: childhood immunizations).

The following agencies set the preventive care guidelines:

- United States Preventive Services Task Force ("USPSTF")
- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC")
- Health Resources and Services Administration ("HRSA")
- American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

The above agencies' recommendations and guidelines may be updated periodically. When updated, they will apply to your **plan.**

Preventive drugs (including both prescription and over-the-counter products) that meet the preventive recommendations described above, and that are listed on the No-Cost Preventive Drug List, will be covered. Coverage will be implemented in the quantities and within the time period allow under applicable law. These drugs will not be subject to any **copayment** amount, **coinsurance** amount, **deductible**, or dollar maximum when obtained from a **participating pharmacy**. Drugs on the No-Cost Preventive Drug List obtained from a non-participating pharmacy will not be covered under this **plan**.

A copay waiver can be requested for drugs or immunizations that meet the preventive recommendations outlined above that are not on the No-Cost Preventive Drug List.

Examples of covered preventive services included are:

- Bone density test
- Cancer screening mammograms
- Healthy diet counseling
- Immunizations
- Obesity screening and counseling
- Preventive eye screenings for infants, children, and adolescents as required by HRSA guidelines
- Routine annual physicals
- Screening for colorectal cancer
- Smoking cessation counseling services
- Well-child care

NOTE: Smoking cessation medications are covered under **PHARMACY BENEFITS** with a **prescription order** from your **health care professional**.

Examples of covered immunizations included are:

- Diphtheria
- Haemophilus influenzae type b
- Hepatitis B
- Measles
- Mumps
- Pertussis
- Polio
- Rubella
- Tetanus
- Varicella
- Any other immunization that is required by law for a child

Covered services are also included for the following preventive screening tests, but are not limited to:

- One screening by low-dose mammography screening (including digital mammography and breast tomosynthesis) for occult breast cancer every 12 months for a **participant** 35 years of age and older
- A diagnostic, medically recognized screening exam for the detection of colorectal cancer for **participants** who are 45 years of age or older and who are at normal risk for developing colon cancer, and a follow-up colonoscopy if the findings are abnormal. An initial or follow-up colonoscopy, or other medical test or procedure for colorectal cancer screening may be subject to **copayment/coinsurance** or **deducible**.

Covered services include, for women who are able to become pregnant, certain drugs and devices approved by the FDA to prevent pregnancy in the following categories:

- Progestin-only contraceptive
- Combination contraceptive
- Emergency contraceptive
- Extended-cycle/continuous oral contraceptives
- Cervical caps
- Diaphragms
- Implantable contraceptive
- Intra-uterine devices (IUDs)
- Injectables
- Transdermal contraceptive
- Vaginal contraceptive devices
- Spermicide
- Condoms

Benefits will also be provided to women with reproductive capacity for FDA approved over-the-counter contraceptives such as spermicide and condoms. Women will need to obtain a written prescription by a **participating provider**. You will be required to pay the full amount and submit a reimbursement claim form along with the written prescription to us with itemized receipts. Visit the website at www.bcbstx.com to obtain a claim form.

The contraceptive drugs and devices listed above may change as FDA guidelines, medical management and medical policies are modified.

Contraceptive drugs and devices not covered under this **Preventive Outpatient Contraceptive Drugs, Devices and Procedures** section may be covered under other sections of this **plan**.

Note: Prescription contraceptive drugs are covered only under the **PHARMACY BENEFITS** portion of this benefit booklet.

Covered services also include:

- Female sterilization procedures for women who are able to become pregnant
- **Outpatient contraceptive services**
- FDA approved over-the-counter female contraceptives with a prescription order from a health care provider

Breastfeeding Support and Services

Covered services include:

- During pregnancy or after delivery when you get them from a certified **provider**:
    - Breastfeeding support services
    - Breastfeeding counseling

Breast Pump, Accessories and Supplies

Covered services include, with a **prescription order,** either:

- Rental of hospital grade breast pumps (not to exceed the total cost)
- Purchase of manual or electric breast pumps

Benefits for electric breast pumps are limited to one per **benefit period**.

Covered services also include, with a **prescription order**:

- Breast pump supplies
- Breast milk storage supplies

You may be required to pay the full amount and submit a claim form to us with a prescription order and the itemized receipt for the breast pump, breast pump supplies, and breast mile storage supplies.

Visit www.bcbstx.com to obtain a claim form.

Cardiovascular Disease Early Detection Tests

Covered services include one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five years when performed by a laboratory that is certified by a recognized national organization:

- Computed tomography (CT) scanning measuring coronary artery calcifications
- Ultrasonography measuring carotid intima-media thickness and plaque

Tests are available to each covered individual who is:

- A male older than 45 years of age and younger than 76 years of age
- A female older than 55 years of age and younger than 76 years of age

The individual must have either:

- Diabetes
- An intermediate or higher risk of developing coronary heart disease based on the Framingham Heart Study coronary prediction algorithm

Cardiovascular disease early detection tests may require **prior authorization** and may be subject to **copayment/coinsurance, deductible** or dollar maximums.

Diagnostic Eye and Ear Screenings

- For participants through age seventeen (17)
- Once every twelve months
- Performed or authorized by a **PCP.**
- Eye screenings may be performed in **PCP** office and do not include refractions.

For participants eighteen (18) and older

- Once every two years
- Performed or authorized by a **PCP.**
- Eye screenings may be performed in **PCP** office and do not include refractions.

Diagnostic eye and ear screenings may require **prior authorization** and may be subject to **copayment/coinsurance, deductible** or dollar maximums.

Diagnostic Mammograms and Other Breast Imaging

Covered services include:

- Magnetic resonance imaging
- Mammography
- Ultrasound imaging

Diagnostic imaging is designed to evaluate:

- A subjective or objective abnormality detected by a **physician** or patient in a breast
- An abnormality seen by a **physician** on a screening mammogram
- An abnormality previously identified by a **physician** as probably benign in a breast for which follow-up imaging is recommended by a **physician**
- An individual with a personal history of breast cancer or dense breast tissue

Diagnostic mammograms and imaging for breast cancer may require **prior authorization**.

Hearing Impairment Screening Test for Newborns

Covered services include:

- A screening test for hearing loss from birth through the date the child is 30 days old
- Necessary diagnostic follow-up care related to the screening test from birth through 24 months of age

Ovarian Cancer Early Detection Test

Covered services include one of the following early detections tests every 12 months for participant 18 years of age or older:

- A CA 125 blood test
- Any other test or screenings approved by the FDA for the detection of ovarian cancer

Ovarian cancer test may require prior authorization and may be subject to **copayment/coinsurance**, **deductible** or dollar maximums.

Women preventive care and screenings

- Well-woman gynecological exam (once every twelve months)
- Early detection of cervical cancer diagnostic exam for **participant** age eighteen (18) and older
- Exam may include but not limited to:
    - Conventional pap smear screening
    - Human papillomavirus detection

You must obtain a **referral** from your **PCP** for follow-up services related to treatment of a disease or condition that is not within the of an OB/GYN.

Outpatient Contraceptive Services means a consultation, examination, procedure, or medical service that is you get on an outpatient basis and that is related to the use of a drug or device meant to prevent pregnancy.

To see a complete listing of the preventive health services available to you at no cost through an **in-network provider** visit www.healthcare.gov/coverage/preventive-care-benefits/ or call the number on the back of your insurance **identification card.** For frequencies and any limits that may apply, contact your **physician** or visit www.bcbstx.com/provider/clinical/clinical-resources/preventive-care.

MEDICAL LIMITATIONS AND EXCLUSIONS

The following are not **covered services** under your **plan**. Refer to the **COVERED SERVICES** section of your benefit booklet for exclusions associated with specific services or supplies.

- Services or supplies of **non-participating providers** or self-**referral** to a **participating provider**, except:
  - Emergency care
  - When authorized by us or a **PCP**
  - Female **participants** may directly access an Obstetrician/Gynecologist
    - Well-women exams
    - Obstetrical care
    - Care of all active gynecological conditions
    - Diagnosis, treatment, and **referral** for any disease or condition within the scope of the professional practice of the Obstetrician/Gynecologist
- Services or supplies which, in the judgment of a **PCP**, or BCBS are not **medically necessary** and essential to the diagnosis or direct care and treatment of the following:
  - Sickness
  - Injury
  - Condition
  - Disease
  - Bodily malfunction
- Any services or supplies determined to be **experimental/investigational** or unproven. You may contact Customer Service at the toll-free telephone number on the back of your **identification card** for more information about what **experimental/investigational** services or supplies may be excluded.
- Clinical technology, services, procedures, and service paradigms designated by a temporary (CPT® Category III) code are not covered, except for certain services otherwise specified by state or federal law, or federal coverage or billing guidelines.
- Management and treatment of Idiopathic Environmental Intolerance (IEI), including laboratory or other diagnostic tests to affirm the diagnosis of IEI.
- Any charges resulting from the failure to keep a scheduled visit with a **participating provider** or for the acquisition of medical records.
- Special medical reports not directly related to treatment.
- Examinations, testing, vaccinations or other services required by **employers**, insurers, schools, camps, courts, licensing authorities, other third parties, or for personal travel.
- Any services or supplies provided by a person who is related by blood or marriage and self-administered services.
- Any services or supplies provided for injuries sustained either:
  - As a result of war, declared or undeclared, or any act of war
  - While on active or reserve duty in the armed forces of any country or international authority
- **Benefits** you are receiving through the following:
  - Medicare
  - Eligible through federal, state, or local government entitlement programs
  - Medicaid and its successors
- Care for conditions that federal, state, or local law requires to be treated in a public facility.

- Appearances at court hearings and other legal proceedings, and any services relating to judicial or administrative proceedings, or conducted as part of medical research.
- Any services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment whether or not **benefits** are, or could upon proper claim be, provided under the Workers' Compensation law.
- Any services, supplies, or prescription drugs received by a **participant** outside the United States, except for **emergency care.** Services or supplies furnished by an institution that is primarily a place of rest, a place for the aged, or any similar institution.
- Abortions are limited to pregnancies that, as certified by a **physician**, places the woman in danger of death.
- Services and supplies for the following except as listed as covered in the **COVERED SERVICES** section of your benefit booklet:
    - Dietary and nutritional services
    - Long term or custodial care
    - Private duty nursing services
    - Any services related to a non-covered service
- Services or supplies provided primarily for:
    - Environmental sensitivity
    - **Clinical Ecology** or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists
    - Inpatient allergy testing or treatment
    - Any services or supplies provided for, in preparation for, or in conjunction with the following, except as described under the **Maternity Care and Family Planning Services** section. Sterilization reversal (male or female)
    - Sexual dysfunction treatment including medications, penile prostheses and other surgery, and vascular or plethysmographic studies that are used only for diagnosing impotence
    - In vitro fertilization and fertility drugs, unless covered by a **rider**
    - Assisted reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct intra-peritoneal insemination, trans-uterine tubal insemination, gamete intra-fallopian transfer, pronuclear oocyte stage transfer, zygote intra-fallopian transfer, and tubal embryo transfer

    Clinical Ecology means the inpatient or outpatient diagnosis or treatment of allergic symptoms by:
        - Cytotoxicity testing (testing the result of food or inhalant by whether or not it reduces or kills white blood cells)
        - Urine auto injection (injecting one's own urine into the tissue of the body)
        - Skin irritation by Rinkel method
        - Subcutaneous provocative and neutralization testing (injecting the patient with allergen)
        - Sublingual provocative testing (droplets of allergenic extracts are placed in mouth)

    Environmental Sensitivity means the inpatient or outpatient treatment of allergic symptoms by controlling environment, sanitizing the surroundings (removal of toxic materials), or use of special nonorganic, nonrepetitive diet techniques.
- Services or supplies in connection with routine foot care, including:

    - In the absence of diabetes: the removal of warts, corns, or calluses, or the cutting and trimming of toenails
    - Circulatory disorders of the lower extremities
    - Peripheral vascular disease
    - Peripheral neuropathy
    - Chronic arterial or venous insufficiency
- Services or supplies in connection with foot care for:
    - Flat feet
    - Fallen arches
    - Chronic foot strain
- Services or supplies provided for reduction of obesity or weight, even if the **participant** has other health conditions which might be helped by a reduction of obesity or weight, except for healthy diet counseling and obesity screening/counseling as may be provided under the **Preventive Services** section of your benefit booklet.
- Services or supplies for, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.
- Alternative treatments such as:
    - Acupuncture
    - Acupressure
    - Hypnotism
    - Massage therapy
    - Aroma therapy
- Services or supplies for:
    - Intersegmental traction
    - Surface EMGs
    - Spinal manipulation under anesthesia
    - Muscle testing through computerized kinesiology machines such as isostation, digital myograph, and dynatron
- Galvanic stimulators or TENS units.
- Disposable or consumable outpatient supplies:
    - 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
- Prosthetic Appliances or orthotic devices not described under the **Diabetes Care** or **Prosthetic Appliances and Orthotic Devices** section of the **COVERED SERVICES** section including, but not limited to:
    - Orthodontic or other dental appliances or dentures

    - Splints or bandages provided by a physician in a non-hospital setting, or purchased over the counter for the support of strains and sprains
    - 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 effect changes in the foot or foot alignment; arch supports; orthotics; braces; splints or other foot care items
- Supplies for smoking cessation programs and the treatment of nicotine addiction, with the exception of prescription and over-the-counter medications for tobacco cessation and tobacco cessation counseling covered under the **Health Maintenance and Preventive Services** section.
- Educational testing and therapy, including the treatment of learning disabilities, developmental delays in speech, motor or language skills, behavioral disorders, including adolescent behavior disorders such as conduct or oppositional disorders, or services that are educational in nature or are for vocational testing or training, except as may be provided under the **Autism Spectrum Disorder** section of the **COVERED SERVICES** section. This exclusion does not apply to developmental delays if the delay is related to a treatable medical condition.
- The following **psychological/neuropsychological testing** and **psychotherapy services**:
    - Educational testing
    - Employer/government mandated testing
    - Testing to determine eligibility for disability **benefits**
    - Testing for legal purposes (e.g., custody/placement evaluations, forensic evaluations, and court mandated testing)
    - Testing for vocational purposes (e.g., interest inventories, work related inventories, and career development)
    - Services directed at e'hancing one's personality or lifestyle
    - Vocational or religious counseling
    - Activities primarily of an educational nature
    - Music or dance therapy
    - Bioenergetic therapy
- Biofeedback (except for an **acquired brain Injury** diagnosis) or other behavior modification services.
- Deluxe equipment such as motor driven wheelchairs and beds (unless determined to be medically necessary); such as:
    - Bed boards
    - Bathtub lifts
    - Over-bed tables
    - Air purifiers
    - Sauna baths
    - Exercise equipment
    - Stethoscopes and sphygmomanometers
    - Experimental and/or research items
    - Replacement, repairs, or maintenance of the DME
- Not all medical supplies are **covered services**, and all are subject to medical review.
- Over-the-counter supplies or medicines and prescription drugs and medications of any kind, except:
    - As provided while confined as an inpatient

- As provided under the **Autism Spectrum Disorder** section
- As provided under the **Diabetes Care**
- Contraceptive devices and FDA-approved over-the-counter contraceptives for **participant** with a written prescription from a **participating provider**

- If covered under the **PHARMACY BENEFITS** section
  - Contraceptive devices, including over-the-counter contraceptive products such as spermicide, when not prescribed by a **participating provider.**
  - New-to-market FDA-approved drugs which are subject to review by Prime Therapeutics Pharmacy and Therapeutic (P&T) Committee prior to coverage of the drug.
- Three-dimensional (3D), four-dimensional (4D), and five-dimensional (5D) obstetrical ultrasounds
- Viscosupplementation (intra-articular hyaluronic acid injection), except for individuals currently receiving maintenance therapy.
- Select medications may be excluded from the medical benefit when a self-administered formulation of the product is available.

PHARMACY BENEFITS

Your **plan** may not cover all prescription drugs and some coverage may be limited. This does not mean you cannot get prescription drugs that are not covered; you can, but you may have to pay for them yourself. For more information about prescription drug **benefits** see your prescription **SUMMARY OF BENEFITS**. You may also contact Customer Service by calling the number on the back of your **identification card** or access Blue Access for Members℠ (BAM) for any questions regarding your **prescription drug benefits**.

We share the cost with you for **medically necessary** covered prescription drugs for a chronic, disabling, or life-threatening illness if the prescription drug:

- Is on the **drug list.**
- Has been approved by the United States Food and Drug Administration (FDA) for at least one indication.
- Is recognized by the following for treatment of the indication for which the drug is prescribed:
    - A prescription drug reference compendium approved by the Department of Insurance
    - Substantially accepted peer-reviewed medical literature

You are responsible for any **deductibles**, **copayments** and/or **coinsurance** amounts, and pricing differences shown on your **SUMMARY OF BENEFITS** that may apply to any covered **prescription drug** dispensed.

Your Cost

How Copayment and/Coinsurance Amounts Apply

When your **provider** has marked the **prescription order** "brand necessary" or "brand **medically necessary**," the pharmacist may only dispense the **brand name drug** and you pay the proper **brand name drug copayment** and/or **coinsurance** amounts after your **deductible** based on the applicable tier.

If your **provider** has not specified a dispensing order prohibiting substitution of a generic equivalent, you may choose to buy the **brand name drug** instead of the **generic drug**.

In this case, your payment amount will be the sum of:

- The correct **copayment** and/or **coinsurance** amount after your **deductible** based on the current tier of the **brand name drug**, plus
- The difference between the **allowable amount** of the generic drug and the **allowable amount** of the **brand name drug**.

Exceptions to this section may be allowed for certain preventive drugs (including prescription contraceptive drugs) if your provider submits a request to us indicating that the generic drug would be medically inappropriate, along with supporting evidence. If we grant the exception request, any difference between the allowable amount for the **brand name drug** and the generic drug will be waived.
If the allowable amount of the covered drug is less than the copayment, you will pay the lower cost.

How Participant Payment is Determined

Prescription drug products are separated into six tiers:

- Tier 1 – Includes mostly **generic drugs** (**preferred**) and may contain some **brand name drugs**.
- Tier 2 – Includes mostly **generic drugs** (**non-preferred**) and may contain some **brand name drugs**.

- Tier 3 – Includes mostly **brand name drugs** (**preferred**) and may contain some **generic drugs**.
- Tier 4 – Includes mostly **brand name drugs** (**non-preferred**) and may contain some **generic drugs**.
- Tier 5 – Includes mostly **specialty drugs** (**preferred**) and may contain some **generic drugs**.
- Tier 6 – Includes mostly **specialty drugs** (**non-preferred**) and may contain some **generic drugs**.

Any **deductible**, **copayment** and/or **coinsurance** amount for **covered drugs** on each drug tier is shown on your **SUMMARY OF BENEFITS**.

Covered Drugs

Diabetes Supplies for Diabetes Care

Covered services include **medically necessary** items of diabetes supplies and blood glucose monitors (including non-invasive monitors and monitors for the blind) for which a **physician** or other provider has written a **prescription order**.

A separate **copayment/coinsurance and any deductibles** will apply to each fill of a prescription purchased on the same day for insulin and insulin syringes.

Emergency Refills of Insulin or Insulin-Related Equipment and Supplies

Covered services include emergency refills of prescription **insulin** or **insulin-related equipment or supplies** without the authorization of the prescribing **provider** in the following situations:

- The pharmacist is unable to contact your **provider** after reasonable effort
- The pharmacist has documentation showing the patient was previously prescribed **insulin** or **insulin-related equipment or supplies** by a **provider**
- The pharmacist assesses the patient to determine whether the emergency refill is appropriate
- The amount of an emergency refill will be the smallest available package and will not exceed a 30-day supply

In addition to the **GLOSSARY** section of this benefit booklet, the following definitions apply to this section:

Insulin means an insulin analog and an insulin-like medication, regardless of the activation period or whether the solution is mixed before the prescription is dispensed.

Insulin-Related Equipment or Supplies means needles, syringes, cartridge systems, prefilled pen systems, glucose meters, continuous glucose monitor supplies, and text strips but does not include insulin pumps.

Injectable Drugs

Covered services include injectable drugs approved by the FDA for self-administration. **Benefits** will not be provided under **PHARMACY BENEFITS** for any self-administered drugs dispensed by a **physician**.

Insulin Drug Program

The total amount you may pay for up to a 30-day supply of a **covered drug** that contains insulin and is used to treat diabetes will not exceed the amount shown on your **SUMMARY of BENEFITS**. This is regardless of the

amount or type of insulin needed to fill the prescription order. The preferred insulin drugs are identified on your **drug list** and do not include an insulin drug administered intravenously.

Insulin drugs obtained from a **non-participating pharmacy** or not identified as a preferred **insulin** drug may be subject to your cost share, if applicable.

Exceptions will not be made for drugs not identified as a preferred **insulin** drug or for an excluded drug.

Preventive Care

Prescription and over-the-counter drugs which have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF") or as required by state law will be covered and will not be subject to any **copayment**, **coinsurance**, **deductible** or dollar maximums when obtained from a **participating pharmacy**.

Select Vaccinations Obtained Through Certain Participating Pharmacies

Benefits for select vaccinations, as shown on your **SUMMARY OF BENEFITS**, are available through certain **participating pharmacies** that have contracted with us to provide this service.

To locate one of these contracting **participating pharmacies** in the **pharmacy vaccine network** in your area, and to determine which vaccinations are covered under this **benefit**, you may access our website at www.bcbstx.com or call us.

Each **participating pharmacy** in the **pharmacy vaccine network** that has contracted with us to provide this service may have:

- Age
- Scheduling
- Other requirements may apply, so you are encouraged to contact them in advance

Childhood immunizations subject to state regulations are not available under this **pharmacy benefit**. Please refer to the **COVERED SERVICES,** section available childhood immunizations **benefits**.

Selecting a Pharmacy

Extended Prescription Drug Supply Program

Your coverage includes **benefits** for up to a 90-day supply of maintenance type drugs purchased from a **participating pharmacy** contracted with us to take part in our extended retail prescription drug supply program. See your **SUMMARY OF BENEFITS** for your cost information.

We will not provide **benefits** for more than a 30-day supply of drugs or diabetic supplies purchased from a **participating pharmacy** in the extended prescription drug supply program.

Mail-Order Program

The mail-order program provides delivery of **covered prescription drugs** directly to your home address. If you and your covered **dependents** choose to use the mail-order service, refer to your **SUMMARY OF BENEFITS** for applicable payment levels.

Some drugs may not be available through the mail-order program. If you have any questions about this mail-order program, need help in determining the amount of your payment, or need to obtain the mail-order prescription form, you may access the website at www.bcbstx.com or contact Customer Service. Mail the completed form, your **prescription order(s)** and payment to the address indicated on the form.

Participating Pharmacy

You can go to any **participating pharmacy**. Your **copayment**/**coinsurance** will be less when using a **preferred participating pharmacy**.

Prescription Drugs Purchased Outside of the Service Area

Covered **prescription drugs** you purchase outside of the **service area:**

- You must submit a completed claim form within 90 days from date of purchase
- We will reimburse you for the **allowable amount** less than the out-of-area drug **copayment/coinsurance** amount.

Specialty Pharmacy Program

This program provides delivery of covered prescription drugs directly to your **health care provider**, administration location or to your home if you are undergoing treatment for a complex medical condition. To determine which drugs are specialty drugs, you should refer to the plan's website at https://www.bcbstx.com/tx/documents/rx-drugs/specialty-drug-tx.pdf or by contacting customer service at the toll-free number on your **identification card**.

In order to receive maximum coverage and the lowest cost to you, you should obtain the **specialty drugs** from a preferred **specialty pharmacy provider**. When you obtain specialty drugs from a preferred **specialty pharmacy provider**, coverage will be provided according to the Specialty Pharmacy Program in your **Summary of Benefits** section of this benefit booklet.

Coverage for **specialty drugs** is limited to a 30-day supply. However, some **specialty drugs** have FDA approved dosing regimens exceeding the 30-day supply limits and you may be allowed more than a 30-day supply, if allowed by your **plan**. Cost share will be based on day supply (1-30-day supply, 31-60-day supply, 61-90 day supply) dispensed.

MedsYourWay™

MedsYourWay™ ("MedsYourWay") may lower your out-of-pocket costs for select **covered drugs** purchased at select retail **participating pharmacies**. MedsYourWay is a program that automatically compares available drug discount card prices and prices under your **benefit plan** for select **covered drugs** and establishes your out-of-pocket cost to the lower price available. At the time you submit or pick up your prescription, present your **identification card** to the pharmacist. This will identify you as a **participant** in MedsYourWay and allow you the lower price available for select **covered drugs**.

The amount you pay for your **prescription** will be applied, if applicable, to your **deductible** and **out-of-pocket maximum**. Available select **covered drugs** and drug discount card pricing through MedsYourWay may change occasionally. Certain restrictions may apply, and certain **covered drugs** or drug discount cards may not be available for the MedsYourWay program. You may experience a different out-of-pocket amount for select **covered drugs** depending upon which retail **pharmacy** is utilized.

For additional information regarding MedsYourWay, please contact a Customer Service representative at the toll-free telephone number on the back of your **identification card** or access Blue Access for Members℠ (BAM).

Participation in MedsYourWay is not mandatory and you may choose not to participate in the program at any time by contacting your customer service representative at the toll-free telephone number on the back of your **identification card** or access Blue Access for Members℠ (BAM).

In the event MedsYourWay fails to provide, or continue to provide, the program as stated, there will be no impact to you. In such an event, you will pay the amount shown on your **SUMMARY OF BENEFITS**.

Member Pay the Difference

You may not be required to pay the difference in cost between the **allowable amount** of the **brand name drug** and the **allowable amount** of the **generic drug** if there is a medical reason you need to take the **brand name drug** and certain criteria are met. Your **provider** can submit a request to waive the difference in cost between the **allowable amount** of the **brand name drug** and of the **allowable amount** of the **generic drug**. In order for this request to be reviewed, **provider** must send in a MedWatch form to the FDA to let them know the issues you experienced with the **generic drug**. Your **provider** must provide a copy of this form when requesting the waiver. The FDA MedWatch form is used to document adverse events, therapeutic inequivalence/failure, product quality problems, and product use/drug error. This form is available on the FDA website. If the waiver is granted, applicable **copayments** and/or **coinsurance amounts** after your **deductible** will still apply.

If a **covered drug** was paid for using any third-party payments, financial assistance, discount, product voucher, or other reduction in out-of-pocket expenses made by you or on your behalf, that amount will be applied to your cost-sharing requirements (including **deductible**, **copayment**, or out-of-pocket maximum).

About Your Benefits

Covered Drug List

We select the drugs listed on the **drug list** based upon the recommendations of a committee, which is made up of **physicians** and pharmacists from across the country, some of whom are affiliated with us. The committee considers existing drugs approved by the FDA, as well as those newly FDA approved for inclusion on the **drug list**. Entire drug classes are also regularly reviewed. Changes to the **drug list** that could have an adverse financial impact to you (i.e., drug exclusion, drug moving to higher payment tier, or drugs requiring step therapy or **prior authorization**) occur with 60-days advance notice prior to coverage renewal annually upon coverage renewal consistent with Texas law. Newly marketed drugs may not be covered until the committee has had an opportunity to evaluate them. Some of the factors committee members evaluate include:

- Each drug's safety
- Effectiveness

- Cost
- How it compares with drugs currently on the **drug list**

We will make the **drug list** and any changes available to you. You can find your **drug list** at https://www.bcbstx.com/rx-drugs/drug-lists/drug-lists or call us to determine the **drug list** that applies to you and whether a particular drug is on the **drug list**.

NOTE: Prescription drugs that are approved by the FDA through the accelerated approval program may be considered **experimental/investigational** and may not be covered.

Drug List Exception Requests

You, or your **provider**, can ask for a **drug list** exception if your drug is not on the **drug list**. To request this exception, your **provider** can call the number on the back of your **identification card** to ask for a review. We will conduct a review and notify you and your prescribing **provider** of the coverage decision within 2 business days after they receive your request for standard review.

If you have a health condition that may jeopardize your life, health, or keep you from regaining function, or your current drug therapy uses a **non**-**covered prescription drug**, your **provider**, may be able to ask for an expedited review process. Otherwise:

- We will let you, and your **provider**, know the coverage decision within:
    - 24 hours after they receive your request for an expedited review.
    - 72 hours after they receive your request for a standard review.
- If the coverage request is denied, we will let you and your **provider** know why it was denied and offer you a covered alternative drug (if applicable).

If your exception is denied, you may appeal the decision according to the appeals process you will receive with the denial determination. You have the right to seek review by an Independent Review Organization as described in the **How to Appeal a Final Internal Adverse Determination to an Independent Review Organization (IRO)** subsection. Call us if you have any questions.

Day Supply

Benefits for **covered drugs** are provided up to the maximum day supply limit as indicated on **SUMMARY OF BENEFITS**. We have the right to determine the day supply. Payment for **covered drugs** under this **plan** may not be paid if drugs are dispensed or delivered in a way intended to change the maximum day supply limit. Some drugs covered under your plan may be subject to certain supply/fill limitations pursuant to diagnoses or new-to-therapy requirements, plan design, and/or state or federal regulations. For specific drug/fill information, please call the customer service toll-free number located on your **identification card**.

Coverage for **specialty drugs** is limited to a 30-day supply. However, some **specialty drugs** have FDA approved dosing regimens exceeding the 30-day supply limits and you may be allowed more than a 30-day supply, if allowed by your **plan**.

Prescription Refills

You may obtain prescription drug refills from any **pharmacy**. Once every 12 months, you will be able to synchronize the start time of certain **covered drugs** used for treatment and management of a chronic illness, so they are refilled on the same schedule for a given time period. When necessary to fill a partial **prescription order** to permit synchronization, we will prorate the **copayment** and/or **coinsurance** amount due for **covered drugs** based on the proportion of days the reduced **prescription order** covers to the regular day supply outlined in your **SUMMARY OF BENEFITS**.

Refills for prescription eye drops to treat a chronic eye disease or condition will be refilled if:

- The original **prescription order** states that additional quantities of the eye drops are needed
- The refill does not exceed the total amount of dosage units authorized by the prescribing **provider** on the original **prescription order**, including refills
- The refill is dispensed on or before the last day of the prescribed dosage period

The refills are allowed:

- Not earlier than the 21st day after the date a **prescription order** for a 30-day supply is dispensed
- Not earlier than the 42nd day after the date a **prescription order** for a 60-day supply is dispensed
- Not earlier than the 63rd day after the date a **prescription order** for a 90-day supply is dispensed

Covered prescription contraceptives include:

- Initial 3-month supply at once
- Up to a 12-month supply for subsequent refills at once
- 12-month maximum supply during each 12-month period

Dispensing Limits

Dispensing limits are based upon FDA dosing recommendations and nationally recognized guidelines. Coverage limits are placed on drugs in certain drug categories. Limits may include:

- Amount of **covered drug** per prescription
- Amount of **covered drug** in a given time period
- Coverage only for **participants** within a certain age range

Quantities of some drugs are restricted regardless of the amount ordered by the **provider**.

If you require a **prescription order** the dispensing limit established by us, ask your **provider** to submit a request for clinical review on your behalf. The **provider** can obtain an override request form by accessing our website at www.bcbstx.com. Any pertinent medical information along with the completed form should be sent to **clinical pharmacy programs** as indicated on the form. The request will be approved or denied after evaluation of the submitted clinical information. We have the right to determine dispensing limits. Payment for **benefits** covered under this **plan** may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or bypassing, the stated maximum amount limitation. If your dispensing limit request is denied, you will be responsible for the full cost of the prescription beyond what your coverage allows.

Non-participating pharmacies do not file your claims electronically and, therefore, will not have this online messaging. Should you choose to have your **prescription order** filled at a non-**participating pharmacy**, it is important that you know **prescription orders** obtained through a non-**participating pharmacy** may be denied for reimbursement based upon this criteria.

Multi-Category Split Fill Program

If this is your first time using select drugs in certain drug classes (e.g., drugs for cancer, multiple sclerosis, lung disorders, etc.) or if you have not filled one of these drugs within 120 days, you may only be able to receive a partial fill (14-15 day supply) of the drug for up to the first 3 months of therapy. This is to help see how the drug is working for you. Your **copayment** and/or **coinsurance** after your **deductible** will be adjusted to align with the amount of drug dispensed. If the drug is working for you and your **provider** wants you to continue on this drug, you may be eligible to receive up to a 30-day supply after completing up to 3 months of the partial supply. For a list of drugs that are included in this program, please visit www.bcbstx.com/prescription-drugs/managing-prescriptions/drug-lists

Controlled Substance Limits

If we determine that you may be receiving quantities of a **controlled substance** not supported by FDA approved dosages or recognized safety or treatment guidelines, any coverage for additional drugs may be subject to review to assess whether **medically necessary** or appropriate. Restrictions may include but not be limited to a certain **provider**, **pharmacy**, quantity, and/or day supply for the prescribing and dispensing of the **controlled substance**.

Therapeutic Equivalent Restrictions

Some drugs have therapeutic equivalents/ therapeutic alternatives. In some cases, we may limit **benefits** to only certain therapeutic equivalents/ therapeutic alternatives. If you do not choose the therapeutic equivalents/therapeutic alternatives that are covered under your **plan**, the drug purchased will not be covered under any benefit level.

Step Therapy

Coverage for certain designated **prescription** drugs or drug classes may be subject to a step therapy program. Step therapy programs favor the use of clinically acceptable alternative drugs before other agents will be covered.

When you submit a **prescription order** to a **participating pharmacy** for one of these designated drugs, the pharmacist will be alerted if the online review of your **prescription** claims history indicates an acceptable alternative drug has not been previously tried. A list of step therapy drugs is available to you and your **provider** on our website at www.bcbstx.com.

If it is **medically necessary**, coverage can be obtained for the **prescription drugs** subject to the **step therapy program** without trying an alternative drug first. In this case, your provider must contact us to obtain **prior authorization** for coverage of such drug. If authorization is granted, the provider will be notified and the drug will then be covered at the applicable **copayment**.

Although you may currently be on a drug that is part of the step therapy program, your claim may need to be reviewed to see if the criteria for coverage of further treatment has been met. A documented treatment with a therapeutic alternative medication may be required for continued coverage of the targeted drug.
Step therapy programs do not apply to prescription drug treatment for the treatment of **stage-four advanced, metastatic cancer** or **associated conditions**.

Coverage for prescription drug treatment for **stage-four advanced, metastatic cancer** or **associated conditions** do not require you to fail to successfully respond to a different drug or provide a history of failure of a different drug, before providing coverage of a prescription drug. This applies only to a prescription drug treatment that is consistent with best practices for the treatment of **stage-four advanced, metastatic cancer** or an **associated condition**; supported by peer-reviewed, evidence-based literature; and approved by the FDA.

For treatment of **mental health condition** for **members** 18 years or older, for **covered drugs** approved by the FDA will not require that the **member**:

- Fail to successfully respond to more than one different drug for each drug prescribed, excluding the generic or pharmaceutical equivalent of the prescribed drug
- Prove a history of failure of more than one different drug for each drug prescribed, excluding the generic or pharmaceutical equivalent of the prescribed

Step Therapy may be required for a trial of generic or pharmaceutical equivalent of a prescribed prescription drug as a condition of continued coverage of the prescribed drug only:

- Once in a **plan** year
- If the generic or equivalent drug is added to the **plan's drug list**

In addition to the **GLOSSARY** section of this benefit booklet, the following definitions are applicable to this ***s*tep therapy** benefit:

Stage-Four Advanced, Metastatic Cancer means a cancer that has spread from the primary or original site of the cancer to nearby tissues, lymph nodes, or other areas or parts of the body.

Associated Conditions means the symptoms or side effects associated with **stage-four advanced, metastatic cancer** or its treatment and which, in the judgment of the **provider**, further jeopardize the health of a patient if left untreated.

Step Therapy Exception Requests

Your prescribing **physician** or other provider may submit a written request for an exception to the step therapy requirements. The step therapy exception request will be considered approved if we do not deny the request within 72 hours after receipt of the request. If your prescribing **physician** or other provider believes that denial of the step therapy exception request could cause you serious harm or death, submission of the request with "Urgent" noted and documenting these concerns will be considered approved if we do not deny the request within 24 hours after receipt of the request. If your step therapy exception request is denied, you have the right to request an expedited internal appeal and have the right to request review by an Independent Review Organization as explained in the **Review of Claim Determinations** subsection of this **benefit booklet**.

Prior Authorization

We require **prior authorization** before select prescription drugs are covered under your **benefits** to ensure that the drug is:

- Safe
- Effective
- Part of a specific treatment **plan**

When you submit a **prescription order** to a **participating pharmacy** for one of these designated drugs, the pharmacist will be alerted online if your **prescription order** is on the list of drugs which requires **prior authorization** before it can be covered. If this occurs, your **provider** will be required to submit an authorization form. This form may also be submitted by your **provider** in advance of the request to the **pharmacy**. The **provider** can obtain the authorization form by accessing our website at www.bcbstx.com. The requested drug may be approved or denied for coverage under the **plan** based upon its accordance with established clinical criteria.

Prior authorization will not be required more than once annually for **covered drugs** used to treat an autoimmune disease, hemophilia or Von Willebrand disease, except for:

- Opioids, benzodiazepines, barbiturates, or carisoprodol
- Prescription drugs that have a typical treatment period of less than 12 months
- Used in a manner other than the FDA approved use
- Drugs that:
    - Have an FDA boxed warning for use
    - Must have specific provider assessment

Right of Appeal

In the event that a requested **prescription order** is denied on the basis of:

- Dispensing limits
- Step therapy criteria
- **Prior authorization** criteria with or without your provider having submitted clinical documentation

You have the right to appeal as explained under the **REVIEW OF CLAIM DETERMINATIONS** subsection of this benefit booklet.

PHARMACY MEDICAL LIMITATIONS AND EXCLUSIONS

Limitations and Exclusions

Pharmacy benefits are not available for:

- New to market FDA approved drugs which have not been reviewed by us prior to coverage of the drug.
- Non-FDA approved drugs.
- **Legend Drugs** which do not by law require a **prescription drug order**, except as indicated under **Preventive Care** in **PHARMACY BENEFITS**, from a physician or authorized provider (except **insulin**, **insulin** analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and select vaccinations administered through certain participating pharmacies as shown on your **SUMMARY OF BENEFITS**); and legend drugs or covered devices for which no valid **prescription order** is obtained. Prescription drugs if there is an over-the-counter product available with the same active ingredient(s) in the same strength. 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.
- Drugs, that the use, or intended use of, would be illegal, unethical, imprudent, abusive, not **medically necessary**, or otherwise improper.
- Drugs obtained by unauthorized, fraudulent, abusive, or improper use of your **identification card**.
- Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction that is not covered under BCBS, or for which **benefits** have been exhausted.
- 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, custodial or chronic care institution, or facility.
- Drugs for which the **pharmacy's** usual retail price to the general public is less than, or equal to, the **copayment**.
- Drugs purchased from a non-**participating pharmacy** in the **service area**, except as provided in the **Clinician-Administered Drugs** section under **COVERERED SERVICES**.
- Devices, technologies, and/or **durable medical equipment** (DME) of any type (even though such devices may require a **prescription drug order**), such as, but not limited to, therapeutic devices, including support garments and other non-medicinal substances, artificial appliance, digital health technologies and/or applications, or similar devices (except disposable hypodermic needles, and syringes for self-administered injections and contraceptive devices). Coverage for contraceptive devices and the rental (or, our option the purchase) of manual or electric breast pumps
- Pharmaceuticals 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 agent.
- Contraceptive devices, including over-the-counter contraceptive products such as spermicide.
- Any special services provided by a **pharmac**y, including but not limited to counseling and delivery.
- Drugs dispensed in quantities in excess of the day supply amounts indicated under the **SUMMARY OF BENEFITS** section, or refills of any prescriptions in excess of the number of refills specified by the provider or by law, or any drugs or medicines dispensed more than one (1) year after the **prescription order** date.
- Administration or injection of any drugs.
- Injectable drugs except self-administered **specialty drugs** or those approved by the FDA for self administration.
- Compounded drugs which do not meet the definition of **compound medications**. 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.)

- Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used, or intended to be used, by intravenous, intramuscular unless approved by the FDA for self-administration, intrathecal, intraarticular injection or gastrointestinal (enteral) infusion in the home setting. Note: this exclusion does not apply to formulas covered under the **Nutritional Support** subsection of **PHARMACY BENEFITS**. A **prescription order** from your **provider** is required.
- Vitamins (except those vitamins which by law require a **prescription order** and for which there is no non-prescription alternative or as indicated in **Preventive Care** under the **PHARMACY BENEFITS** section.).
- Allergy serum and allergy testing materials. However, you do have certain **benefits** available under **Allergy Care** within the **COVERED SERVICES** section.
- Athletic performance enhancement drugs.
- Bulk powders.
- Surgical supplies.
- Ostomy products.
- Diagnostic agents. This exclusion does not apply to diabetic test strips.
- Drugs used for general anesthesia.
- Rogaine, minoxidil or any other drugs, medications, solutions, or preparations used, or intended for use, in the treatment of hair loss, hair thinning, or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.
- Any prescription antiseptic or fluoride mouthwashes, mouth rinses or topical oral solutions or preparations.
- Fluoride supplements, except as required by law.
- Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
- Retin A or pharmacologically similar topical drugs.
- Drugs prescribed and dispensed for the treatment of obesity, or for use in any program of weight reduction, weight loss, or dietary control.
- Drugs to treat sexual dysfunction, including, but not limited to, sildenafil citrate, phentolamine, apomorphine, and alprostadil in oral and topical form.
- **Prescription orders** which do not meet the required step therapy criteria.
- **Prescription orders** which do not meet the required prior authorization criteria.
- Some drugs are manufactured under multiple names and have many therapeutic equivalents. In such cases, we may limit **benefits** to specific therapeutic equivalents. If you do not accept the therapeutic equivalents that are covered under this **plan**, the drug purchased will not be covered under any benefit level.
- Specialty Drugs, unless obtained through the **Specialty Pharmacy Provider.**
- Replacement of drugs or other items that have been lost, stolen, destroyed, or misplaced.
- Shipping, handling, or delivery charges.
- Certain drug classes where there is an over-the-counter alternative available.
- Brand name proton pump inhibitors.
- Non-sedating antihistamine drugs and combination medications containing a non-sedating antihistamine and decongestant, including, but not limited to, Allegra, Claritin, Clarinex, or Zyrtec.
- **Prescription orders** written by a member of your immediate family, or a self-prescribed **prescription order**.

- Repackages, institutional packs, clinic packs, or other custom packaging.
- Drugs determined to have inferior efficacy or significant safety issues.
- Self-administered drugs dispensed or administered by a **physician** in his/her office.
- Drugs that are not considered **medically necessary**, or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines.
- Drugs/products which are not included on the **drug list**, unless specifically covered elsewhere under the **certificate** of coverage, and/or such coverage is required in accordance with applicable law or regulatory guidance.

UTILIZATION MANAGEMENT

Utilization Management

Utilization management may be called a **medical necessity** review, which is used for a procedure, service, inpatient admission, and/or length of stay and is based on **HMO medical policy** and/or level of care review criteria.

Medical Necessity reviews may occur:

- Prior to care, before the start of services (**prior authorization**)
- During care (concurrent review)
- Completed after care (post-service medical necessity review)

Please refer to **medical necessity** or **medically necessary** in the **GLOSSARY** section of this **benefit booklet** for additional information regarding any limitations and/or special conditions pertaining to your **benefits**.

Prior Authorization

You need pre-approval from us for some covered services. Another term for pre-approval is prior authorization. This ensures that certain covered services are not denied based on medical necessity or experimental/investigational.

Prior authorization requires the **provider** to get approval from us before you are admitted to the hospital or for certain types of **covered services**. Renewal of an existing **prior authorization** issued by us may be requested by a **provider** up to 60 days prior to the expiration of the existing **prior authorization**.

For additional information and a current list of medical and health care services that require **prior authorization**, please visit the website at www.bcbstx.com.

Upon receipt of a request for **prior authorization from a provider**, we shall review and issue a determination:

- Not later than the 3rd calendar day after receipt by us for non-hospitalization care
- Within 24 hours of receipt for inpatient and concurrent hospitalization care
- Within one hour of receipt if the proposed services involve post-stabilization treatment or a **life-threatening disease or condition**.
- Some Texas-licensed **providers** may qualify for an exemption from **prior authorization** requirements for a particular health care service if the **provider** met criteria set forth by applicable law for the particular health care service. If so, **prior authorization** is not required for a particular service where an exemption applies and will not be denied based on **medical necessity** or medical appropriateness of care. Other **providers** providing your care may not be exempt from such requirements. Exemptions do not apply for services that are materially misrepresented or where the **provider** failed to substantially perform the particular service.

Prior authorization does not guarantee payment of **benefits**. For additional information and a current list of medical and health care services that require **prior authorization**, please visit the website at www.bcbstx.com/find-care/where-you-go-matters/utilization-management

Length of Stay/Service Review

Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions under this plan.

A length of service review/concurrent **medical necessity** review means you, your provider, or other authorized representative submits a request to extend care beyond the approved time limit. The HMO will provide a decision within the timeframes described under the **Review of Claim Determinations** section.

An extension of a previously approved length of stay/service will be based solely on whether continued Inpatient care or other health care services are **medically necessary**. If the extension is determined not to be **medically necessary**, the coverage for the length of stay/service will not be extended, except as otherwise described under the **COMPLAINT AND APPEAL PROCEDURES** section.

Recommended Clinical Review Option

A **recommended clinical review is:**

- An optional voluntary **medical necessity** review for a **covered service** that does not require a **prior authorization.**
- Occurs before, during or after services are completed.
- Limits situations where you must pay for a non-approved service.

To determine if a **recommended clinical review** is available for a specific service, please visit our website at www.bcbstx.com/find-care/where-you-go-matters/utilization-management for the **recommended clinical review** list.

If a **recommended clinical review** determines the proposed services are not **medically necessary**, you have the right to file an appeal as described under the **CLAIM FILING AND APPEALS PROCEDURES** section. All appeal and review requirements related to **medical necessity** determinations, including independent review, apply to services where your **provider** requests a recommended clinical review.

Contacting Medical and Behavioral Health

You may contact us for a **prior authorization or recommended clinical review** by calling the toll-free telephone number on the back of your **identification card** and following the prompts to the medical or **behavioral health** unit or via the member portal.

Post-Service Medical Necessity Review

A **post-service medical necessity review** maybe referred to as a retrospective review or post-service claims request and determines:

- Your eligibility
- Availability of **benefits** at the time of service
- Medical necessity

Post-Service Medical Necessity Review means the process of determining coverage after treatment has already occurred and is based on **medical necessity** guidelines. Can also be referred to as a retrospective review or post- service claims request.

Note: No provision found in the above sections guarantees payment of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions under your **plan**.

CLAIM FILING AND APPEAL PROCEDURES

Our Receipt of Claims

A claim will be considered received by us for processing upon actual delivery to our **administrative office** in the proper manner and form and with the required information. If the claim is not complete, it may be denied, or we may contact either you or the **provider** for additional information.

Once the claim has been processed, we will notify you with an **explanation of benefits**.

Review of Claim Determinations

Claim Determinations

When we receive a properly submitted claim, we have authority and discretion under the **plan** to interpret and determine **benefits** in accordance with the **plan's** provisions. You have the right to a review by us of any determination of a claim, a request for **prior authorization**, or any other determination made by us concerning your **benefits** under the **plan**.

Note: If we are going to discontinue coverage of prescription drugs or intravenous infusions that you are receiving, we will notify you at least 30 days before the date coverage will be discontinued.

Timing of Required Notices and Extensions

There are four types of claims as defined below:

- **Urgent care clinical claim** means any pre-service claim that requires **prior authorization**. If it is for medical care of treatment and your **physician** determines that a delay in getting medical care or treatment could put your life or health at risk; or delay might put your ability to regain maximum function at risk. It could also be a situation in which you need care to avoid severe pain that cannot be adequately managed without the care or treatment.

  For **urgent care clinical claims**, you should call us (at the toll-free number listed on the back of your **identification card**) as soon as possible. You do not need to submit **urgent care clinical claims** in writing.
- **Pre-Service Claim** means any non-urgent request for **benefits** that involves services you have not yet received and requires **prior authorization**.

  This period may be extended one time by us for up to 15 days, if we do both:
  - Determines that such an extension is necessary due to matters beyond the control of the **plan.**
  - Notify you, prior to the expiration of the initial 15 day period, of the circumstances requiring the extension of time and the date by which we expect to render a decision.

  If additional information is necessary to decide the claim, the time period for making the decision is suspended from the day you are notified to the earlier of:
  - The date of which your response is received by BCBS
  - The date established by us for the furnishing of the requested information (at least 45 days).
- **Post-Service Claim** means notification in a form acceptable to us that a service has been rendered or furnished to you.

  This notification must include full details of the service received, including:
  - Your name, age and gender

- Identification number
- Name and address of the **provider**
- An itemized statement of the service rendered or furnished
- Date of service
- Diagnosis
- Claim charge
- Any other information which we may request in connection with services rendered to you.

This period may be extended onetime by us for up to 15 days, if we do both:

- Determines that such an extension is necessary due to matters beyond the control of the **plan**.
- The date established by us for the furnishing of the requested information (at least 45 days).

- **Concurrent Care** claims means determinations is relating to care that is being received at the same time as the determination. The notice will be provided no later than 24 hours after receipt of your claim.

Type of Notice (Claim) or Extension	Time Period
Urgent Care Clinical Claim	
If your claim is incomplete, we must notify you within:	24 hours
If you are notified that your claim is incomplete, you must provide information to complete your claim to us within:	48 hours after receiving notice
We 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 emergencies), but no later than:	72 hours
After receiving the completed claim (if the initial claim is incomplete), within:	48 hours
Pre-Service Claims	
If your claim is filed improperly, we must notify you within:	5 days
If you claim is incomplete, we must notify you within:	15 days
If your claim is incomplete, you must then provide completed claim information to us within:	45 days after receiving notice
We must notify you of any adverse claim determination:	
If the initial claim is complete within:	15 days
If the initial claim is incomplete within:	30 days
If post-stabilization care is required after an emergency, within:	The time appropriate to the circumstance not to exceed one hour after the time of request

Type of Notice (Claim) or Extension	Time Period
Post-Service Claims (Retrospective Review)	
If your claim is incomplete, you will be notified within:	30 days after claim is received
After receiving the completed claim (if the initial claim was incomplete) within:	45 days after receiving notice
Concurrent Care Claim	
We will notify you of our determination for such a request within:	24 hours after receipt of your claim for **benefits**

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 us with the following information, if applicable:

- Reason for the determination
- A reference to the **benefit plan** provisions, or the contractual, administrative or protocol for the determination
- A description of additional information necessary and an explanation of why it is necessary
- Subject to privacy laws and other restrictions, if any:
  - Identification of the claim
  - Date of service
  - Health care **provider**
  - Claim amount (if applicable)
  - Statement describing denial codes with their meanings and standards used.
  - Diagnosis/treatment codes with their meanings and the standards used (upon receipt)
- An explanation of the **claim administrator's** internal review/appeals and external review processes (and how to initiate a review/appeal or external review).
- 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
- A statement in non-English languages(s) that written notices 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 languages(s) that indicates how to access the language services provides by us (in certain situations)
- Copy of all documents, records, and other information relevant to the claim (provided free of charge on request)
- Copy of rule, guideline, protocol or other similar criterion (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.
- **Experimental/ investigational** treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request (if the denial was based on **medical necessity**).
- Urgent care clinical claims:
  - Description of the expedited review procedure applicable.

- Decision may be provided orally, so long as a written notice is given to the claimant within 3 days of verbal notification.
- Contact information for applicable office of health insurance consumer assistance or ombudsman (as appropriate).

Claim Appeal Procedures

Claim Appeal Procedures - Definitions

Adverse Benefit Determination means our determination that the health care services you have received, or may receive are:

- **Experimental / investigational**
- Not **medically necessary** nor appropriate

An **adverse determination** includes a denial, reduction or termination of a **benefit**, a pre-service claim, urgent care clinical claim, and a benefit resulting from a utilization review, treatment previously approved being reduced or terminated, or not paying (in whole or in part) for a benefit or claim.

Final Internal Adverse Benefit Determination means an **adverse benefit determination** that has been upheld by us or your **employer:**

- Completion of BCBS or your **employer's** internal review/appeal process.

Expedited Clinical Appeals

Expedited clinical appeal is an appeal of a clinically urgent nature related to health care services, including but not limited to:

- Ongoing emergencies
- Procedures or treatments ordered by a health care **provider**
- Continued hospitalization

Appeal Process	Time Period
Prior to an authorization for a current course of treatment or continued hospitalization is terminated or reduced, we will send you a notice within 24 hours giving you an opportunity to appeal.	During the review process, coverage for the ongoing course of treatment will continue.
Concurrent Clinical appeal or **pre-service appeal**	Within 24 hours of the appeal's receipt, we will tell you if more information is needed to complete our review. Within 24 to 72 hours, depending on the immediacy of the condition, we will let you know our decision.

How to Appeal an Adverse Benefit Determination

You have the right to have an internal review for you following:

- Any determination of a claim
- Any determination of a request for **preauthorization**
- Any other determination made by the **claim administrator** in accordance with the **benefits** and procedures

You, or an authorized representative may act on your behalf, and file an **adverse benefit determination** appeal. In urgent care clinical claim situations your **provider** may appeal on your behalf. If you choose an authorized representative, we must be notified in writing. To obtain an authorized representative form, you or your representative may call us at the number on the back of your **identification card**.

If you believe we incorrectly denied all or part of your **benefits**, you may have your claim reviewed. We will review its decision in accordance with the following procedure:

- You must file an appeal within 180 days from the time you receive a notice of a denial or partial denial. You may call or write to the **claim administrator's** administrative office with your reason for making the appeal. We will take your information when you call us. However, a call request will not constitute a request for review. Send your written request to:

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

The review of our decision will take place as follows:

Appeal Process	Time Period
You may present evidence and testimony in support of your claim.	Within 180 calendar days or during the review process
You may review your claim file and relevant documents. You may submit written issues, comments, and additional medical information.	Within 180 calendar days or during the review process
We will give you any new or additional information we use to review your claim before the date a final decision on the appeal is made. To allow you an opportunity to respond before the final determination is made.	Within 180 calendar days or during the review process
The review and decision of your appeal will be made by personnel not involved in making the initial adverse decision.	During the review process
If the initial adverse decision was based on a medical result, the review will be made by a **physician** associated or contracted with us, and/or by external advisors, who were not involved in the initial Adverse Benefit Determination.	During the review process
Non-urgent concurrent or **pre-service appeal**, within	30 days upon receipt of the appeal
Non-urgent **post-service appeal**, within	60 days upon receipt of the appeal

If You Need Assistance

If you have any questions about the claims procedures or the review procedure, write or call the **claim administrator** headquarters at 1-800-521-2227. Our **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

Notice of Appeal Determination

We will provide you a written notice of our appeal determination. If your appeal is a clinical appeal, the health care **provider** who recommended the services involved will receive the appeal determination.

The written notice to you includes:

- The reason for the determination, including the guidelines used in denying the claim and a discussion of the decision, **benefit plan** provisions, contractual, administrative, or procedure basis.
- 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 – subject to privacy laws and other restrictions, if any. Upon request, diagnosis/treatment codes with their meanings and the standards used.
- An explanation of the **claim administrator's** external review process (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 internal review.
- If available, and upon request, a document in non-English language(s)showing how to access the language services provided by the **claim administrator**, including a written notice of claim denials and certain other benefit information.
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information related to claim for **benefits**.
- Any internal rule, guideline, procedure, or other similar reasons relied upon in the determination, and instructions on getting a copy of these, upon request, without any cost to you.
- An explanation of the scientific or clinical decision relied upon in the determination, or instructions on getting a copy of the explanation, upon request, without any cost to you.
- A description of the standard that was used in denying the claim and discussion of the decision.
- Health Insurance Consumer Assistance Ombudsman contact information (as appropriate).

If we deny your appeal or in part, or you do not receive a timely decision, you may request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the **Standard External Review** section below.

If you need assistance with the internal claims and appeals or the external review processes, 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).

Standard External Review

You or your authorized representative 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).

Request for External Review

You or your authorized representative must file a request for a standard external review within four months after the date of receipt of notice (or 48 hours following the receipt of the notice), whichever is later, to perfect your request. If your claim is not eligible for external review we will provide the following in your notice:

- Outline ineligibility reasons
- Provide the Department of Labor's Employee Benefits Security Administration (toll-free number 1-866-444-EBSA (3272)).

An external review is available for **adverse benefit determinations** and **final adverse benefit determinations** that involve medical judgment including, but not limited to:

- Requirements for **medical necessity**, appropriateness, health care setting and level of care.
- Effectiveness of covered b**enefit.**
- Determinations that a treatment was **experimental/investigational**.
- Determinations you are eligible to a reasonable alternative standard for a reward under a wellness program.
- Determination of compliance with the non-quantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act.

Preliminary review

You will be notified within one business day after the preliminary review is completed if your request is eligible or if additional information is needed. We must complete a preliminary review within five business days of request receipt to determine whether:

- You are, or were, covered under the **plan** at the time the health care item or service was requested.
- The **adverse benefit determination** or the **final adverse internal benefit determination** does not relate to you not meeting the requirements for eligibility under the terms of the **plan** (e.g., worker classification or similar determinations).
- You have exhausted the **claim administrator's** internal appeal process. Unless, you are not required to exhaust the internal appeals process under the interim final regulations.
- You or your authorized representative have provided all the information and forms required to process an external review.

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

An independent review is a review made by an organization independent of us. This is called an **independent review organization (IRO).**

IRO Guidelines:

- When an eligible request for external review is completed within the time period allowed, an IRO will be assigned.
- IRO assigned will be accredited by URAC or similar nationally- recognized accrediting organization.
- IRO will be unbiased and independent.
- We must contract with at least.
- We must contract with at least three IROs for assignments.
- IRO assignments will be rotated or randomly selected.
- IRO may not be eligible for any financial incentives.

IRO Procedures:

- Use of legal experts where appropriate to make coverage determinations.
- Timely notification to you, or your authorized representative in writing, of eligibility and acceptance for external review. This notice will include information that you may submit in writing within 10 business days 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.
- Within five business days after the date of assignment of the IRO, we must provide the IRO document and information considered in the **adverse benefit determination** or **final internal adverse benefit determination.** Failure by us to timely provide the documents and information must not delay the external review. If we fail to timely provide the documents and information, the IRO may terminate the external review and decide to reverse the **adverse benefit determination** or **final internal adverse benefit determination**. Within one business day after making the decision, the IRO must notify BCBS and you or your authorized representative.
- Upon receipt of any you or your authorized representative submit, within one business day the IRO must forward the information to BCBS. Upon receipt of the information, we may reconsider the **adverse benefit determination or final internal adverse benefit determination** that is the subject of the external review. Reconsideration by us must not delay the external review. The external review may be terminated because of the reconsideration only if we decided, 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, we must provide written notice of its decision, we must provide written notice of its decision to you and the IRO. The IRO must terminate the external review upon receipt of notice from BCBS
- Review the information and documents timely received. In reaching a decision, the IRO will review the claim from the beginning and not be bound by any decisions or conclusions reached during our internal claims and appeals process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
    - Your medical records.
    - The attending **health care practitioner's** recommendation.
    - Reports from appropriate **health care practitioners** and other documents submitted by BCBS, you or your treating **provider.**
    - The terms of your **plan** to ensure the IRO's decision is not contrary to the terms of the **plan**, unless the terms are inconsistent with applicable law.
    - 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.

- Any applicable clinical review criteria developed and used by us, unless the criteria are inconsistent with the terms of the **plan** or with applicable law.
- 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.

- 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 BCBS and you or your authorized representative
- The notice of final external review decision will contain:
  - 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.
  - The date the IRO received the assignment to conduct the external review and the date of the IRO decision.
  - References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision.
  - A discussion of the principal reason or reasons for its decisions, including the rational for its decision and any evidence- based standards that were relied on in making its decision.
  - A statement that the determination is binding except to the extent to the extent that other remedies may be available under State or Federal law to either BCBS or you or your authorized representative.
  - A statement that judicial review may be available to you or your authorized representative.
  - Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

After a final external review decision process the IRO must:

- Maintain records of all claims and notices for 6 years
- The records must be available for examination by BCBS, state or federal oversight agency upon request
- Exception is when such disclosure would violate state or federal privacy laws, and you or your authorized representative

Reversal of Our Decision:

- Upon receipt of a notice of a final review decision we must immediately provide coverage or payment (including immediately authorizing or immediately paying **benefits**) for the claim.

Appeal Process	Time Period
STANDARD EXTERNAL REVIEW	
You receive notice of an **adverse benefit determination** or **final internal adverse benefit determination** and must file your request for a standard external review, within	4 months
Preliminary review: The HMO receives your external review request and completes a review to determine whether:	5 business days upon receipt

• You were covered under the **plan** at the time the service was provided • 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 **plan** • You have completed the HMO's internal appeal process (unless You are not required to complete the internal appeals process • You have provided the information and forms required to process an external review	
You will be notified if your request is eligible or if further information or documents are needed. If your claim is not eligible for external review, we will outline the reasons why in the notice.	1 business day
Referral to IRO	
The HMO will assign an eligible request to an IRO.	
EXPEDITED EXTERNAL REVIEW	
You may request an expedited external review with the HMO at the time you receive: • An **adverse benefit determination**, if it involved your medical condition and the timeframe for an expedited internal appeal would seriously jeopardize Your life, health, or Your ability to regain maximum function • A **final internal adverse benefit determination** involved your medical condition and the timeframe for a standard external review would seriously jeopardize Your life, health, or Your ability to regain maximum function, or it 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.	
Preliminary Review: The HMO determines if your request meets the requirements in the	Immediately

preliminary review (above) and will send you a notice of its eligibility determination	
Referral to IRO	
The HMO will assign an eligible request to an IRO and provide all necessary documents and information considered in making the **adverse benefit determination** or **final internal adverse benefit determination**	

In addition to the information contained in the table above:

The 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 a standard review. In reaching a decision, the IRO must review the claim from the beginning and is not bound by any decisions or conclusions reached during our internal claims and appeals process.

Notice of Final External Review Decision

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth in the **Standard External Review** section above, within 72 hours after the IRO receives your request. If the notice is oral, a written notice will be given within 48 hours of the oral notice. The IRO must provide written confirmation of the decision to us and you or your authorized representative.

Exhaustion

For a standard internal review, you have the right to request an external review after the internal review process has been completed and you have received the **final internal adverse benefit determination.** For an expedited internal review, you may request external review at the same time as the request for expedited internal review. The IRO will determine whether your request is appropriate for an expedited external review or if the expedited internal review process must be completed before an external review may be requested.

You will be considered to have exhausted the internal review process and may request an external review if:

- We waive the internal review process.
- We failed to comply with the internal claims and appeals process other than a minor 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 *small* violations that do not cause, and are not likely to cause, prejudice or harm to you so long as we shows that the violation was for good cause or due to matters beyond our control and that the violation occurred in the context of an ongoing, good faith exchange of information between you and BCBS.

An 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.

Interpretation of Employer's Plan Provisions

The **plan administrator** has given us the initial authority to establish or construe the terms and conditions of the **health benefit plan** and the discretion to interpret and determine **benefits** in accordance with the **health benefit plan's** provisions.

The **plan administrator** has all powers and authority necessary or appropriate to control and manage the operation and administration of the **health benefit plan**.

All powers to be exercised by us or the **plan administrator** shall be exercised in a non-discriminatory manner and shall be applied uniformly to assure similar treatment to persons in similar circumstances.

GENERAL PROVISIONS

This section includes:

- The **benefits** you are qualified to receive
- How to get **benefits**
- Your relationship with **hospitals**, **physicians,** and other providers
- Your relationship with us
- Coordination of **benefits** when you have other coverage and reimbursement
- Termination of coverage with us
- Continuation of group coverage

Termination of Coverage

Termination of Individual Coverage

Coverage under the **plan** for you and/or your **dependents** will automatically end when:

- Your part of the group **premium** is not received promptly by us
- You no longer satisfy the definition of an **employee** as defined in this **benefit booklet**, including termination of employment
- The **plan** is ended, or the **plan** is amended, at the direction of the **employer**, to end the coverage of the class of **employees** to which you belong
- A **dependent** ceases to be a **dependent** as defined in the **plan**

However, when any of these events occur, you and/or your **dependents** may be eligible for continued coverage. See **COBRA Continuation Coverage,** in the **GENERAL PROVISIONS** section.

We may refuse to renew coverage of an eligible person, or **dependent** for fraud or intentional misrepresentation of material fact by that individual.

Termination of the Group

The coverage of all **participants** will end if the **group** is stopped in accordance with the terms of the **plan**.

COBRA Continuation Coverage

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), **participants** may have the right to continue coverage, after the date coverage ends. **Participants** will not be eligible for COBRA continuation if the contract holder is exempt from the provisions of COBRA; however, the **participant** may be eligible for State Continuation Coverage.

Minimum Size of Group

The **group** must have normally employed more than twenty (20) employees on a typical business day during the prior **calendar year**. This refers to the number of full-time and part-time **employees** employed, not the number of **employees** covered by a **plan**.

Loss of Coverage

If coverage terminates as the result of termination (other than for wrongdoing) or lowering of employment hours, then the **participant** may elect to continue coverage for eighteen (18) months from the date coverage would otherwise end.

A covered **dependent** may choose to continue coverage for thirty-six (36) months from the date coverage would otherwise end if coverage stops as the result of:

- Divorce
- Subscriber's death
- Subscriber's entitlement to Medicare **benefits**
- A covered **dependent child** no longer meets the **dependent** eligibility requirements

COBRA continuation coverage under this **plan** ends at the earliest of the following events:

- The last day of the continued coverage whether eighteenth (18) month or thirty-sixth (36) month period.
- The first day on which timely payment of contribution is not made subject to the **administrative services agreement.**
- The first day on which the **group agreement** between the **group** and us is not in full force and effect.
- The date the **employer** stops providing any group health **plan** to any **employee.**
- **The** first day on which you are actually covered by any other **group health benefit plan.** In the event you have a preexisting condition and would be denied coverage under the new **health benefit plan** for a preexisting condition, continuation coverage will not be terminated until the last day of the continuation period, or the date upon which the preexisting condition becomes covered under the new **health benefit plan**, whichever occurs first.
- The date you are entitled to Medicare.

Extensions of Coverage Periods

The eighteen (18) month coverage period may be extended if an event which could otherwise qualify a **participant** for the thirty-six (36) month coverage period occurs during the eighteen (18) month period, but in no event may coverage be longer than thirty-six (36) months from the first qualifying event.

Coverage may be extended up to an added eleven (11) months for a total of twenty-nine (29) months for a **participant** who is determined to be disabled as defined under the Social Security Act and the **participant** notifies the **employer** before the end of the initial eighteen (18) month period. This provision is limited to **participants** who are disabled at any time during the first sixty (60) days of COBRA continuation and only if the qualifying event is termination of employment (other than for gross misconduct) or reduction of employment hours.

Responsibility to Provide Participant with Notice of Continuation Rights

The **group** is responsible for providing a 60 day notification to **participants** from the date of the COBRA qualifying event. Which is required by the Consolidated Omnibus Budget Reconciliation Act of 1985, and the Tax Reform Act of 1986.

Responsibility to Pay Contributions to the Claim Administrator

The initial coverage of 60 days will be extended if the subscriber:

- Pay the applicable contribution charges within 45 days of submitting the application to the group
- Group remit that information to us

Contributions due to us for the continuation of coverage shall be due in accordance with the procedures of:

- Administrative services agreement
- Calculated in accordance with applicable federal law and regulations

For additional information regarding your COBRA coverage, please refer to the Continuation Coverage Rights described more fully in the federally mandated COBRA Notice that follows this plan.

Paper Check – Automatic Clearing House/Electronic Funds

We will not charge an additional fee to a **payee** if such person elects to receive the payment by paper check instead of by an automated clearinghouse transaction or other electronic funds transfer.

Payee means individual who resides in this state, or a corporation, trust, partnership, association, or other private legal entity authorized to do business in this state that receives money as payment under an agreement.

Coordination of Benefits

Coordination of Benefits ("COB") applies when you have health care coverage through more than one **health care plan**. The order of benefit determination rules governs the order in which each **health care plan** will pay a claim for benefits. The **health care plan** that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. The **health care plan** that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans equal 100 percent of the total **allowable expense**.

For purposes of this Coordination of Benefits section only, the following words and phrases have the following meanings:

Allowable expense means a health care expense, including **dependents**, coinsurance, and copayments, that is covered at least in part by any **health care plan** covering the person for whom claim is made. When a **health care plan** (including this **health care plan**) provides benefits in the form of services, the reasonable cash value of each service rendered is considered to be both an **allowable expense** and a benefit paid. An expense that is not covered by any plan covering the person is not an **allowable expense**. In addition, any expense that a health care **provider** or **physician** by law or in accord with a contractual agreement is prohibited from charging a covered person is not an **allowable expense**.

Health care plan means any of the following (including this **health care plan**) that provide benefits or services for, or by reason of, medical care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts:

Group, blanket, or franchise accident and health insurance policies, excluding disability income protection coverage; individual and group health maintenance organization evidences of coverage; individual accident and health insurance policies; individual and group preferred provider benefit plans and exclusive provider benefit plans; group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care; medical care components of individual and group long-term care contracts; limited benefit coverage that is not issued to supplement individual or group in force policies; uninsured arrangements of group or group-type coverage; the medical benefits coverage in automobile insurance contracts; and Medicare or other governmental benefits, as permitted by law.

Health care plan does not include: disability income protection coverage; the Texas Health Insurance Pool; workers' compensation insurance coverage; hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage; supplemental benefit coverage; accident only coverage; specified accident coverage; school accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis; benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; a state plan under Medicaid; a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan; or other nongovernmental plan; or an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

Each contract for coverage is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

The **claim administrator** has the right to coordinate benefits between this **health care plan** and any other **health care plan** covering you.

The rules establishing the order of benefit determination between this **plan** and any other **health care plan** covering you on whose behalf a claim is made are as follows:

1. The benefits of a **health care plan** that does not have a coordination of benefits provision shall in all cases be determined before the benefits of this **plan.**

2. If according to the rules set forth below in this section the benefits of another **health care plan** that contains a provision coordinating its benefits with this **health care plan** would be determined before the benefits of this **health care plan** have been determined, the benefits of the other **health care plan** will be considered before the determination of benefits under this **health care plan**.

The order of benefits for your claim relating to paragraphs 1 and 2 above, is determined using the first of the following rules that applies:

1. Nondependent or **dependent**. The **health care plan** that covers the person other than as a **dependent**, for example as an employee, member, policyholder, subscriber, or retiree, is the primary plan, and the **health care plan** that covers the person as a **dependent** is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **health care plan** covering the person as a **dependent** and primary to the **health care plan** covering the person as other than a **dependent**, then the order of benefits between the two plans is reversed so that the **health care plan** covering the person as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other **health care plan** is the primary plan. An example includes a retired employee.

2. **Dependent Child Covered Under More Than One Health Care Plan.** Unless there is a court order stating otherwise, **health care plans** covering a **dependent** child must determine the order of benefits using the following rules that apply.

a. For a **dependent** child whose parents are married or are living together, whether or not they have ever been married:

(i) The **health care plan** of the parent whose birthday falls earlier in the **calendar year** is the primary plan; or

(ii) If both parents have the same birthday, the **health care plan** that has covered the parent the longest is the primary plan.

b. For a **dependent** child whose parents are divorced, separated, or not living together, whether or not they have ever been married:

(i) if a court order states that one of the parents is responsible for the **dependent** child's health care expenses or health care coverage and the **health care plan** of that parent has actual knowledge of those terms, that **health care plan** is primary. This rule applies to plan years commencing after the **health care plan** is given notice of the court decree.

(ii) if a court order states that both parents are responsible for the **dependent** child's health care expenses or health care coverage, the provisions of 2.a. must determine the order of benefits.

(iii) if a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the **dependent** child, the provisions of 2.a. must determine the order of benefits.

(iv) if there is no court order allocating responsibility for the **dependent** child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(I) the **health care plan** covering the **custodial parent**;

(II) the **health care plan** covering the spouse of the **custodial parent**;

(III) the **health care plan** covering the non**custodial parent**; then

(IV) the **health care plan** covering the spouse of the non**custodial parent**.

c. For a **dependent** child covered under more than one **health care plan** of individuals who are not the parents of the child, the provisions of 2.a or 2.b. must determine the order of benefits as if those individuals were the parents of the child.

d. For a **dependent** child who has coverage under either or both parents' **health care plans** and has his or her own coverage as a **dependent** under a spouse's **health care plan**, paragraph 5. below applies.

e. In the event the **dependent** child's coverage under the spouse's **health care plan** began on the same date as the **dependent** child's coverage under either or both parents' **health care plans**, the order of benefits must be determined by applying the birthday rule in 2.a. to the **dependent** child's parent(s) and the **dependent's** spouse.

3. **Active, Retired, or Laid-off Employee.** The **health care plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The **health care plan** that covers that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a **dependent** of an active employee and that same person is a **dependent** of a retired or laid-off employee. If the **health care plan** that covers the same person as a retired or laid-off employee or as a **dependent** of a retired or laid-off employee does not have this rule, and as a result, the **health**

care plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if paragraph 1. above can determine the order of benefits.

4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another **health care plan**, the **health care plan** covering the person as an employee, member, subscriber, or retiree or covering the person as a **dependent** of an employee, member, subscriber, or retiree is the primary plan, and the COBRA, state, or other federal continuation coverage is the secondary plan. If the other **health care plan** does not have this rule, and as a result, the **health care plans** do not agree on the order of benefits, this rule does not apply. This rule does not apply if paragraph 1. above can determine the order of benefits.

5. **Longer or Shorter Length of Coverage.** The **health care plan** that has covered the person as an employee, member, policyholder, subscriber, or retiree longer is the primary plan, and the **health care plan** that has covered the person the shorter period is the secondary plan.

6. If the preceding rules do not determine the order of benefits, the **allowable expenses** must be shared equally between the **health care plans** meeting the definition of **health care plan**. In addition, this **health care plan** will not pay more than it would have paid had it been the primary plan.

When this **health care plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **health care plans** are not more than the total **allowable expenses**. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **allowable expense** under its **health care plan** that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all **health care plans** for the claim equal 100 percent of the total **allowable expense** for that claim. In addition, the secondary plan must credit to its plan deductible (if applicable) any amounts it would have credited to its deductible in the absence of other health care coverage.

If a covered person is enrolled in two or more **closed panel health care plans** and if, for any reason, including the provision of service by a nonpanel **provider**, benefits are not payable by one **closed panel health care plan**, COB must not apply between that **health care plan** and other **closed panel health care plans**.

If inpatient care began when you were enrolled in a previous **health care plan**, after you make your **copayment** under this plan, we will pay the difference between benefits under this **plan** and benefits under the previous contract or insurance policy, for services on or after the effective date of this plan.

Benefits provided directly through a specified **provider** of an employer shall in all cases be provided before the benefits of this **plan**.

For purposes of this provision, BCBSTX may, subject to applicable confidentiality requirements set forth in this **plan**, release to or obtain from any insurance company or other organization necessary information under this provision. If you claim benefits under this **plan**, you must furnish all information deemed necessary by us to implement this provision.

None of the above rules as to coordination of benefits shall delay your health services covered under this **plan**.

Whenever payments have been made by BCBSTX with respect to **allowable expenses** in a total amount, at any time, in excess of 100% of the amount of payment necessary at that time to satisfy the intent of this part, we shall have the right to recover such payment, to the extent of such excess, from among one or more of the following as we shall determine: any person or persons to, or for, or with respect to whom, such payments were made; any insurance company or companies; or any other organization or organizations to which such payments were made.

You must complete and submit consents, releases, assignments, and other documents requested by BCBSTX to obtain, or assure, reimbursement under workers' compensation. If you fail to cooperate, you will be liable for the amount of money we would have received if you had cooperated. Benefits under workers' compensation will be determined first and benefits under this plan may be reduced accordingly.

Reimbursement - Acts of Third Parties

We will provide services to you due to the act or omission of another person. However, if you are entitled to a recovery from any third party with respect to those services, you shall agree in writing, subject to the provisions of Section 140.005 of the Civil Practice and Remedies Code:

- To reimburse us to the extent of the **allowable amount** that would have been charged to You for health care services if You were not covered under this **plan**. Such reimbursement must be made immediately upon collection of damages for **hospital** or medical expenses by you, whether by action at law, settlement, or otherwise.
- To assign us a right of recovery from a third party for **hospital** and medical expenses paid by us, on your behalf, and to provide the us with any reasonable help necessary for us to pursue a recovery. In addition, we will be entitled to recover attorneys' fees and court costs related to its subrogation efforts only if we aids in the collection of damages from a third party.

Alternate Service Area Access

An "Alternate Service Area" means the service area(s) covered by health maintenance organizations participating in the Blue Cross and Blue Shield Association Away From Home Care® Program outside of the state of Texas. For the names of those **health maintenance organizations** and their service areas or for a list of **participating providers** in an alternate service area, please contact customer service at the toll-free telephone number located on your **identification card**.

If you are temporarily residing in an **alternate service area**, you may obtain **Covered Services** in the alternate service area. For a **subscriber**, coverage is available if you are, or will be, residing in the alternate service area at least ninety (90) days, limited to a maximum of one hundred eighty (180) days. For **dependents**, including an eligible **dependent** who permanently resides outside the **service area** and is subject to a valid medical court order, coverage is available if the **dependent** is or will be residing in the alternate service area at least ninety (90) days, limited to a maximum of three hundred sixty-five (365) days. **Participants** may renew qualification within the alternate service area by submitting a request for alternate service area access and receiving approval from BCBS.

This **plan** remains in full force and effect while you are in the alternate service area, and you may avail yourself of **Covered Services** under this **plan** by returning to the **service area**. **Emergency care and other covered services**

in the alternate service area will be covered in agreement with the terms and conditions of this p**lan**. We will provide you with terms and conditions of the alternate **plan**, including the **benefits** offered, may be different from this **plan** and will determine the **Covered Services**, other than **emergency care**, that you may receive while in the alternate service area.

To qualify for coverage in an alternate service area, you must:

- Submit a request prior to relocating in an alternate service area
- You may be required to select a **PCP** from a list of **participating providers** for the alternate service area

We will determine the date coverage begins for the alternate service area. Coverage will begin either:

- The effective date of **participant's** eligibility
- The first day of the month following our receipt of the request for **alternate service area** access

If approved, we will issue written notification.

Assignment

This **plan** is not assignable by the **group** without the written consent of BCBS. The coverage and any **benefits** under this **plan** are not assignable by any **participant** without the written consent of BCBS.

Cancellation

Except as otherwise provided under this **plan**, we shall not have the right to cancel or terminate any **plan** issued to any subscriber while:

- The **group agreement** remains in force and effect
- While you remain in the eligible class of the group **employees**
- Your contributions are paid in agreement with the terms of this **plan**

Clerical Error

Clerical error, whether of group or us, in keeping any records pertaining to the coverage under this **plan**, will not cancel coverage otherwise valid or continue coverage already terminated.

Force Majeure

In the event that due to circumstances not within the commercially reasonable control of BCBS, the rendering of professional or **hospital services** provided under this **plan** is delayed or rendered impractical, we shall make a good faith effort to arrange for an alternative method of providing coverage. These circumstances may include, but are not limited to:

- Major disaster
- Epidemic
- The complete or partial destruction of facilities
- Riot
- Civil insurrection
- Disability of a significant part of the **participating providers'** personnel
- Similar causes

In such event, participating providers shall render the **hospital** and **professional services** provided for under the **plan** in so far as practical, and according to their best judgment; but BCBS and **participating providers** shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Form or Content of Plan

No agent or employee of BCBS is authorized to change the form or content of this **plan** except to make necessary and proper insertions in blank spaces. Changes can be made only through endorsement authorized and signed by an officer of BCBS. No agent or other person, except an authorized officer of BCBS has authority to:

- Waive any conditions or restrictions
- Extend the time for making a payment
- Bind BCBS by making any promise
    - Representation
    - By giving
    - Receiving any information

Gender

The use of any gender herein shall be deemed to include the other gender. When appropriate the use of the singular herein shall be deemed to include the plural (and vice versa).

Identity Theft Protection

The identity theft protection services include:

- Credit monitoring
- Fraud detection
- Credit/identity repair
- Insurance to help protect your information

These identity theft protection services are currently provided by BCBSTX's chosen outside vendor. Accepting or declining these services is optional for **participants**.

You may accept identity theft protection services by enrolling in the program online at www.bcbstx.com, or by calling the toll-free telephone number on the back of your **identification card**.

Services may automatically end when the person is no longer an eligible **participant**. Services may change or be stopped at any time with reasonable notice. We do not guarantee that a particular vendor or service will be available at any given time.

Incontestability

All statements made by you are considered representations and not warranties. A statement may not be used to void, cancel or non-renew your coverage or reduce **benefits** unless it is in a written enrollment application signed by the **subscriber** and a signed copy of the enrollment application has been furnished to **subscriber** or to the **subscriber's** personal representative. Coverage may only be contested because of fraud or intentional misrepresentation of material fact on the enrollment application.

Information Concerning Employee Retirement Income Security Act Of 1974 (ERISA)

If the **health benefit plan** is part of an "employee welfare **benefits plan**" and "welfare **plan**" as those terms are defined in ERISA:

- The employer will supply summary descriptions, annual reports, and summary annual reports to you and other **plan participants** and to the government as required by ERISA and its regulations.
- We will give the **employer** this **benefit** booklet as a description of **benefits** available under this **plan**. Upon written request by the employer, we will send any information which we have that will help the employer in making its annual reports.
- **Claims** for **benefits** must be made in writing in the required time. Claim filing and claim review health procedures are found in the **CLAIM FILING AND APPEALS PROCEDURES** section of this **benefit booklet**.
- We are not the ERISA "**plan administrator**" for **benefits** or activities pertaining to the **health benefit plan**.
- This benefit booklet is not a summary **plan** description.
- The **employer** has given us the authority and discretion to interpret the **health benefit plan** provisions and to make eligibility and **benefit** determinations. Any decisions made by your **employer** shall be final and conclusive.

Interpretation of Plan

The laws of the state of Texas shall be applied to interpretations of this **plan**. Where applicable, the interpretation of this **plan** shall be guided by the direct-service nature of our operations as opposed to a health insurance program. If this **plan** contains any provision not in conformity with the Texas Health Maintenance Organization Act or other applicable laws, this **plan** shall not be rendered invalid but shall be understood and applied as if it were in full compliance with the Texas Health Maintenance Organization Act and other applicable laws. Changes in state or federal law or regulations, or interpretations thereof, may change the terms and conditions of coverage.

Limitation of Liability

Liability for any errors or omissions by us (or its officers, directors, employees, agents, or independent contractors) in the administration of this **plan:**

- In the performance of any duty of responsibility contemplated by this **plan**
- Shall be limited to the maximum **benefits** which should have been paid under the **plan** had the errors or omissions not occurred
- Unless any such errors or omissions are found to be the result of willful misconduct or gross negligence of BCBS

Modifications

This **plan** shall be subject to amendment, modification, and termination in agreement with any provision of this **plan** or by mutual agreement between us and **group** without the consent or concurrence of **participants**. By electing medical and **hospital** coverage under us or accepting our **benefits**, all **participants** legally capable of contracting, and the legal representatives of all **participants** incapable of contracting, agree to all terms, conditions, and provisions of this **plan**.

Notice

You may send a notice to us via first-class mail. You may prepaid postage through the United States Postal Service to the address on the face page of this **plan**.

BCBS, or Group by agreement between us and Group, may send you notices. These notices may be delivered:

- Through the United States Postal Service at the last address known to us

Electronically, if permitted by applicable law

Our Ownership Interests

BCBS, subsidiaries or affiliates may have ownership interests in certain **providers. Providers** who provide **covered services** related to **benefits** and requirement or provide services to certain **providers** to our:

- **Participants**
- Vendors

Other third parties

Overpayments

Your group's **plan** and BCBSTX have the right to receive a refund of an **overpayment** from:

- The person to, or for whom, such **benefits** were paid
- Any insurance company or **plan**
- Any other persons, entities, or organizations, including, but not limited to, **participating providers** or **non-participating providers**

If no refund is received, we (in our capacity as insurer or administrator) and/or your group's **benefit plan** have the right to deduct any refund for any **overpayment** due, up to an amount equal to the **overpayment**, from:

- Any future **benefit** payment made to any person or entity under this **benefit booklet**, even if it is for the same or a different **participant**
- Any future benefit payment made to any person or entity under another BCBSTX-administered ASO **benefit plan** and/or BCBSTX-administered insured **benefit plan** or policy
- Any future **benefit** payment made to any person or entity under another BCBSTX-insured **group benefit plan** or individual policy
- Any future **benefit** payment, or other payment, made to any person or entity
- Any future payment owed to one or more **participating providers** or non-**participating providers**

Further, we have the right to reduce your **benefit plan's** or policy's payment to a **provider** by the amount necessary to recover another BCBSTX **plan's** or policy's overpayment to the same **provider** and to pay the recovered amount to the other BCBSTX **plan** or policy.

Overpayment means when we or your group's **benefit plan** pay **benefits** for eligible expenses received by you or your **dependents** and it is found that the payment was more than it should have been or was made by mistake.

Participant Data Sharing

You may apply for and receive replacement coverage under certain circumstances like from involuntary termination of your health coverage sponsored by the **group**/**employer**.

The replacement coverage will be coverage offered by us. If you do not live in the **service area**, coverage will be offered by the Blue Cross and/or Blue Shield Plan whose **service area** covers the geographic area where you live.

As part of the **benefits** that we offer you, if you do not live in the **service area**, we may assist you in applying for and getting such replacement coverage, subject to applicable eligibility requirements, from the Blue Cross and/or Blue Shield Plan available in the **service area** in which you live.

To do this we may:

- Contact you directly and/or
- Provide the Blue Cross and/or Blue Shield Plan whose **service area** covers the geographic area where you live, with your personal information and other general information relating to your coverage under this **plan**. Only your necessary information will be provided to prepare the appropriate Blue Cross and/or Blue Shield Plan to offer you uninterrupted coverage through replacement coverage.

Participant/Provider Relationship

The choice of a health care **provider** should be made by you or your **dependents**. If you and your participating provider cannot establish a satisfactory relationship:

- **Participating provider** may send a written request to us to terminate the relationship
- The request may apply to other provider in the same group practice

Rescission

Recission is not considered:

- A cancellation or non-renewal of coverage due to failure to pay required **premiums** in the required time or contributions toward the cost of coverage (including COBRA **premiums**)

You will be given 30 days advance notice of rescission. A rescission is considered an **adverse benefit determination** of which you may seek:

- Internal review
- External review

Rescission is the cancellation or discontinuance of coverage that has retroactive effect. Your coverage may not be rescinded unless:

- You or a person seeking coverage on your behalf performs an:
    - Act, practice or omission that constitutes fraud
    - Makes an intentional misrepresentation of a material fact

Relationship of Parties

The relationship between us and **participating providers** is that of an independent contractor relationship. **Participating providers** are not agents or our employees. BCBS or any employee of ours is not an employee or agent of **participating providers**. We are not liable for:

- Any claim
- Demand on account of damages arising
- Any connection with injuries suffered by you while receiving care from any **participating provider**

We make no express or implied warranties or representations concerning the qualifications, continued participation, or quality of services of any **physician**, **hospital** or other **participating provider**.

Reports and Records

We are entitled to receive from any **provider** of services to **participants**, information reasonably necessary to administer this **plan** subject to all applicable confidentiality requirements described below. By accepting coverage you and your covered **dependents**, authorizes all providers who renders services to:

- Disclose all facts and reports to us or medical, dental or health professional that may assist us in reviewing your treatment or claim. Facts pertaining to your:
    - Care
    - Treatment
    - Physical condition
- Permit us to copy your records

Information contained in your medical records and information received will be kept confidential per applicable law. Any information received from the following will be confidential:

- **Physicians**
- Surgeons
- **Hospitals**
- Other **health care professionals**
- Incident to the **physician**-patient relationship
- **Hospital**-patient relationship

Subtitles

The subtitles included within this **plan** is provided for the purpose of identification and convenience. They are not part of the complete **plan** as described in **entire plan.**

Entire **plan** means:

- This **plan**
- Attachments
- Amendments
- Group agreement
- Individual applications

If any subscribers constitute the entire contract between the parties and the effective date replace all other contracts between the parties.

GLOSSARY

Allowable Amount or Allowed Amount means the maximum amount determine by BCBS to be eligible for consideration of payment for a particular **covered drug, covered service** and supply rendered by a **participating provider**. Your **deductible**, **copay**, and **coinsurance** are based on the provisions of the **participating provider** and **participating pharmacy** contracts and the terms of your **plan**. **Prescription Drugs** purchased outside of the **service area**, the **allowable amount** is based on the **participating pharmacy** contract rate.

Behavioral Health means any condition or disorder involving a mental health condition or substance use disorder listed under any of the diagnostic categories in the mental disorders section of the most recent edition of the International Classification of Disease or in the mental disorders section of the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

Behavioral Health Provider means a **physician** or other professional provider who renders services for mental and **behavioral health** conditions or **substance use disorder** and is operating within the scope of such license.

Benefits mean the payment, reimbursement, and indemnification of any kind which you will receive from and through the **plan** under this **contract**.

Benefit Period means the period during which you receive covered services for which the plan will provide benefits.

Brand Name Drug means a drug or product manufactured by a single manufacturer as defined by a nationally recognized **provider** of drug product database information. There may be some cases where multiple manufacturers will produce the same product under one license, known as a co-licensed product, which would also be considered as a **brand name drug**. There may also be situations where a drug's classification changes from generic to brand name due to a change in the market resulting in the generic being a single source, or the drug product database information changing, which would also result in a corresponding change in **copayment** obligations from generic to brand name.

Brand Name Drug (Non-Preferred) means a **brand name** drug which appears on the applicable **drug list** as **non-preferred brand name drug**.

Brand Name Drug (Preferred) means a **brand name drug** which appears on the applicable **drug list** as **preferred brand name drug**. The **drug list** is available by accessing the website at https://www.bcbstx.com.

Calendar Year means the period beginning January 1 of any year and ending December 31 of the same year.

Claim Administrator means Blue Cross and Blue Shield of Texas, a Division of health Care Service Corporation. The **claim administrator** has no fiduciary responsibility for the operation of the **plan.** The **claim administrator** assumed only the authority and discretion as given by the employer to interpret the **plan** provisions and make eligibility and benefit determinations.

Coinsurance means the percentage of the allowed amount you pay as your share of the bill. For example, if your **plan** pays 80% of the allowed amount, 20% would be your **coinsurance.**

Copayment or copay means the set amount you pay each time you receive a **covered service** or pharmacy benefit.

Covered Drugs means any legend drug:

- Which is included on the applicable **drug list**
- Which is **medically necessary** and is ordered by an authorized **provider** for you or your **dependent**
- Written or verbal **prescription order** is provided by an authorized **health care practitioner**
- A separate charge is customarily made
- Which is not consumed at the time and place that the **prescription order** is written
- For which the FDA has given approval for at least one indication
- Which is dispensed by a **pharmacy,** and you received while covered under the **plan**, except when received from a **provider's** office, or during confinement while a patient in a **hospital** or other acute care institution or facility (refer to **Limitations and Exclusions**)

Note: **Covered drug(s)** under **PHARMACY BENEFITS** also means insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, including disposable syringes and needles needed for self-administration.

Covered Services mean a service or supply shown in this **certificate** for which **benefits** will be provided.

Custodial Care means service that are designed to assist patients in meeting the activities of daily living and maintain life and/or comfort. These services can be safely provided by trained non-professional personnel. They are to assist with routine medical needs and activities of daily living (e.g., simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g., bathing, eating, dressing, etc.).

Deductible means the amount you are required to pay the **participating provider** before receiving **Covered Service benefits**.

Dependent means your spouse or **domestic partner** (provided your **employer** covers **domestic partners**) or any **child** covered under the **plan**.

Child means a:
- Natural **child**
- A step**child**
- A foster **child**
- An adopted **child** including those placed with you for adoption

A **child** must also be under twenty-six (26) years of age, regardless of:
- Financial dependency
- Residency
- Student status
- Employment status
- Marital status

Dietary and Nutritional Services means the education, counseling, or training of a **participant** (including printed material) regarding:
- Diet
- Regulation or management of diet
- The assessment or management of nutrition

Drug List means a list of drugs that may be covered under the **PHARMACY BENEFITS** portion of the **plan**. This list is available by accessing the website at www.bcbstx.com. You may also contact **Customer Service** at the toll-free number on your **identification card** for more information.

Emergency Care means health care services provided in:

- **Hospital** emergency facility
- Freestanding emergency medical care facility
- Comparable facility

Service is 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 their condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- Placing the patient's health in serious jeopardy
- Serious impairment of a bodily function
- Serious dysfunction of any bodily organ or part
- Serious disfigurement
- In the case of a pregnant woman, serious jeopardy to the health of the fetus

Employee means an individual employed by a group/**employer**. For purposes of this **plan**, the term **employee** will also include those individuals who are no longer an **employee** of the **employer**, but who are **participants** covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or continued under the appropriate provisions of the Texas Insurance Code.

Employer means a **group**, as defined, in which there exists an employment relationship between a **participant** and the **group**.

Experimental/Investigational means the use of any treatment, procedure, facility, equipment, drug, device, or supply (including emerging technologies, services, procedures, and service paradigms) not accepted as standard medical treatment of the condition being treated and any of such items requiring Federal or other governmental agency approval not granted at the time services were provided. Approval by a Federal agency means that the treatment, procedure, facility, equipment, drug, device or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient. Approval by a federal agency will be taken into consideration by us in assessing **experimental/investigational** status but will not be determinative.

As used herein, medical treatment includes medical, surgical, or dental treatment.

Standard medical treatment means the services or supplies that are in general use in the medical community in the United States, and:

- Have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated.
- Are appropriate for the **hospital** or other provider in which they were performed.
- The **physician** or other professional provider has had the appropriate training and experience to provide the treatment or procedure.

The medical staff of BCBSTX shall determine whether any treatment, procedure, facility, equipment, drug, device, new or existing technologies, or supplies are **experimental/investigational**, and will consider factors such as the guidelines and practices of Medicare, Medicaid, or other government-financed programs and approval by a federal agency in making its determination. Prescription drugs that are approved by the FDA through the accelerated approval program may be considered **experimental/investigational**.

Although a **physician** or other professional provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, we still may determine such services or supplies to be **experimental/investigational** within this definition. Treatment provided as part of a clinical trial, or a research study is **experimental/investigational**.

Gender Transition means a medical process by which an individual's anatomy, physiology, or mental state is treated or altered, including by the removal of otherwise healthy organs or tissue, the introduction of implants or performance of other plastic surgery, hormone treatment, or the use of drugs, counseling, or therapy, for the purpose of furthering or assisting the individual's identification as a member of the opposite biological sex or group or demographic category that does not correspond to the individual's biological sex.

Gender Transition Procedure or Treatment means a medical procedure or treatment performed or provided for the purpose of assisting an individual with a **gender transition**.

Generic Drug means a drug that has the same active ingredient as a **brand name drug** and is allowed to be produced after the **brand name drug's** patent has expired. In determining the brand or generic classification for **covered drugs** we utilize the generic/brand status assigned by a nationally recognized **provider** of drug product database information. You should know that not all drugs identified as a "generic" by the drug product database, manufacturer, **pharmacy**, or your **provider** will be considered generic by us.

Generic Drug (Non-Preferred) means a **generic drug** which appears on the **drug list** as **Non-Preferred generic drug.**

Generic Drug (Preferred) means a **generic drug** which appears on the **drug list** as **preferred generic drug**. The **drug list** is available by accessing the website at https://www.bcbstx.com.

Group means the employer or party that has entered into an Administrative Services Agreement with us under which we will provide for or arrange health services for eligible **participants** of the **group** who enroll.

Health Benefit Plan means a group, blanket, or franchise insurance policy, a certificate issued under a group policy. A group **hospital** service contract, or a **group subscriber** contract or evidence of coverage issued by a health maintenance organization that provides health care benefits.

Health Care Practitioner means a licensed person with prescription authority such as:

- Advanced practice nurse
- Doctor of medicine
- Doctor of dentistry
- Physician assistant
- Doctor of osteopathy
- Doctor of podiatry

HMO (Health Maintenance Organization) means Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation.

Hospital means an acute care institution that:

- Is duly licensed by the state in which it is located and must be accredited by the Joint Commission on Accreditation of Healthcare Organizations or certified under Medicare
- Is primarily engaged in providing, on an inpatient basis, medical care and treatment of sick and injured persons through medical, diagnostic, and major surgical facilities
- Provides all services on its premises under the supervision of a staff of **physicians**
- Provides 24-hour a day nursing and **physician** service

Has in effect a **hospital** utilization review **plan**

Hospital Services (except as expressly limited or excluded in this **plan**) means those **medically necessary Covered Services** that are generally and customarily provided by acute general **hospitals**; and prescribed, directed or authorized by the PCP.

Identification Card means the card issued to the **employee** by us indicating pertinent information applicable to their coverage.

Infertility means the condition of a presumably healthy **participant** who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual sexual intercourse. This does not include conditions for male **participants** when the cause is a vasectomy or orchiectomy or for female **participants** when the cause is a tubal ligation or hysterectomy.

Insulin means an insulin analog and an insulin-like medication, regardless of the activation period or whether the solution is mixed before the prescription is dispensed.

Insulin-Related Equipment or Supplies means needles, syringes, cartridge systems, prefilled pen systems, glucose meters, continuous glucose monitor supplies, and text strips but does not include insulin pumps.

Legend Drugs mean drugs, biologicals, or compounded prescriptions which are required by law to have a label stating "Caution - Federal Law Prohibits Dispensing Without a Prescription," and which are approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose.

Medically Necessary or **Medical Necessity** means those services or supplies covered under the **plan** which are:

- Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, or bodily malfunction
- Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States
- Not primarily for the convenience of the **participant**, **physician**, **behavioral health provider**, the **hospital**, or the other provider
- The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the **participant**.
- If more than one health intervention meets the requirements listed above, **medically necessary** means the most cost effective in terms of type of intervention or settings, frequency, extent, or duration, which is safe and effective for the patient's illness, injury, or disease and supports improved health.

When applied to hospitalization, this further means that the **participant** requires acute care as a bed patient due to the nature of the services provided or the **participant's** condition, and the **participant** cannot receive safe or adequate care as an outpatient. We do not determine course of treatment or whether particular health care services are received. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between the **participant**, **physician**, **behavioral health provider**, the **hospital**, or the other provider

The medical staff of BCBSTX shall determine whether a service or supply is **medically necessary** under the **plan** and will consider the views of the state and national medical communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a **physician**, **behavioral health provider** or other provider may have prescribed treatment, such treatment may not be **medically necessary** within this definition.

Medicare means Title XVIII of the Social Security Act and all amendments thereto.

Out-of-Area means not within the **service area.**

Participant means an **employee** or **dependent** whose coverage has become effective under this **contract**.

Participating describes a **provider** that has entered into a contractual agreement with us for **covered services**.

Participating Pharmacy means an independent retail **pharmacy,** chain of retail **pharmacies,** mail-order **pharmacy**, or **specialty drug pharmacy** which has entered into a written agreement with us to provide pharmaceutical services to **participants** under this **plan**.

Pharmacy means a state and federally licensed establishment that is physically separate and apart from any **provider's** office, and where **legend drugs** and devices are dispensed under **prescription orders** to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state.

Pharmacy Vaccine Network means the **network** of select **participating pharmacies** which have a written agreement with us to provide certain vaccinations to you under this **plan**.

Physician means a person, when acting within the scope of their license, who is a Doctor of Medicine or Doctor of Osteopathy. The terms Doctor of Medicine or Doctor of Osteopathy shall have the meaning assigned to them by the state in which they are licensed and operating.

Plan means Blue Cross and Blue Shield of Texas (BCBSTX), a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association issued group **benefits** contract.

Plan Administrator means the **Group Health Plan (GHP)** or a named administrator of the **plan** having fiduciary responsibility form its operation. BCBS are not the **plan administrator.**

Participating Pharmacy (Preferred) means a **participating pharmacy** which has a written agreement with us to provide pharmaceutical services to **participants** or an entity chosen by us to administer its prescription drug program that has been designated as a **preferred participating pharmacy**.

Premium means the amount the **group** or you are required to pay to us for continue coverage.

Prescription Order means a written or verbal order from your authorized **health care practitioner** to a pharmacist for a drug or device to be dispensed.

Primary Care Physician/**Practitioner** or **PCP** means:

- **Participating physician**
- Physician assistant
- Advanced practice nurse

PCP is primarily responsible for:

- Providing
- Arranging
- Coordinating all aspects of your health care.

You and your **dependents** must each select a **PCP** from those listed by the HMO to provide primary care services. You may choose a **PCP** who is:

- Family practitioner
- Internist
- Pediatrician
- Obstetrician/Gynecologist

The PA or APN must work under the supervision of a **participating** family practitioner, internist, pediatrician and/or Obstetrician/Gynecologist in the same HMO network.

Prior-Authorization means the process that determines in advance the **medical necessity** or **experimental/investigational** nature of certain care and services under this **plan**.

Professional Services means those **medically necessary covered services** rendered by **physicians** and other health care professionals.

Provider means a **hospital**, **physician**, **behavioral health provider**, other provider, or any other person, company, or institution furnishing to a **participant** an item of service or supply.

Referral means an electronic or written authorization made by your **PCP** to direct you to a specialist for medically necessary services and/or supplies.

Rider(s) means additional or expanded **benefits** which are made available to the **group**. Such **rider(s)**, when purchased, will be attached to and incorporated into the **plan**.

Service Area means the geographical area served by us and approved by state regulatory authorities. The **service area** includes the area shown and described in this **plan**.

Specialist means a duly licensed **physician**, other than a **PCP**.

Specialty Drug means a drug used to treat complex medical conditions. Specialty Drugs are typically given by injection but may be topical or taken by mouth. They also often require careful adherence to treatment **plans**, may have special handling or storage requirements, and may not be stocked by retail pharmacies.

Specialty Drug (**Non-Preferred)** means a **specialty drug** which appears on the **drug list** as **non-preferred specialty drug.**

Specialty Drug (Preferred) means a **specialty drug** which appears on the applicable **drug list** as **preferred specialty drug**. The **drug list** is available by accessing the website at https://www.bcbstx.com.

Specialty Pharmacy Program Provider means a **participating pharmacy** which has entered into a written agreement with us to provide **specialty drugs** to **participants** under this **plan.**

Subscriber means a person who meets all applicable eligibility and enrollment requirements of this **plan**, and whose enrollment application and contributions have been received.

AMENDMENTS

AMENDMENTS

CERTIFICATE

NO SURPRISES ACT AMENDMENT

Amendment Effective Date: This **amendment** is effective on the **employer's contract anniversary date** or for the **plan year** of your **employer's group health plan** occurring on or after January 1, 2022.

The terms of this **amendment** supersede the terms of the **certificate** to which this **amendment** is attached and becomes a part of the **certificate**. Unless otherwise required by Federal or Texas law, in the event of a conflict between the terms on this **amendment** and the terms of the **certificate**, the terms on this **amendment** apply. However, definitions set forth in this **amendment** are for purposes of this **amendment** only. Additionally, for purposes of this **amendment**, references to you and your mean any **member**, including **subscriber** and **dependents**.

The certificate is hereby amended as indicated below:

PCP Selection

The **plan** generally requires the designation of a **primary care physician/practitioner (PCP).** You have the right to designate any **PCP** who participates in our network and who is available to accept you or your family members.

Until you make this designation, Blue Cross and Blue Shield of Texas (BCBSTX) designates one for you. For information on how to select a **PCP** and for a list of the participating **PCP**s, contact BCBSTX at www.bcbstx.com or customer service at the toll-free number on the back of your **identification card**.

For **dependent** children, you may designate any **participating provider** who specializes in pediatric care as their **Primary Care Physician/Practitioner (PCP).**

OB/GYN Care

You are not required to obtain a **referral** or authorization from your **Primary Care Physician/Practitioner (PCP)** or Women's Principal Health Care Provider (WPHCP) before obtaining **covered services** from any **participating provider** specializing in obstetrics or gynecology. However, before obtaining covered obstetrical or gynecological care, the **provider** must comply with certain policies and procedures required by your **plan**, including **prior authorization** and **referral** policies. For a list of **participating providers** who specialize in obstetrics or gynecology, visit www.bcbstx.com or contact customer service at the toll-free number on the back of your **identification card**.

Continuity of Care

If you are under the care of a **participating provider** as defined in the benefit booklet who stops participating in the **plan's** network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), you may be able to continue coverage for that **provider's covered services** at the in-network **benefit** level if one of the following conditions is met:

1. You are undergoing a course of treatment for a serious and complex condition,
2. You are undergoing institutional or inpatient care,
3. You are scheduled to undergo nonelective surgery from the **provider** (including receipt of postoperative care from such **provider** with respect to such surgery),

4. You are pregnant or undergoing a course of treatment for your pregnancy, or
5. You are determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if You are currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), and (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date. The **plan** notifies you of the **provider's** termination, or any longer period provided by state law. If you are in the second or third trimester of pregnancy when the **provider's** termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery. You have the right to appeal any decision made for a request for **benefits** under this provision, as explained in the Certificate.

Federal No Surprises Act

1. Definitions

The definitions below apply only to Section IV. Federal No Surprises Act, of this Amendment. To the extent the same terms are defined in this section those terms will apply only to their use in the section, respectively.

Air Ambulance Services means, for purposes of this section, medical transport by helicopter or airplane for patients.

Emergency Medical Condition means, for purposes of this section only, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition: (i) placing the health of the individual, or with respect to a pregnant individual unborn child in serious jeopardy; (ii) constituting a serious impairment to bodily functions; or (iii) constituting a serious dysfunction of any bodily organ or part.

Emergency Services means, for purposes of this section only,

- A medical screening examination performed in the emergency department of a **hospital** or a freestanding emergency department
- Further medical examination or treatment you receive at a **hospital**, regardless of the department of the **hospital**, or a Freestanding Emergency Department to evaluate and treat an **emergency medical condition** until your condition is stabilized
- **Covered services** you receive from a **non-participating provider** during the same visit after your **emergency medical condition** has stabilized unless:
    - Your **non-participating provider** determines you can travel by non-medical or non-emergency transport.
    - Your **non-participating provider** has provided you with a notice to consent form for balance billing of services.
    - You have provided informed consent.

Non-Participating Provider means, for purposes of this section only, with respect to a covered item or service, a **physician** or other health care provider who does not have a contractual relationship with HMO for furnishing such item or service under the plan.
Non-Participating Emergency Facility means, for purposes of this section only, with respect to a covered item or service, an emergency department of a **hospital** or an independent freestanding emergency department that does not have a contractual relationship with HMO for furnishing such item or service under the plan.

Participating Provider means, for purposes of this section only, with respect to a **covered service**, a **physician** or other health care provider who has a contractual relationship with HMO setting a rate (above which the **provider** cannot bill the member) for furnishing such item or service under the plan regardless whether the provider is considered a preferred or in-network **provider** for purposes of in-network or out-of-network benefits under the subject plan.

Participating Facility means, for purposes of this section only, with respect to **covered service**, a **hospital** or ambulatory surgical center that has a contractual relationship with HMO setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the plan. Whether the **provider** is considered a preferred or in-network **provider** for purposes of in-network or out-of-network benefits under the subject plan.

Qualifying Payment Amount means, for purposes of this section only, a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

Recognized Amount means, for purposes of this section only, an amount determined pursuant a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no state law that provides a method for determining the total amount payable for the item or service, the lesser of the **qualifying payment amount** or billed charges.

2. Federal No Surprises Act Surprise Billing Protections

a. The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by **non-participating providers** and non-participating emergency facilities. The items and services included in these protections ("Included Services") are listed below.

- Emergency services obtained from a **non-participating providers** or non-participating emergency facility.
- Covered non-emergency services performed by a **non-participating provider** at a participating facility (unless you give written consent and give up balance billing protections).
- Air ambulance services received from a **non-participating providers**, if the services would be covered if received from a participating provider.

b. Claim Payments

For Included services, the **plan** will send an initial payment or notice of denial of payment directly to the Provider.

c. Cost-Sharing

For non-emergency services performed by **non-participating providers** at a **participating facility**, and for emergency services provided by a **non-participating providers** or non-participating emergency facility, the Recognized Amount is used to calculate your cost-share requirements, including **Deductibles, Copayments,** and **Coinsurance**.

For Air Ambulance Services received from a **Non-Participating Provider**, if the services would be covered if received from a **Participating Provider**, the amount used to calculate your cost-share requirements,

including **deductibles, copayments**, and **coinsurance**, will be the lesser of the qualifying payment amount or **billed charges**.

For included services, these cost-share requirements will be counted toward your in-network **deductible** and/or out-of-pocket maximum, if any.

3. Prohibition of Balance Billing

You are protected from balance billing on included services as set forth below.

If you receive **emergency services** from a **Non-participating provider** or **non-participating emergency facility**, the most the **non-participating provider** or **non-participating emergency facility** may bill you is your in-network cost-share. You cannot be balance billed for these **emergency services** unless You give written consent and give up your protections not to be balanced billed for services you receive after you are in a stable condition.

When you receive covered **non-emergency services** from a **non-participating provider** at a **participating facility**, the most those **non-participating providers** may bill you is your **plan's** in-network cost-share requirements. When you receive emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services at a Participating Facility, Non-**participating providers** can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at **participating facilities**, **non-participating providers** can't balance bill you unless you give written consent and give up your protections.

If your **plan** includes air ambulance services as a covered service, and such services are provided by a **non-participating provider**, the most the **non-participating provider** may bill you is your in-network cost-share. You cannot be balance billed for these air ambulance services.

NOTE: The revisions to y plan made by this amendment are based upon the No Surprises Act, a federal law enacted in 2020 and effective for plan years beginning on or after January 1, 2022. To the extent federal regulations are adopted or additional guidance is issued by federal regulatory agencies that alter the terms of this amendment, the regulations and any additional guidance will control over conflicting language in this amendment.

NOTICES

NOTICES

CONTINUATION COVERAGE RIGHTS UNDER COBRA

NOTE: Certain **employers** may not be affected by CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA). See your employer or group administrator should you have any questions about COBRA.

INTRODUCTION
You are receiving this notice because you have recently become covered under your **employer**'s **group health plan** (the **plan**). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the **plan**. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to you when you would otherwise lose your **group** health coverage. It can also become available to other members of your family who are covered under the **plan** when they would otherwise lose their **group** health coverage.

For additional information about your rights and obligations under the **plan** and under federal law, you should review the **plan**'s summary plan description or contact the **plan administrator**.

WHAT IS COBRA CONTINUATION COVERAGE?
COBRA continuation coverage is a continuation of **plan** coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your **dependent** children could become qualified beneficiaries if coverage under the **plan** is lost because of the qualifying event. Under the **plan**, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an **employee**, you will become a qualified beneficiary if you lose your coverage under the **plan** because either one of the following qualifying events happens:

Your hours of employment are reduced; or
Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an **employee**, you will become a qualified beneficiary if you lose your coverage under the **plan** because any of the following qualifying events happens:

Your spouse dies;
Your spouse's hours of employment are reduced;
Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the **plan** because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);

- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the **plan** as a "**dependent child**."

If the plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your **employer**, and that bankruptcy results in the loss of coverage of any retired employee covered under the **plan**, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the **plan**.

WHEN IS COBRA COVERAGE AVAILABLE?
The **plan** will offer COBRA continuation coverage to qualified beneficiaries only after the **plan administrator** has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the **plan administrator** of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or legal separation of the **employee** and spouse or a **dependent child**'s losing eligibility for coverage as a **dependent child**), you must notify the **plan administrator** within 60 days after the qualifying event occurs. Contact your **employer** and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

HOW IS COBRA COVERAGE PROVIDED?

Once the **plan administrator** receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the **plan** is determined by the Social Security Administration to be disabled and you notify the **plan administrator** in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and **dependent** children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months if notice of the second qualifying event is properly given to the **plan**. This extension may be available to the spouse and **dependent** children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the **plan** as a **dependent** child, but only if the event would have caused the spouse or dependent child to lose coverage under the **plan** had the first qualifying event not occurred.

IF YOU HAVE QUESTIONS

Questions concerning your **plan** or your COBRA continuation coverage rights, should be addressed to your **plan administrator**. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the **plan administrator** informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the **plan administrator**.

PLAN CONTACT INFORMATION

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

INTER-PLAN ARRANGEMENTS NOTICE

BLUE CROSS AND BLUE SHIELD OF TEXAS,

A DIVISION OF HEALTH CARE SERVICE CORPORATION

Inter-Plan Arrangements

Out-of-Area Services

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation (herein called "the **claim administrator**") has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter- Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you obtain healthcare services outside of our **service area**, the claims for these services may be processed through one of these Inter-Plan Arrangements.

Typically, when accessing care outside our **service area**, you will obtain care from healthcare **providers** that have a contractual agreement (i.e., are "**participating providers**") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from **non-participating providers**. Our payment practices in both instances are described below.

For inpatient facility services, the Host Blue's **participating provider** is required to obtain prior authorization review. If prior authorization review is not obtained, the **participating provider** will be sanctioned based on the Host Blue's contractual agreement with the **provider**, and the member will be held harmless for the **provider** sanction.

We cover only limited healthcare services received outside of our Service Area. As used in this section, "Covered Services" include Emergency Care, Urgent Care, and follow-up care obtained outside the geographic area we serve. Any other services will not be covered when processed through any Inter-Plan Arrangements, unless authorized by your Primary Care Physician/Practitioner ("PCP")/the Claim Administrator.

A. BlueCard® Program

Under the BlueCard Program, when you obtain Covered Services within the geographic area served by a Host Blue, we will remain responsible for what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating healthcare Providers.

The BlueCard Program enables you to obtain Covered Services, as defined above, from a healthcare Provider participating with a Host Blue, where available. The Participating healthcare Provider will automatically file a claim for the Covered Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the Member Copayment amount indicated in the Certificate of Coverage, Schedule of Copayments and Benefit Limits.

Emergency Care Services: If you experience a Medical Emergency while traveling outside our Service Area, go to the nearest Emergency or Urgent Care facility.

Whenever You receive Covered Services and the claim is processed through the BlueCard Program, the amount you pay for such services, if not a flat dollar Copayment, is calculated based on the lower of:

- The billed covered charges for the Covered Services, or
- The negotiated price that the Host Blue makes available to us.

Often, this "negotiated price" is a simple discount that reflects the actual price the Host Blue pays to your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with an individual Provider, or a Provider group, that may include settlements, incentive payments, and/or other credit or charges. Occasionally, it may be an average price based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over-or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied after a claim has already been paid.

Federal or state laws or regulations may require a surcharge, tax, or other fee that applies to insured accounts. If applicable, the Claim Administrator will include any such surcharge, tax, or other fee as part of the claim charge passed on to you. If federal law or any state laws mandate other liability calculation methods, including a surcharge, the Claim Administrator would then calculate your liability for any Covered Services according to the applicable law in effect when care is received.

B. Non-Participating Healthcare Providers outside our Service Area

Liability Calculation

Except for Emergency Care and Urgent Care, services received from a non-Participating Provider outside of our Service Area will not be covered.

For Emergency Care and Urgent Care services received from non-Participating Providers within the state of Texas, please refer to the "Emergency Services" section of this Plan.

For Emergency Care and Urgent Care services that are provided outside of the Service Area by a non-Participating Provider, the amount(s) you pay for such services will be calculated using the methodology described in the "Emergency Services" section for non-Participating Providers located inside our Service Area. Federal or state law, as applicable, will govern payments for out- of- network emergency services.

C. Blue Cross Blue Shield Global Core

If you are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands in certain ways. For instance, although Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional Providers, the network is not served by a Host Blue. As such, when you receive care from Providers outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands, you will typically have to pay the Providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, will arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts/deductibles, coinsurance, etc. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services.

You must contact Blue Cross and Blue Shield of Texas to obtain Prior Authorization for non- emergency inpatient services.

Outpatient Services

Physicians, Urgent Care centers and other outpatient Providers located outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

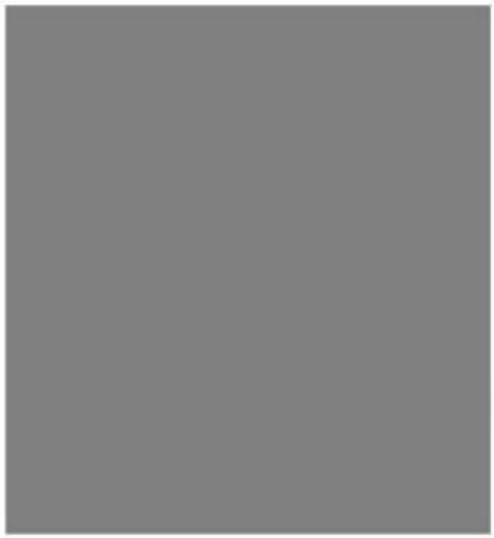
Submitting a Blue Cross Blue Shield Global Core Claim

When you pay for Covered Services outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form the Provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the Claim Administrator, the service center, or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the Blue Cross Blue Shield Global Core service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.









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