Administered by:

BlueCross BlueShield of Texas







Your Health Care Benefits Program
Blue Balance Funded

ATBCP206

This booklet describes the **group health plan** which we provide to protect you from the financial burden of catastrophic illness or injury.

To assure the professional handling of your health care **claims**, we have engaged Blue Cross and Blue Shield of Texas as **claim administrator**.

Please read the information in this benefit booklet carefully so you will have a full understanding of your health care benefits. If you want more information or have any questions about your health care benefits, please contact the Employee Benefits Department.

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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 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.

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

SUMMARY OF BENEFITS

Blue Balance Funded[SM]

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.

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 1st 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 - 01/01/2027.

Benefit Period	Calendar Year

Deductible	**In-Network Providers**	**Out-of-Network Providers**
Individual	$3,000	$6,000
Family	$9,000	$18,000
• Three month deductible carryover applies • Out-of-network deductible amounts will not be applied toward meeting the in-network deductible • In-network deductible amounts will not be applied to out-of-network deductible amounts • All applicable out-of-network pharmacy claims apply toward the out-of-network deductible		

Out-of-Pocket Maximum	**In-Network Providers**	**Out-of-Network Providers**
Individual	$7,350	Unlimited
Family	$14,700	Unlimited
• Out-of-network out-of-pocket maximum amounts will not be applied toward meeting the in-network out-of-pocket maximum • In-network out-of-pocket maximum amounts will not be applied to out-of-network maximum amounts • Includes calendar year deductible and copays		

Acupuncture

Description	In-Network You pay	Out-of-Network You pay
Acupuncture	Not covered	Not covered

Allergy Injections

Description	In-Network You pay	Out-of-Network You pay
Allergy Injections When billed separately from an office visit	30% coinsurance after calendar year deductible	50% coinsurance after calendar year deductible

Ambulance Services

Description	You pay
Air Ambulance	30% coinsurance after calendar year deductible
Ground Ambulance	30% coinsurance after calendar year deductible

Behavioral Health Services (Mental Health/Substance Use Disorder)

Description	In-Network You pay	Out-of-Network You pay
Inpatient Facility Services	30% coinsurance after calendar year deductible	50% coinsurance after calendar year deductible
Inpatient Physician Services	30% coinsurance after calendar year deductible	50% coinsurance after calendar year deductible
Outpatient Facility Services	30% coinsurance after calendar year deductible	50% coinsurance after calendar year deductible
Outpatient Physician Services	30% coinsurance after calendar year deductible	50% coinsurance after calendar year deductible

Chiropractic Care

Description	In-network You pay	Out-of-network You pay
Chiropractic Care	30% coinsurance after calendar year deductible	50% coinsurance after calendar year deductible
Limits	35 visit maximum per calendar year	
Visit limits are combined with physical therapy, occupational therapy, and outpatient rehabilitation.		

Durable Medical Equipment (DME)

Description	In-network You pay	Out-of-network You pay
DME	30% coinsurance after calendar year deductible	50% coinsurance after calendar year deductible

Emergency Services

Description	In-network You pay	Out-of-network You pay
Emergency Care Facility Charges	$500 per occurrence deductible then 30% coinsurance after calendar year deductible	$500 per occurrence deductible then 30% coinsurance after calendar year deductible
Emergency Care Physician Charges	30% coinsurance after calendar year deductible ER copay waived if admitted	30% coinsurance after calendar year deductible ER copay waived if admitted
Emergency Care Lab & X-ray without emergency room or treatment room	No coinsurance	50% coinsurance after calendar year deductible

Gender Affirming Care

Description	In-network You pay	Out-of-network You pay
Gender Affirming Care	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Hearing Aids and Audiological Services

Description	In-network You pay	Out-of-network You pay
Hearing Aids	30% coinsurance after calendar year deductible	50% coinsurance after calendar year deductible
Limits	1 per ear per 36-month period for hearing aids	

Home Health Care

Description	In-Network You pay	Out-of-Network You pay
Home Health Care	30% coinsurance after calendar year deductible	50% coinsurance after calendar year deductible Prior authorization required
Limits	60 visits maximum per calendar year	

Hospice Care

Description	In-Network You pay	Out-of-Network You pay
Hospice Care	No coinsurance	50% coinsurance after calendar year deductible
Limits	Unlimited	
• Includes bereavement counseling and respite care		

Imaging, Lab, & X-ray

Description	In-Network You pay	Out-of-Network You pay
MRI, CT Scan, PET Scan	30% coinsurance after calendar year deductible	50% coinsurance after calendar year deductible
Independent Lab & X-ray	No coinsurance	50% coinsurance after calendar year deductible

Infertility Treatment

Description	In-Network You Pay	Out-of-Network You pay
Infertility Treatments	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Artificial Insemination	Not covered	Not covered
In-Vitro Fertilization	Not covered	Not covered

Infusion Therapy

Description	In-Network You pay	Out-of-Network You pay
In the Home, Office, or Infusion Suite	$50 copay	50% coinsurance after calendar year deductible
In Hospital Setting	$500 copay	50% coinsurance after calendar year deductible

Inpatient Hospital Services

Description	In-Network You pay	Out-of-Network You pay
Inpatient Facility	30% coinsurance after calendar year deductible	50% coinsurance after calendar year deductible
Inpatient Physician Services	30% coinsurance after calendar year deductible	50% coinsurance after calendar year deductible
Penalty for Failure to Obtain Prior Authorization	No penalty for failure to obtain prior authorization for services	$250 penalty for failure to obtain prior authorization for services
• Certain services will require prior authorization; you can call the number on the back of your identification card for more information • 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	Out-of-network You pay
Maternity Care	Covered based on type of service and where it is received	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	Covered based on type of service and where it is received
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	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. • Benefit period deductible and coinsurance apply to subsequent visits and to all out-of-network provider services		

Occupational Therapy Services

Description	In-network You pay	Out-of-network You pay
Office Visit	30% coinsurance after calendar year deductible	50% coinsurance after calendar year deductible
In an Outpatient Setting	30% coinsurance after calendar year deductible	50% coinsurance after calendar year deductible
Limits	35 visit maximum (combined)	
• Benefits for autism spectrum disorder will not apply towards and are not subject to any occupational therapy services visits maximum. • Visit limit applied to a combination of physical therapy, occupational therapy, and chiropractic care.		

Outpatient Hospital Services

Description	In-Network You pay	Out-of-Network You pay
Outpatient Facility Surgery	30% coinsurance after calendar year deductible	50% coinsurance after calendar year deductible
Outpatient Physician Services	30% coinsurance after calendar year deductible	50% coinsurance after calendar year deductible
Penalty for Failure to Obtain Prior Authorization	Claim will be denied	50% coinsurance not to exceed $500

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 BENEFIT**

Physical Therapy Services

Description	In-network You pay	Out-of-network You pay
Office Visit	30% coinsurance after calendar year deductible	50% coinsurance after calendar year deductible
In an Outpatient Setting	30% coinsurance after calendar year deductible	50% coinsurance after calendar year deductible
Limits	35 visits each calendar year	
• Benefits for autism spectrum disorder will not apply towards and are not subject to any speech therapy services visits maximum. • Visit limit applied to a combination of physical therapy, occupational therapy, and chiropractic care.		

Physician and Specialist Services

Description	In-Network You pay	Out-of-Network You pay
Primary Care Office Visit or Consultation	$50 copay	50% coinsurance after calendar year deductible
Primary Care Telehealth/Telemedicine Visit	$50 copay	50% coinsurance after calendar year deductible
Specialty (Specialist) Office Visit or Consultation	$100 copay	50% coinsurance after calendar year deductible
Specialty (Specialist) Telehealth/Telemedicine Visit	$100 copay	50% coinsurance after calendar year deductible
Mental Health/Substance Use Office Visit	$50 copay	50% coinsurance after calendar year deductible
Mental Health-Substance Use Telehealth/Telemedicine Visit	$50 copay	50% coinsurance after calendar year deductible
Retail Health Clinic	$50 copay	50% coinsurance after calendar year deductible
Virtual Visits	$50 copay	Not applicable

Preventive Care Services

Description	In-network You pay	Out-of-network You pay
Preventive Care Services	No charge	50% coinsurance after calendar year deductible

Private Duty Nursing

Description	In-network You pay	Out-of-network You pay
Private Duty Nursing	Not covered	Not covered

Skilled Nursing Facility

Description	In-Network You pay	Out-of-Network You pay
Skilled Nursing Facility	30% coinsurance after calendar year deductible	50% coinsurance after calendar year deductible Prior authorization required
Limits	25 days maximum per calendar year	

Speech Therapy

Description	In-network You pay	Out-of-network You pay
Office Visit	30% coinsurance after calendar year deductible	50% coinsurance after calendar year deductible
In an Outpatient Setting	30% coinsurance after calendar year deductible	50% coinsurance after calendar year deductible
Limits	No Maximum	

- 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	Out-of-Network You pay
Physician & Facility Services	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Transplant Services (Organ and Tissue Transplants)

Description	In-network You pay	Out-of-network You pay
Organ and Tissue Transplants	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Travel and Lodging	Not covered	

Urgent Care

Description	In-network You pay	Out-of-network You pay
Urgent Care Center Visit	$75 copay	50% coinsurance after calendar year deductible
• Includes lab & x-ray services. • Excludes certain diagnostic procedures.		

Weight Loss Services

Description	In-network You pay	Out-of-network You pay
Weight Loss Services	Covered based on type of service and where it is received	

Wigs

Description	In-network You pay	Out-of-network You pay
Wigs	Not covered	

SUMMARY OF BENEFITS FOR PHARMACY BENEFITS

This is your summary of benefits for prescription drugs. It shows your cost share including **deductible amounts, copayment amounts** and **coinsurance amounts** and how they apply to the **covered prescription drugs** you receive under this **plan**. The information below summarizes your cost share and any limits that may apply to prescription drugs. You may contact Customer Service at the telephone number on the back of your member **identification card** or access your self-service online member portal, Blue Access for Members℠ (BAM) for any questions or additional information.

The **PHARMACY BENEFITS** section of this **benefit booklet** includes details on how the following **pharmacy benefits** work:

- How copayment and/coinsurance amounts apply
- How payment is determined (i.e., what are the tiers)
- **Prior authorizations**
- Limitations and exclusions

Retail Pharmacy Cost Share

Retail Pharmacy Program	Preferred Participating Pharmacy You Pay	Non-Participating Pharmacy You Pay
Tier 1 Generic Drugs (Preferred)	$0 copay	50% coinsurance plus non-preferred copay/coinsurance
Tier 2 Generic Drugs (Non-Preferred)	$10 copay	50% coinsurance plus non-preferred copay/coinsurance
Tier 3 Brand Name Drugs (Preferred)	$50 copay	50% coinsurance plus non-preferred copay/coinsurance
Tier 4 Brand Name Drugs (Non-Preferred)	$100 copay	50% coinsurance plus non-preferred copay/coinsurance
Preferred Pharmacy Retail Network Differential	Additional $10 Generic/ $20 Preferred and Non-Preferred Brand Member cost share	
• One copayment per 30-day supply at a participating pharmacy		

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)	$0 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 Retail Prescription Drug Supply (if allowed by the Prescription Order) - one Copayment Amount per 30-day supply, up to a 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	Non-Participating Pharmacy
Tier 5 Specialty Drugs (Preferred)	$150 copay	50% coinsurance plus non-preferred copay/coinsurance
Tier 6 Specialty Drugs (Non-Preferred}	$250 copay	50% coinsurance plus non-preferred copay/coinsurance
Limits	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 You Pay	Other Pharmacy You Pay
Select Vaccinations Obtained through Pharmacies	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 available under the pharmacy benefits portion of your plan. • The copayment amount 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.

Select covered drugs, determined by the plan, may be covered with no member cost share, to make these medications more affordable to members.

INTRODUCTION

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

The defined terms throughout this booklet are in bold font and are defined in the **GLOSSARY**.

The terms "you" and "your" as used in this benefit booklet refer to the **employee**.

The terms "we" and "us" as used in this benefit booklet refer to the claim administrator/BCBSTX.

In-Network Benefits

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

To receive **in-network benefits** as shown on your **SUMMARY OF BENEFITS (SOB)**, you must choose **providers** within the **network** for all care (except for emergencies). The **network** has been established by BCBSTX and consists of **physicians**, **specialty care providers**, **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 finding an **in-network provider** you can view our **provider** directory by visiting our website at www.bcbstx.com.

You are responsible for paying any **deductibles**, **copays**, and coinsurance. You may be required to pay for limited or non-covered services. No claim forms are required.

Out-of-Network Benefits

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

You will be responsible for paying:

- Billed charges above the **allowable amount** as determined by the **claim administrator**
- **Coinsurance** and **deductibles**
- Limited or non-**covered services**
- Failure to obtain **prior authorization** penalty

Your Insurance Identification Card

Show your **identification card** each time you receive services from a **provider**. 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 applies 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.

Medical Necessity

All services and supplies for which benefits are available under the **plan** must be **medically necessary** as determined by us. Charges for services and supplies which we determine are not **medically necessary** will not be eligible for benefit consideration and may not be used to satisfy **deductibles** or to apply to the **co-share** stop-loss amount.

Pharmacy Benefits

Benefits are provided for those **covered drugs** as explained in the **PHARMACY BENEFITS** section and shown on your **SUMMARY OF BENEFITS** in this benefit booklet. The amount of your payment under the **plan** depends on whether:

- The **prescription order** is filled at a **participating pharmacy**, or at a non-Participating **pharmacy**, or through the mail-order program
- The **prescription order** is filled by a **provider** contracting with BCBSTX
- A Preferred or **non-preferred generic drug** is dispensed
- A Preferred or **non-preferred brand name drug** is dispensed
- A **specialty drug** is dispensed

Important Contact Information

Resource	Contact Information	Accessible Hours
Customer Service Helpline	1-800-521-2227	Monday – Friday 8:00 a.m. – 8:00 p.m.
Website	www.bcbstx.com	24 hours a day 7 days a week
Medical Prior Authorization Helpline	1-800-441-9188	Monday – Friday 6:00 a.m. – 6:00 p.m.
Mental Health/**Substance Use Disorder** Prior Authorization Helpline	1-800-528-7264	24 hours a day 7 days a week

WHO GETS BENEFITS

No eligibility rules or variations in premium will be imposed based on your health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any 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. Coverage under this **plan** does not require documentation certifying a Covid-19 vaccination or require documentation of post-transmission recovery as a condition for obtaining coverage or receiving benefits under this **plan**. Variations in the administration, processes or benefits of this **plan** that are based on clinically indicated, reasonable medical management practices, or are part of permitted wellness incentives, 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. You are eligible for coverage under this benefit booklet when you satisfy the following:

- Meet the definition of an **eligible person** as specified by your **employer**
- Have applied for this coverage
- Have received a Blue Cross and Blue Shield of Texas insurance **identification card**

Dependent Eligibility

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

- Your spouse
- Your **domestic partner** (Note: **domestic partner** coverage is available at your **employer's** discretion. Contact your **employer** for information on whether **domestic partner** coverage is available for your group)
- Your child until the month they turn age 26
- Any other **child** such as a step**child**, an eligible foster **child**, an adopted **child** or **child** placed for adoption (including a **child** for whom you, your spouse or your **domestic partner** is a party in a legal action in which the adoption of the **child** is sought), under 26 years of age
- A **child** of any age who is medically certified as **disabled** and **dependent** upon you, your spouse or **domestic partner**

This plan does not include benefits for grandchildren unless legal guardianship is obtained.

Note: Civil union and domestic partnership coverage is available at your **employer's** discretion. Contact your **employer** for information on whether **civil union** or **domestic partner** coverage is available under your **plan**.

Applying for Coverage

You and your 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

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**.

Special Enrollment Period

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

- You or your **dependent** lose other health insurance coverage or COBRA continuation coverage
- You lose a **dependent**
- You gain a **dependent** through:
  - Birth
  - Adoption or placement for adoption
  - Legal guardianship or placement of a foster child
  - Marriage or **domestic partnership**
- 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 a Medicaid plan or a state **child** health plan

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
- If you are adding a **dependent** due to marriage or establishment of a **domestic partnership**, adoption, or a child being involved in a suit for which an adoption of the child is sought, or your **employer** receives a court order to provide health coverage for a **participant's** child or your spouse, you must submit an enrollment application/change form and the coverage of the **dependent** will become effective.
- When you divorce or terminate a **domestic partnership** or your child reaches the age indicated on your **SUMMARY OF BENEFITS** as "Dependent Child Age Limit," or a **participant** in your family dies, coverage under the **plan** terminates in accordance with the **Termination of Coverage** provisions selected by your **employer**.

Employee Application/Change Form

You can obtain an **employee** application/change form from your **employer,** by calling the number on your **identification card** or by accessing your self-service member portal, Blue Access for Members (BAM) for the qualifying events listed above. If a **dependent's** address and zip code are different from yours, be sure to indicate this information on the form. After you have completed the form, return it to your **employer**.

Use this form if you want to:

- Notify the **plan** of a change to your name
- Add **dependents**
- Drop **dependents**
- Cancel all or a portion of your coverage

- Notify the **plan** of changes in address for you and your **dependents**. An address change may result in benefit changes for you and your **dependents** if you move out of the **plan service area** of the **network**.

Notify your **employer** promptly if any of these events occur. Benefits for expenses incurred after termination are not available. If your **dependent's** coverage is terminated, refund of contributions will not be made for any period before the date of notification. If benefits are paid prior to notification to the **claim administrator** by the **plan administrator**, refunds will be requested.

Please refer to the **Continuation of Group Coverage Federal** subsection in this benefit booklet for additional information.

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 **plan anniversary 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**. However, if this **plan** is replacing a discontinued **health benefit plan** or self-funded **health benefit plan**, benefits for any **employee** or **dependent** may be delayed until the expiration of any applicable extension of benefits provided by the previous **health benefit plan** or self-funded **health benefit plan**.

Dependent Special Enrollment Coverage

	Coverage
Newborn Children	Automatic for first 60 days after birth Effective on the date of birth After 60 days: Notify us through the **plan administrator** and pay applicable charges for coverage to continue Effective on the plan anniversary date after next open enrollment period
Adopted Children (includes children involved in adoption suit)	Automatic for the first 60 days after adoption/date suit for adoption is sought After 60 days: We must receive all required forms and contributions for coverage to continue Effective on the plan anniversary date after next open enrollment period
Court Ordered Dependent Children	Automatic for the first 31 days after **employer** receives notification of court order After 31 days: Notify us through the **plan administrator** for coverage to continue Effective on plan anniversary date after next open enrollment period
Spouse, Domestic Partner, Child	Written application required within 31 days qualifying as **dependent** Effective on the date became eligible **dependent** After 31 days: Effective on plan anniversary date after next open enrollment period

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 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 coverage under the prior **health benefit plan** or self-funded **health benefit**

plan 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 of coverage is terminated
- Incurring a claim that would meet or exceed a lifetime limit on all benefits under prior health plan coverage
- The other **plan** no longer offers any benefits to the class of similarly situated individuals that include you or your **dependent**
- If coverage was through a health maintenance organization (HMO), you or your **dependent** no longer reside, live, or work in the service area of that HMO and no other benefit option is available

- Exhaustion of continuation under Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended
- 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

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 this section:

Health Status Related Factor means:

- Health status
- Medical condition, including both physical and mental illness
- 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

Open Enrollment Period means the 31-day period preceding the next **contract date** during which **employees** and **dependents** may enroll for coverage.

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.

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**, pay the entire expense after you reach your **out-of-pocket maximum**
- Expenses in this general rule means the **allowable amount** for services received from an **in-network provider** and an **out-of-network provider**

Allowable Amount

The **allowable amount** is the maximum amount of benefits we will pay for expenses you incur under the plan. We have established an **allowable amount** for:

- **Medically necessary** services, supplies, and procedures provided by **in-network providers** that have contracted with us or any other Blue Cross and/or Blue Shield **plan**, and
- **Medically necessary** services, supplies, and procedures provided by **out-of-network providers** that have not contracted with us or any other Blue Cross and/or Blue Shield **plan**.

When you choose to receive **medically necessary** services, supplies, or care from a **provider** that does not contract with us, you will be responsible for any difference between our **allowable amount** and the amount charged by the **out-of-network provider**.

You will also be responsible for charges for services, supplies, and procedures limited or not covered under the **plan**.

Your benefits are calculated on a **calendar year** benefit period basis unless otherwise stated. At the end of a **calendar year**, a new benefit period starts for each **participant**.

Deductible(s)

Benefits under your **plan** will be available after you meet your **deductible(s)** as shown on your **SUMMARY OF BENEFITS**. Should the federal government adjust the **deductible** amount(s) applicable to this type of coverage, the **deductible** amount(s) will be adjusted accordingly.

How individual **deductibles** work:

- **Benefits** will be available after your individual **deductible** amount, shown in 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.**

The following may be exceptions to the **deductible(s)**:

- In-network preventive care services are not subject to **deductibles**.
- If "three-month **deductible** carryover applies." This means that any expenses incurred during the last three months of a **calendar year** and applied toward satisfaction of the **calendar year deductible** for that **calendar year** may be applied toward satisfaction of the **deductible** for the following **calendar year**.
- **Eligible expenses** applied toward satisfying the individual and family in-network **deductible** will only apply to the in-network **deductible**. **Eligible expenses** applied toward satisfying the individual and family out-of-network **deductible** will only apply to the out-of-network **deductible**.

Copayments

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**.

A copayment as indicated on your **SUMMARY OF BENEFITS** will be required for each **physician** office visit when services are received by:

- A family practitioner
- A general practitioner
- An obstetrician/gynecologist
- A pediatrician
- An internist
- A **professional other provider**

In-network preventive care services are not subject to this **copayments** provision.

The following **covered services** are not subject to an office visit copayment. but may be subject to **deductible** and/or coinsurance (if applicable). Benefits will be provided at the payment levels shown in your **SUMMARY OF BENEFITS**.

- Surgery performed in the **physician's** office
- Physical therapy billed separately from an office visit
- Occupational modalities in conjunction with physical therapy
- Allergy injections billed separately from an office visit
- Therapeutic injections
- Any services requiring **prior authorization**
- Certain diagnostic procedures
- Services provided by an independent lab, imaging center, radiologist, pathologist, and anesthesiologist
- Outpatient treatment therapies or services such as radiation therapy, chemotherapy, and renal dialysis

A **copay** will be required for each visit to an **urgent care center**. If the services provided require a return office visit (lab services for instance) on a different day, a new copay will be required. The following services are not subject to a copay. Benefits will be provided at the payment levels shown in your **SUMMARY OF BENEFITS**:

- Surgery performed in the urgent care center
- Physical therapy billed separately from an urgent care visit

- Occupational modalities in conjunction with physical therapy
- Allergy injections billed separately from an urgent care visit
- Therapeutic injections
- Any services requiring **prior authorization**
- Certain diagnostic procedures
- Outpatient treatment therapies or services such as radiation therapy, chemotherapy, and renal dialysis

A **copay** will be required for facility charges for each **hospital** outpatient emergency room visit. If admitted to the **hospital** as a direct result of the emergency condition or accident, the copay will be waived.

If shown in your **SUMMARY OF BENEFITS**, a copay will be required for each visit to a **retail health clinic** and each virtual visit.

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** received from **in-network providers** before we (your **plan**) will begin to cover all charges at 100% for the remainder of the **benefit period**.

The **out-of-pocket maximum** will **not** include:

- Any penalty incurred due to your failure to follow the plan's requirements for **prior authorization**
- Services, supplies, or charges limited or excluded by the **plan**
- Expenses not covered because a benefit maximum has been reached
- Any **eligible expenses** paid by the primary **plan** when BCBSTX is the secondary **plan** for purposes of coordination of benefits

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** (except for those charges specifically excluded below) paid by us at 100% of the **allowable amount**.

The following are exceptions to the **out-of-pocket maximum** described above:

- There are separate **out-of-pocket maximums** for **in-network benefits** and **out-of-network benefits**.

Freedom of Choice

Each time you need medical care, you can choose to:		
See a Network Provider	**See an Out-of-Network Provider**	
	ParPlan Provider (refer to ParPlan, below, for more information)	**Out-of-Network Provider** (not a contracting Provider)
• You receive the higher level of benefits (**in-network benefits**) • You are not required to file claim forms. • You are not balance billed; **network providers** will not bill for costs exceeding the **claim administrator**'s **allowable amount** for **covered services**. • Your **provider** will obtain **prior authorization** for necessary services	• You receive the lower level of benefits (**out-of-network benefits**) • You are not required to file claim forms in most cases; ParPlan **providers** will usually file claims for you. • You are not balance billed; ParPlan **providers** will not bill for costs exceeding the **claim administrator's allowable amount** for **covered services** • In most cases, ParPlan **providers** will obtain **prior authorization** for necessary services	• You receive **out-of-network benefits** (the lower level of benefits) • You are required to file your own claim forms. • You may be billed for charges exceeding **claim administrator's allowable amount** for **covered services.** • You must obtain **prior authorization** for necessary services

ParPlan

When you consult a **physician** or **professional other provider** who does not participate in the network, you should ask if they participate in our ParPlan a simple direct-payment arrangement. If the **physician** or **professional other provider** participates in the ParPlan, they agree to:

- File all claims for you
- Accept our **allowable amount** determination as payment for **medically necessary** services
- Not bill you for services over the **allowable amount** determination.

You will receive **out-of-network benefits** and be responsible for:

- Any **deductibles**
- **Coinsurance**
- Services that are limited or not covered under the plan

Specialty Care Providers

A wide range of specialty care **providers** is included in the **network**. When you need a specialist's care, **in-network benefits** will be available, but only if you use a **network provider**.

There may be occasions however, when you need the services of an **out-of-network provider**. This could occur if you have a complex medical problem that cannot be taken care of by a **network provider**.

- If the services you need are not available from **network providers**, **in-network benefits** will be provided

when you use **out-of-network providers**.

- If you choose to see an **out-of-network provider** and if the services could have been provided by a **network provider**, only **out-of-network benefits** will be available.

Use of Non-Contracting Providers

When you choose to receive services, supplies, or care from a **provider** that does not contract with us (a non-contracting **provider**), you receive **out-of-network benefits** (the lower level of benefits). Benefits for **covered services** will be paid based on our non-contracting **allowable amount**, which in most cases is less than the **allowable amount** applicable for our contracted **providers**. Please see the definition of **allowable amount** in the **GLOSSARY** section of this benefit booklet.

Note: The **non-contracted providers** are not required to accept our non-contracting allowable amount as payment in full. They may balance bill you for the difference between our non-contracting **allowable amount** and the non-contracting **provider's billed charges.** You will be responsible for this balance bill amount, which may be very large. You will also be responsible for charges for services, supplies, and procedures limited or not covered under the **plan,** any applicable **deductibles, coinsurance,** and **copays**.

However, if you

- Pay the non-contracting **provider** a rate less that the average discounted rate which would be paid by us to an **in-network provider** directly for a covered and **medically necessary** service or supply; and
- The non-contracting **provider** does not submit a claim to us for that service or supply;

then you may submit the appropriate document with a claim form to us, and allowable credit will, as applicable, be applied towards your **in-network deductible** and **out-of-pocket maximum**.

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**. It is your responsibility to ensure that **prior authorization** is obtained, or those services may carry a cost share penalty or a denial of payment. Refer to the **UTILIZATION MANAGEMENT** section or contact customer service by calling the number on the back of your **identification card** or visiting the Blue Access for Members℠ (BAM) website for additional information including which services may require **prior authorization**.

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
- Community reintegration services
- Neurobehavioral testing
- Neurocognitive rehabilitation
- Neurocognitive therapy
- Neurofeedback therapy
- Neurophysiological testing
- Neurophysiological treatment
- Neuropsychological testing
- Neuropsychological treatment
- Post-acute transition services
- Psychophysiological testing
- Psychophysiological treatment
- Remediation

Treatment for an **acquired brain injury** 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.

Benefits for **acquired brain injury** will not be subject to any visit limit indicated on your **SUMMARY OF BENEFITS**.

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.

Ambulances Services

Covered services include:

- Emergency ground transportation by means of a specifically designed and medically equipped vehicle used for transporting the sick and injured.

Non-emergency ground ambulance transportation to or from a **hospital** or medical facility, outside of the acute care **hospital** setting, may be considered **medically necessary** if your condition is such that trained ambulance attendants are required to monitor your clinical status (e.g., vital signs and oxygenation), or provide treatment such as oxygen, intravenous fluids or drugs, in order to safely transport you, or you are confined to bed and cannot be safely transported by any other means.

Air ambulance emergency transportation is covered when:

- Terrain and/or distance require the use of air **ambulance services** rather than ground ambulance.
- Your physical condition or other medical circumstance is critical and requires rapid transportation from one **hospital**/facility to another.

Non-emergency air ambulance transportation may be covered when transportation from a **hospital** emergency department, health care facility, or inpatient setting to an equivalent or higher level of acuity facility may be considered **medically necessary** when you or your **dependent** require acute **inpatient** care and services are not available at the originating facility and commercial air transport or safe discharge cannot occur. Such transfer must be to the nearest facility able to perform the **medically necessary** services not available at the originating facility.

The following are **not covered services**:

- Non-emergency ground or air ambulance transportation services provided primarily for the convenience of you, your family/caregivers, **physician**, or the transferring facility.
- Travel or ambulance services because it is more convenient for the patient than other modes of transportation whether or not recommended by a **physician** or **professional other provider.**

Ambulance services means local transportation to the closest facility appropriately equipped and staffed for treatment of your condition.

Autism Spectrum Disorder

Covered services may include:

- Evaluation and assessment services
- Screening at 18 and 24 months
- Applied behavior analysis
- Behavior training and behavior management
- Speech therapy
- Occupational therapy
- Physical therapy
- Medications or nutritional supplements used to address symptoms of **autism spectrum disorder**

Your **physician** or **behavioral health practitioner** must prescribe these services in a recommended treatment

plan. Individuals providing treatment prescribed under this **plan** must be:

- Licensed, certified, or registered by an appropriate agency of the state of Texas
- Recognized and accepted by an appropriate agency of the United States (professional credentials)
- 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.

Benefits for **autism spectrum disorder** will not apply towards any maximum indicated on your **SUMMARY OF BENEFITS**. Please review the physical medicine services and Benefits for Speech and Hearing Services provisions of this benefit booklet.

Autism Spectrum Disorder (ASD) means a neurobiological disorder that includes autism, Asperger's syndrome, or pervasive development disorder- - not otherwise specified. A neurobiological disorder means an illness of the nervous system caused by genetic, metabolic, or other biological factors.

Behavioral Health

Mental Health Care, Treatment of Mental Health Condition and Treatment of Substance Use Disorder

Benefits for expenses incurred for **mental health care**, treatment of **mental health condition** and treatment of **substance use disorder** will be the same as for treatment of any other sickness.

Any expenses incurred for the services of a **crisis stabilization unit or facility**, a **residential treatment center**, or a **residential treatment center for children and adolescents** for **medically necessary mental health care** or treatment of **mental health condition** in lieu of inpatient **hospital** services will, for the purpose of this benefit, be considered **inpatient hospital expenses**.

Inpatient treatment of **substance use disorder** must be provided in a **substance use disorder treatment center** or **hospital**. Benefits for the medical management of acute life-threatening intoxication (toxicity) in a **hospital** will be available on the same basis as for sickness generally as described under **Inpatient Hospital Expense**.

Mental health care provided as part of the **medically necessary** treatment of **substance use disorder** will be considered for benefit purposes to be treatment of **substance use disorder** until completion of **substance use disorder** treatments. (**Mental health care** treatment after completion of **substance use disorder** treatments will be considered **mental health care**.)

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 care** and **mental health condition** services to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

Mental Health Care means any one or more of the following:

- The diagnosis or treatment of a mental disease, disorder, or condition listed in the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association*, as revised, or any other diagnostic coding system as used by the **claim administrator**, whether or not the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin;
- The diagnosis or treatment of any symptom, condition, disease, or disorder by a **physician**, **behavioral health practitioner** or **professional other provider** (or by any person working under the direction or

supervision of a **physician**, **behavioral health practitioner** or **professional other provider**) when the eligible expense is:

- Individual, group, family, or conjoint psychotherapy
- Counseling
- Psychoanalysis
- Psychological testing and assessment
- The administration or monitoring of psychotropic drugs
- **Hospital** visits or consultations in a facility listed below

- Electroconvulsive treatment
- Psychotropic drugs
- Any of the services listed above, performed in or by a **hospital**, facility **other provider**, or other licensed facility or unit providing such care

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

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 degree 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 or 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 onsite nursing care and supervision for at least one shift a day with on call availability for other shifts.

Residential Treatment Center for Children and Adolescents means a child-care institution which is appropriately licensed and accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Association of Psychiatric Services for Children as a residential treatment center for the provisions of **mental health care** and **mental health condition** services for emotionally disturbed children and adolescents.

Mental Health Condition means the following psychiatric illnesses 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 or depressive)
- Schizophrenia

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 which provides a program for the treatment of **substance use disorder** pursuant to a written treatment **plan** approved and monitored by a **behavioral health practitioner** and which facility is also:

- 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 Organization
- 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.

Biomarker Testing

Covered services include **medically necessary** biomarker testing for the purpose of:

- Diagnosis
- Treatment
- Appropriate management
- Ongoing monitoring of a member's 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; or
    - 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.

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; or

- 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 high risk of developing coronary heart disease, based on the Framingham Heart Study coronary prediction algorithm.

Certain Therapies for Children with Developmental Delays

Covered services include:

- Occupational therapy evaluations and services
- Physical therapy evaluations and services
- 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 three, when services under the **individualized family service plan** are ended, other services covered under this **plan** will be available. All contractual provisions of this **plan** will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximums.

Developmental Delay means a significant variation in normal development as measured by appropriate diagnostic instruments 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 costs and related services you have from a **provider** in connection with participation in an approved clinical trial.

Routine Patient Care Costs means the costs of any **medically necessary** health care service for which benefits are provided under the **plan**, without regard to whether the **participant** is participating in a clinical trial.

Routine patient care costs do not include:

- The investigational item, device, or service, itself
- Items and services that are provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Contraceptive/Birth Control Services

Covered services include contraceptive services such as:

- Contraceptive counseling
- Examinations, procedures and medical services related to contraceptives
- Reproductive sterilization procedures
- FDA approved prescription drugs and devices – prescription contraceptive drugs may be covered under your **PHARMACY BENEFITS**.

Cosmetic, Reconstructive, or Plastic Surgery

Covered services may include:

- Correction of defects incurred in an **accidental injury.**
- Reconstructive surgery following cancer surgery.
- Surgery performed on a newborn child for the treatment or correction of a congenital defect.
- Surgery performed on a covered **dependent** child (other than a newborn child) under the age of 19 for the treatment or correction of a congenital defect other than conditions of the breast.
- Reconstructive surgery following a mastectomy, including:
    - Surgery and reconstruction of the other breast to achieve a symmetrical appearance.
    - Prostheses
    - Treatment of physical complications, including lymphedemas, at all stages of the mastectomy
- Reconstructive surgery performed on a covered **dependent** child due to craniofacial abnormalities to:
    - Improve function
    - Create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Cosmetic, Reconstructive, or Plastic Surgery means surgery that:

- Can be expected or is intended to improve the physical appearance of a **participant.**
- Is performed for psychological purposes.
- Restores form but does not correct or materially restore a bodily function.

Accidental Injury means accidental bodily injury resulting, directly and independently of all other causes, in initial necessary care provided by a **physician** or **professional other provider**.

Dental Services

Covered services include:

- Oral Surgery

- Services for treatment or correction of a congenital defect
- The correction of damage caused solely by **accidental injury**, including injury resulting from:
  - Domestic violence or a medical condition
  - Healthy, un-restored natural teeth and supporting tissues

An **accidental injury** does not include injury resulting from:

- Biting
- Chewing

Covered Oral Surgery means maxillofacial surgical procedures limited to:

- Excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths
- Surgical and diagnostic treatment of conditions affecting the temporomandibular joint (including the jaw and the craniomandibular joint) as a result of an accident, a trauma, a congenital defect, a developmental defect, or a pathology.
- Removal of complete/partial bony impacted teeth
- Incision and drainage of facial abscess
- Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses.

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

If you are unable to undergo dental treatment in a dental office or under local anesthesia due to a documented physical, mental or medical reason, as determined by your physician or by the dentist providing the dental care, you will have coverage for **medically necessary**, non-dental related services to the dental treatment.

The following are not covered services:

- Any other dental services, except as excluded in the **MEDICAL LIMITATIONS AND EXCLUSIONS** section of this benefit booklet, for which you incur **inpatient hospital expenses** for a **medically necessary** inpatient **hospital** admission, will be determined as described in the **GLOSSARY** under **Inpatient Hospital Expenses**.
- Any non-surgical (dental restorations, orthodontics, or physical therapy) or non-diagnostic services or supplies (oral appliances, oral splints, oral orthotics, devices, or prosthetics) provided for the treatment of the temporomandibular joint (including the jaw and craniomandibular joint) and all adjacent or related muscles.
- Any items of **medical-surgical expenses** incurred for dental care and treatments, dental surgery, or dental appliances, except as provided for in this **Dental Services** section.
- Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.

Diabetic Equipment, Supplies and Self-Management

You are eligible for coverage if you have been diagnosed with:

- Insulin dependent diabetes
- Non-insulin dependent diabetes

- Elevated blood glucose levels induced by pregnancy
- Another medical condition associated with elevated blood glucose levels

Covered services include:

- Diabetes equipment:
  - Blood glucose monitors (including noninvasive glucose monitors and monitors for the blind)
  - Insulin pumps (both external and implantable) and associated appurtenances, which include:
    - Insulin infusion devices
    - Batteries
    - Skin preparation items
    - Adhesive supplies
    - Infusion sets
    - Insulin cartridges
    - Durable and disposable devices to assist in the injection of insulin
    - Other required disposable supplies
  - Podiatric appliances, including up to two pairs of therapeutic footwear per **calendar year**, for the prevention of complications associated with diabetes

- Diabetes supplies (covered under the **PHARMACY BENEFITS** portion of your **plan**):
  - Test strips specified for use with a corresponding blood glucose monitor
  - Visual reading and urine test strips and tablets for glucose, ketones, and protein
  - Lancets and lancet devices
  - Insulin and insulin analog preparations
  - Injection aids, including devices used to assist with insulin injection and needleless systems
  - Biohazard disposable containers
  - Insulin syringes
  - Prescriptive and non-prescriptive oral agents for controlling blood sugar levels
  - Glucagon emergency kits

- Repairs and necessary maintenance of insulin pumps not otherwise provided for under the manufacturer's warranty or purchase agreement
- Rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump
- New or improved treatment, monitoring equipment, or supplies that become available and are:
  - Approved by the U. S. Food and Drug Administration (FDA)
  - **Medically necessary** and appropriate
  - Prescribed by your **physician** or **other provider**
- Diabetes self-management training for which a **physician** or **professional other provider** has written an order is limited to the following when rendered by or under the direction of a **physician**.

  Initial and follow-up instruction concerning:
  - The physical cause and process of diabetes
  - Nutrition, exercise, medications, monitoring of laboratory values and the interaction of these in the effective self-management of diabetes
  - Prevention and treatment of special health problems for the diabetic patient
  - Adjustment to lifestyle modifications
  - Family involvement in the care and treatment of the diabetic patient. The family will be included in certain sessions of instruction for the patient

Diabetes self-management training will include the development of an individualized management **plan** that is created for and in collaboration with you (and/or your family) to understand the care and management of diabetes, including nutritional counseling and proper use of equipment and supplies.

Diagnostic Services

Covered services include:

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

The following are covered diagnostic and diagnostic imaging service examples:

- Radiology and x-ray
- Ultrasounds
- Nuclear medicine
- Laboratory and pathology
- ECG, EEG, PET, CT, MRI and other electronic medical procedures
- Bone Scan
- Cardiac Stress Test
- Myelogram
- Sleep Studies
- Diagnostic mammography and other breast imaging

Diagnostic imaging is covered to the same extent as **Mammography Screening** under **PREVENTIVE CARE**, without age restrictions.

Diagnostic imaging means an imaging exam using mammography, ultrasound imaging, or magnetic resonance imaging (MRI) that is designed to evaluate:

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

Durable Medical Equipment

Covered services include:

- The rental and/or purchase of durable medical equipment with a written prescription for your therapeutic use. Rental equipment is not to exceed the total cost of the equipment. If you purchase your durable medical equipment the equipment will only be covered if you need it for long-term use.

The following are covered equipment examples:

- Wheelchair, cane, crutches, walker, ventilator, oxygen tank
- Mandibular reconstruction devices
- Internal cardiac valves, internal pacemakers
- External heart monitors (cardiac event detection monitoring device)

The following are examples of non-covered equipment:

- Modifications to home or vehicle such as: vehicle lifts or star lifts
- Biofeedback equipment
- Computer assisted communication devices
- Home spirometers or telespirometers
- Replacement of lost or stolen durable medical equipment
- Personal comfort, hygiene or convenience items such as support garments and air purifiers
- Physical fitness equipment

The following are **not covered services**:

- Any items that include, but are not limited to, an orthodontic or other dental appliance; splints or bandages provided by a **physician** in a non-hospital setting or purchased "over the counter" for support of strains and sprains; orthopedic shoes which are a separable part of a covered brace, specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or affect changes in the foot or foot alignment, arch supports, elastic stockings and garter belts.

NOTE: This exclusion does not apply to podiatric appliances when provided as diabetic equipment.

Durable medical equipment also known as (DME) means equipment or supplies ordered by a health care provider that help you complete your daily activities, serves a medical purpose and the equipment can withstand repeated daily or extended use.

Note: Diabetes supplies considered DME will not apply toward any benefit maximum

Emergency Services

Covered services include:

- **Emergency care** services provided in:
- Emergency room
- Freestanding emergency room

Other comparable facilities that are not **emergency care** may be excluded from **emergency care** coverage. If you disagree with our determination in processing your benefits as non-emergency care instead of **emergency care**, you may call us at the number on the back of your **identification card**.

Please review the **Review of Claim Determinations** subsection of this benefit booklet for specific information on your right to seek and obtain a full and fair review of your claim.

Emergency services does not require **prior authorization**. However, if reasonably possible, contact your network **physician** or **behavioral health practitioner** before going to the emergency room/treatment room. If not reasonably possible, go to the nearest emergency facility, whether or not the facility is in the network.

Whether you require hospitalization or not, you should notify your network **physician** or **behavioral health practitioner** within 48 hours, or as soon as reasonably possible, of any emergency medical treatment so they can recommend the continuation of any necessary medical services.

Benefits for emergency services, including **emergency care** for behavioral health services and accidental injury, will be determined as shown on your **SUMMARY OF BENEFITS**. Copay will be required for facility charges for each emergency room/treatment room visit as indicated on your **SUMMARY OF BENEFITS**. If admitted for the emergency condition immediately following the visit, the copay will be waived and **prior authorization** of the inpatient **hospital** admission will be required.

All treatment received following the onset of an **accidental injury** or **emergency care** will be eligible for **in-network benefits**. For a non-emergency, **in-network benefits** will be available only if you use **network providers**. For a non-emergency, if you can safely be transferred to the care of a **network provider** but are treated by an **out-of-network provider**, only **out-of-network benefits** will be available.

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

The following are not covered services:

- Any services or supplies provided for, in preparation for, or in conjunction with:
  - Sterilization reversal (male or female)
  - Sexual dysfunctions
  - In vitro fertilization
  - Promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct intra-peritoneal insemination, trans-uterine tubal insemination, gamete intra-fallopian transfer, pronuclear oocyte stage transfer, zygote intra-fallopian transfer, and tubal embryo transfer.

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.

Foot Orthotics

Benefits for **medically necessary** foot orthotics that are consistent with the Medicare Benefit Policy Manual are available and will be determined on the same basis as any other sickness. There is no **calendar year** maximum. This is in addition to, and does not affect the coverage for podiatric appliances as shown under **Diabetic Equipment, Supplies and Self-Management**.

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 include:

- 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

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 Impairment Screening Tests for Newborn

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 tests from birth through the date the child is 24 month

Deductibles indicated on your **SUMMARY OF BENEFITS** will not apply to this provision.

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

The following are not covered services:
- Food or home delivered meals
- Homemaker services
- Services provided primarily for custodial care
  Transportation services

Home health agency means a business that provides **home health care** and is licensed, approved, or certified by the appropriate agency of the state in which it is located or is certified by Medicare as a supplier of **home health care**.

Home health care means the health care services which are provided during a visit by a **home health agency** to patients confined at home due to a sickness or injury requiring skilled health services on an intermittent, part-time basis.

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 means a facility or agency primarily engaged in providing skilled nursing services and other therapeutic services for terminally ill patients and which is:
- Licensed in accordance with state law (where the state law provides for such licensing) or
- Certified by Medicare as a supplier of **hospice care**

Hospice Care means services for which benefits are provided under the **plan** when provided by a Hospice to patients confined at home or in a Hospice facility due to a terminal sickness or terminal injury requiring skilled health care services.

Infertility Treatment

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

- Services rendered in connection with a diagnosis and/or treatment of infertility
- Evaluation services to determine underlying cause of infertility
- Surgical treatment to correct medical condition causing infertility
- Assisted reproductive procedures such as:
  - Ovulation induction
  - Sperm identification

The following are **not covered services**:

- Artificial insemination
- In vitro fertilization

Infusion Therapy

Covered services include:

Infusion and injectable therapy

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, "**infusion therapy**" 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.

Maternity Care

A copay will be required for the initial office visit for maternity care but will not be required for subsequent visits. **Dependent** children will be eligible for maternity care benefits.

Services and supplies incurred for delivery of a child will be considered maternity care and are subject to all provisions of the plan.

Covered services include inpatient care for the birthing parent/mother 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.

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

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

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 birthing parent's/mother's **hospital admission** for the delivery will be considered inpatient **hospital** services of the child 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**.

Pregnancy Complications

Dependent children will be eligible for treatment of complications of pregnancy.

Complications of Pregnancy means conditions (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 abortion
- Similar medical and surgical conditions of comparable severity
- 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.

Complications of pregnancy do not include:

- False labor
- Occasional spotting
- **Physician**-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.

Mammography Screening

Benefits are available for a screening by low-dose mammography for the presence of occult breast cancer for a **participant** 35 years of age and older, as shown in Preventive Care on your **SUMMARY OF BENEFITS**, except that benefits will not be available for more than one routine mammography screening each **calendar year**. Low-dose mammography includes digital mammography or breast tomosynthesis.

The copay and coinsurance shown on your **SUMMARY OF BENEFITS** for Preventive Services will apply.

Organ and Tissue Transplants

Covered services and supplies include:

- X-rays
- Laboratory testing
- Chemotherapy
- Radiation therapy
- Procurement of organs or tissues from a living or deceased donor, and complications arising from transplant
- Evaluation of organs or tissues including, but not limited to, the determination of tissue matches.
- Donor search and acceptability testing of potential live donors
- Removal of organs or tissues from living or deceased donors
- Transportation and short-term storage of donated organs or tissues

Benefits will be available for:

- A recipient who is covered under this **plan**
- A donor who is a **participant** under this **plan**

In order to receive **covered services** and supplies by a **hospital**, **physician**, or **other provider** related all the following conditions must be met:

- The transplant procedure is not **experimental/investigational** in nature
- Donated human organs or tissue or an FDA-approved artificial device are used
- You are covered under the plan
- The transplant procedure obtains **prior authorization**
- You meet all criteria established by us in written medical policies
- You meet all protocols established by the **hospital** where the transplant is performed

No benefits are available for the following services or supplies:

- Expenses related to maintenance of life of a donor for purposes of organ or tissue donation
- Living and/or travel expenses of the recipient or a live donor
- Purchase of the organ or tissue
- Organs 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
- Donor expenses for a **participant** in connection with an organ and tissue transplant if the recipient is not covered under this **plan**

No benefits are available for any organ or tissue transplant procedure (or the services performed in preparation for, or in conjunction with, such a procedure) which we consider to be **experimental/investigational**.

Prior authorization is required for any organ or tissue transplant. Review the **UTILIZATION MANAGEMENT** section in this benefit booklet for more specific information about **prior authorization**.

- Such specific **prior authorization** is required even if the patient is already a patient in a **hospital** under another **prior authorization**.

- At the time of **prior authorization**, we will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if we determine that an extension is **medically necessary**.

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:

- A postmenopausal individual not receiving estrogen replacement therapy
- You have:
    - Vertebral abnormalities
    - Primary hyperparathyroidism
    - 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 Services

Covered services include:

- Services performed at a medical facility without an overnight stay and are not referenced elsewhere in the **COVERED SERVICES** section of this benefit booklet. Examples of outpatient services:

- Chemotherapy
- Dialysis treatment
- Electroconvulsive therapy
- Radiation therapy treatments
- Respiratory therapy
- Surgery
- Urgent care

Ovarian Cancer Early Detection Test

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

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

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 individual under the **plan** who is at least:
  - 50 years of age and asymptomatic
  - 40 years of age with a family history of prostate cancer or another prostate cancer risk factor

Retail Health Clinics

Covered services include diagnosis and treatment of uncomplicated minor conditions that can be handled without a traditional primary care office visit, urgent care visit or **emergency care** visit.

Retail Health Clinic means a **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

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 of hearing aids.
- Treatment related to the maintenance of your cochlear implants

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

Telehealth, Telemedicine, Teledentistry

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.

Urgent Care means the delivery of medical care in a facility dedicated to the delivery of scheduled or unscheduled, walk-in care outside of a **hospital** emergency room, freestanding emergency room, comparable facility, or **physician's** office. The necessary medical care is for a condition that is not life-threatening.

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

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

Virtual Provider means a licensed **provider** that has entered into a contractual agreement with us to provide diagnosis and treatment of injuries and illnesses through either:

- Interactive audio communication (via telephone or other similar technology)
- Interactive audio/video examination and communication (via online portal, mobile application, or similar technology)

Virtual Visits means services provided for the treatment of non-emergency medical and behavioral health conditions as described in **Virtual Visits** provision.

PREVENTIVE CARE

Preventive covered services are intended to help keep you healthy, supporting you in achieving your best health through early detection. 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/counseling
- Routine annual physicals
- Screening for colorectal cancer
- Smoking cessation counseling services
- Well-child care

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 **deductible**.

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**.

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:

- 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 **calendar year**.

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

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

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

Women preventive care and screenings

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

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.

- Any services or supplies which are not **medically necessary** and essential to the diagnosis or direct care and treatment of a sickness, injury, condition, disease, or bodily malfunction.
- Any **experimental/Investigational** services and supplies. 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 portion of a charge for a service or supply that is in excess of the **allowable amount** as determined by the **claim administrator**.
- 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 or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, provided, however, that this exclusion shall not be applicable to any coverage held by the **participant** for hospitalization and/or **medical-surgical expenses** which is written as a part of or in conjunction with any automobile casualty insurance policy.
- Any services or supplies for which a **participant** is not required to make payment or for which a **participant** would have no legal obligation to pay in the absence of this or any similar coverage, except services or supplies for treatment of mental illness or mental retardation provided by a tax supported institution of the State of Texas.
- Any services or supplies provided by a person who is related to the **participant** by blood or marriage.
- Any services or supplies provided for injuries sustained:
    - 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.
- Any charges:
    - Resulting from the failure to keep a scheduled visit with a **physician** or **professional other provider**
    - For completion of any insurance forms
    - For acquisition of medical records
- Room and board charges incurred during a **hospital admission** for diagnostic or evaluation procedures unless the tests could not have been performed on an outpatient basis without adversely affecting the **participant's** physical condition or the quality of medical care provided.
- Any services or supplies provided before the patient is covered as a **participant** hereunder or any services or supplies provided after the termination of the **participant's** coverage.
- Any services or supplies provided for **dietary and nutritional services**, except as may be provided under the **plan** for:

- Preventive care services as shown on your **SUMMARY OF BENEFITS**
- An inpatient nutritional assessment program provided in and by a **hospital** and approved by the **claim administrator**
- Benefits for **autism spectrum disorder**
- Benefits for treatment of diabetes
- Benefits for certain therapies for children with developmental delays

- Any services or supplies provided for **custodial care**.
- Any services or supplies provided for **Cosmetic, Reconstructive, or Plastic Surgery**, except as provided for in the **Cosmetic, Reconstructive, or Plastic Surgery** section.
- Any services or supplies provided for:
  - Treatment of myopia and other errors of refraction, including refractive surgery
  - Orthoptics or visual training
  - Eyeglasses or contact lenses, provided that intraocular lenses shall be specific exceptions to this exclusion.
  - Examinations for the prescription or fitting of eyeglasses or contact lenses
  - Restoration of loss or correction to an impaired speech or hearing function, except as may be provided under the **Speech and Hearing Services** and **Autism Spectrum Disorder** sections.
- Any occupational therapy services which do not consist of traditional physical therapy modalities and which are not part of an active multi-disciplinary physical rehabilitation program designed to restore lost or impaired body function.
- Any services or supplies provided primarily for:
  - **Environmental sensitivity**
  - Clinical Ecology or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists
  - Inpatient allergy testing or treatment

  Environmental Sensitivity means the inpatient or outpatient treatment of allergic symptoms by:
    - Controlled environment
    - Sanitizing the surroundings, removal of toxic materials
    - Use of special non-organic, non-repetitive diet techniques

  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)

- Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.
- Any services or supplies in connection with routine foot care, including the removal of warts, corns, or calluses, or the cutting and trimming of toenails in the absence of severe systemic disease.

- Any services or supplies in connection with foot care for flat feet, fallen arches, and chronic foot strain.
- With the exception of prescription and over-the-counter medications for tobacco cessation and tobacco cessation counseling covered in this **plan**, supplies for smoking cessation programs and the treatment of nicotine addiction are excluded.
- Any services or supplies provided for the following treatment modalities:
    - Acupuncture
    - Intersegmental traction
    - Surface EMGs
    - Spinal manipulation under anesthesia
    - Muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.
- Any services or supplies furnished by a **contracting facility** for which such facility had not been specifically approved to furnish under a written contract or agreement with us will be paid at the Out-of-Network benefit level.
- Any benefits in excess of any specified dollar, day/visit, or **calendar year** maximums.
- Any services and supplies provided to a **participant** incurred outside the United States, except for **emergency care**.
- Replacement **prosthetic appliances** when it is necessitated by misuse or loss by the **participant**.
- Private duty nursing services
- Any **covered drugs** for which benefits are available under the **PHARMACY BENEFITS** portion of the **plan**.
- Any outpatient prescription or nonprescription drugs
- Any services or supplies provided for reduction mammoplasty
- 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 Care** section of your benefit booklet.
- Biofeedback (except for an **acquired brain injury** diagnosis) or other behavior modification services
- Any related services to a non-covered service. 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.
- Self-administered drugs dispensed or administered by a **physician** in their office
- Any services or supplies from more than one **provider** on the same day(s) to the extent benefits were duplicated.
- Behavioral health services provided at behavioral modification facilities, boot camps, emotional group academies, military schools, therapeutic boarding schools, wilderness programs, halfway houses and group homes, except for **covered services** provided by appropriate **providers** as described in this benefit booklet.
- Any of the following applied behavior analysis (ABA) services:
    - Services with a primary diagnosis that is not **autism spectrum disorder**
    - Services that are facilitated by a **provider** that is not properly credentialed.
    - Activities primarily of an educational nature
    - Respite, shadow, or companion services

    - Any other services not provided by an appropriately licensed **provider** in accordance with nationally accepted treatment standards.
- Any services or supplies not specifically defined as **eligible expenses** in this **plan**
- Any related services to a non-covered service. 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
- Cannabis. Cannabis means all parts of the plant genus Cannabis containing delta-9-tetrahydrocannabinol (THC) as an active ingredient, whether growing or not, the seeds of the plant, the resin extracted from any part of the plant, and every cannabis-derived compound, manufacture, salt, derivative, mixture or preparation of the plant, its seeds or its resin. Cannabis with THC as an active ingredient may be called marijuana.
- Abortions are limited to pregnancies that, as certified by a physician, places the individual in danger of death
- Viscosupplementation (intra-articular hyaluronic acid injection), except for individuals currently receiving maintenance therapy
- Three-dimensional (3D), four-dimensional (4D), and five-dimensional (5D) obstetrical ultrasounds

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 if the prescription drug:

- Is on the drug list
- Has been approved by the FDA for at least one indication.
- Is prescribed to treat a chronic, disabling, or life-threatening illness.
- 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**, **copays** and/or **coinsurance** amounts, and pricing difference shown on your **SUMMARY OF BENEFITS**.

Your Cost

Copayments

Copayments for a **preferred participating pharmacy**, **participating pharmacy** or a **provider** that supplies **preferred specialty drugs** are shown on your **SUMMARY OF BENEFITS**. The amount you pay depends on the **covered drug** dispensed. If the **allowable amount** of the **covered drug** is less than the **copay**, you will pay the lower cost.

Pharmacy Out-of-Pocket Maximum

There is no **pharmacy** out-of-network **out-of-pocket maximum** amount for individual or family coverage under this **plan**. You will continue to be responsible for any **deductibles**, **copays** and **coinsurance**, if applicable.

Individual Pharmacy Out-of-Pocket Maximum

When expenses paid toward the **pharmacy out-of-pocket maximum** amount for your **benefit period** equals the "individual **pharmacy out-of-pocket maximum**" shown on your **SUMMARY OF BENEFITS** then your expense limit has been met. Any additional eligible claims for drugs or diabetic supplies submitted during that **benefit period** will be paid by us.

Family Pharmacy Out-of-Pocket Maximum

When expenses paid toward the **pharmacy out-of-pocket maximum** for all **members** on your **plan** in a **benefit period** equals the "family **pharmacy out-of-pocket maximum**" shown on your **SUMMARY OF BENEFITS** then your family **pharmacy** expense limit has been met. No **member** will be required to contribute more than the individual **pharmacy out-of-pocket maximum** to the family **pharmacy out-of-pocket maximum**. Any additional eligible claims for drugs or diabetic supplies submitted during that **benefit period** we be paid by us.

Covered Drugs

Diabetes Supplies for Treatment of Diabetes

Covered services include **medically necessary** items of diabetes supplies for which a **physician** or authorized provider has written an order.

Covered diabetic supplies include:

- Biohazard disposable containers
- Blood glucose monitors
- Glucagon emergency kits
- Injection aids, including devices used to assist with insulin injection and needleless systems
- Insulin and insulin analog preparations
- Insulin syringes
- Lancets and lancet devices
- Prescriptive and non-prescriptive oral agents for controlling blood sugar levels
- 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

A separate copay 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 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.

You are responsible for the same **deductibles**, **copays**, coinsurance and any pricing differences that may apply to the items dispensed in the same manner as for nonemergency refills of diabetes equipment or supplies.

Insulin Drug Program

The total amount you may pay for a **covered drug** that contains insulin and is used to treat diabetes will not exceed the amount shown on your **SUMMARY OF BENEFITS**, up to a 30-day supply, regardless of the amount or type of insulin needed to fill the **prescription order**. The preferred insulin drugs are identified on you **drug list** and do not include an insulin drug administered intravenously.

Insulin drugs obtained from a **participating pharmacy** or a **non-participating pharmacy** or not identified as a preferred insulin drug may be subject to a **copay**, coinsurance, **deductibles** or dollar maximums, if applicable. Exceptions will not be made for drugs not identified as a preferred insulin drug or for an excluded drug.

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**. You are responsible for any coinsurance, **deductibles**, copayments, and pricing differences that may apply to the **covered drug** dispensed.

Preventive Care

Prescription and over-the-counter drugs 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 **copay**, **coinsurance**, **deductible** or dollar maximum when obtained from a **participating pharmacy**. **Covered drugs** obtained from a non-participating **pharmacy**, may be subject to **copay**, **coinsurance**, **deductibles** or dollar maximums, if applicable.

Select Vaccinations Obtained through Select 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.

Please note that each **pharmacy** that provides 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 these Pharmacy Benefits. Refer to your BCBSTX medical coverage for benefits available for childhood immunizations.

Smoking Cessation

Prescription and over-the-counter drugs for smoking cessation and the treatment of nicotine addiction are covered with a prescription.

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

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

Orally Administered Anticancer Drugs

Covered services include **medically necessary** orally administered anticancer drugs that are used to kill or slow the growth of cancerous cells. No **deductible**, **coinsurance** or a **copay** will apply to certain orally administered anticancer medications when received from a **participating pharmacy**.

When you receive certain orally administered anticancer drugs from a participating pharmacy, no cost share will apply except for your deductible, if applicable. Coverage of prescribed orally administered anticancer drugs when received from a non-preferred specialty **pharmacy** or non-participating **pharmacy** will be provided on a basis no less favorable than intravenously administered or injected cancer medications. To determine if a specific drug is included in this benefit contact customer service at the toll-free number on your **identification card**.

Specialty Drugs

Benefits are available for **specialty drugs**. **Specialty drugs** are generally prescribed to treat a chronic complex medical condition. They often require careful adherence to treatment **plans** and have special handling and storage requirements. You may obtain these drugs from either a retail **pharmacy** or through the specialty **pharmacy** program (see **Specialty Pharmacy Program** below). In order to receive the highest level of benefits, use a **specialty pharmacy provider** to obtain **specialty drugs**. Please note that some **specialty drugs** may not be stocked by retail pharmacies.

Coverage for **specialty drugs** are limited to a 30-day supply. However, 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 the day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.

Proton Pump Inhibitors

Benefits are available for **generic drug** proton pump inhibitors.

Retin A or Pharmacologically Similar Topical Drugs

Retin A or pharmacologically similar topical drugs are covered.

Selecting a Pharmacy

Participating Pharmacy

When you go to a **participating pharmacy**:

- Present your **identification card** to the pharmacist along with your **prescription order**
- Provide the pharmacist with the birth date and relationship of the patient
- Sign the insurance claim log
- Pay the appropriate **copay** for each **prescription order** filled or refilled

Participating pharmacies have agreed to accept as payment in full the least of:

- The billed charges
- The **allowable amount** as determined by the **claim administrator**
- Other contractually determined payment amounts

You may be required to pay for limited or non-covered services. No claim forms are required.

You can go to the **pharmacy** of your choice. However, we may cover more of the cost of your prescription drugs when you receive them from a **preferred participating pharmacy**. **Preferred participating pharmacies** may charge less than **participating pharmacies**. Refer to your **SUMMARY OF BENEFITS** for information on what you pay for prescription drugs.

If you are unsure whether a **pharmacy** is a **preferred participating pharmacy** or a **participating pharmacy**, you may access our website at www.bcbstx.com or contact the customer service helpline telephone number shown in this benefit booklet or on your **identification card**.

Non-Participating Pharmacy

If you have a **prescription order** filled or obtain a covered vaccination at a non-participating **pharmacy**, you will pay the **pharmacy** the total cost. You may submit a claim form to us with itemized receipts verifying that the **prescription order** was filled or a covered vaccination was provided. We will reimburse you for **covered drugs** and covered vaccinations less:

- The appropriate **copay** and/or **coinsurance** and **deductible**, if any
- Any pricing differences that may apply to the **covered drug** or covered vaccination you receive.

You will not be reimbursed for any charges over our **allowable amount** for the **covered drugs**.

However, you may submit the documentation with a claim form to us, and allowable credit will, as applicable, be applied towards your **in-network deductible** and **out-of-pocket maximum** if:

- You directly pay a non-**participating pharmacy** a rate less than the average discounted rate which would be paid by us to a **participating pharmacy** for a covered and **medically necessary** service or supply; and
- The non-**participating pharmacy** does not submit a claim to us for that service or supply

Then you may submit the documentation with a claim form to us, and allowable credit will, as applicable, be applied towards your **in-network deductible** and **out-of-pocket maximum**.

Extended Prescription Drug Supply Program

Your coverage includes benefits for up to a 90-day supply of covered maintenance type drugs and diabetic

supplies purchased from a **preferred participating pharmacy** contracted with us to take part in the extended retail prescription drug supply program (which will include retail or mail-order pharmacies). See your **SUMMARY OF BENEFITS** for your cost information.

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

Cost share will be based on day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.

Day Supply

Benefits for **covered drugs** obtained from a **participating pharmacy** or through **providers** that supply **preferred specialty drugs** are provided up to the maximum day supply limit as indicated on your **SUMMARY OF BENEFITS**. We have the right to determine the day supply. Payment for covered drugs under this **plan** may be denied 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 supply/fill information, please call the customer service toll-free number located on your **identification card**.

If you are leaving the country or need an extended supply of medication, call customer service at least two weeks before you intend to leave. (Extended supplies or vacation override are not available through the mail-order **pharmacy** but may be approved through the retail **pharmacy** only. In some cases, you may be asked to provide proof of continued enrollment eligibility under the **plan**.)

Mail-Order Program

The mail-order program provides delivery of **covered drugs** directly to your home address. If you and your covered **dependents** elect 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.

If you send an incorrect payment amount for the **covered drug** dispensed, you will:

- Receive a credit if the payment is too much
- Be billed for the appropriate amount if it is not enough

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. If you need help determining which of your prescription drugs is considered a specialty drug, you can refer to the Prescription Drug section of our website at www.bcbstx.com or contact Customer Service by calling the number on the back of your insurance **identification card**.

In order to receive maximum coverage and the lowest cost to you, you should obtain the specialty drug 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 may be allowed greater than a 30 day-supply, if allowed by your **plan** benefits.

MedsYourWay™

MedsYourWay™ ("MedsYourWay") may lower your out-of-pocket costs for select **covered drugs** purchased at select retail 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**.

How Preferred Brand Name Drug Pricing Difference Applies

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**.

If there is no **generic drug** for your **brand name drug prescription order**, you will pay no more than the applicable **brand name drug copay**. If you receive a **preferred brand name drug** when a **generic drug** is available, your payment amount will be the sum of:

- The difference between the **allowable amount** of the **brand name drug** and the **allowable amount** of the **generic drug**, plus
- The **preferred brand name drug copayment amount**.

Exceptions may be allowed for certain preventive drug (including prescription contraceptive medications) if your **provider** submits a request to us indicating that the **generic drug** would be medically inappropriate, along with supporting documentation. If we grant the exception request, any difference between the **allowable amount** for the **brand name drug** and the **generic drug** will be waived.

Member Pay the Difference

If you obtain a **brand name drug** when a **generic drug** is available, you will pay the applicable Copayment and/or Coinsurance amount after your **deductible** based on current tier of **brand name drug** plus the difference between the **allowable amount** of the **non-preferred brand name drug** and the **allowable amount** of the **generic drug**. The difference between the **allowable amount** of the **non-preferred brand name drug** and the **allowable amount** of the **generic drug** will not apply to the **deductible** and **out-of-pocket maximum** and will continue to be applicable after the **out-of-pocket maximum** is met. 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, your **provider** must send in a MedWatch form to the Food and Drug Administration (FDA) to let them know the issues you experienced with generic equivalent. Your **provider** must provide a copy of this form when requesting the waiver. The FDA MedWatch form is used to document adverse events, therapeutic equivalence/failure, product quality problems, and product use/medication error. This form is available on the FDA website. If the waiver is granted, applicable **deductible**, Copayment, and/or Coinsurance Amounts will still apply. For additional information, you may access the website at www.bcbstx.com or contact customer service at the toll-free number on your **identification card**.

Exceptions to this provision may be allowed for certain preventive medications (including prescription contraceptive medications) if your **provider** submits a request to us indicating that the **generic drug** would be medically inappropriate, along with supporting documentation. If BCBSTX grants the exception request, any difference between the **allowable amount** for the **brand name drug** and the **generic drug** will be waived.

How Payment is Determined

Prescription drug products are separated into tiers. Generally, each drug is placed into one of six drug 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**, **copay** or **coinsurance** for **covered drugs** on each drug tier is shown on your **SUMMARY OF BENEFITS**. You can also contact customer service at the toll-free number on your **identification card**.

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. 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/prescription-drugs/managing-prescriptions/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.

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, you, or your provider, can call the number on the back of your **identification card** to ask for a 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 drug, you, or 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 72 hours after we receive your request for an expedited 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 and Independent Review Organization (IRO)** subsection. Call us if you have any questions.

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 **copay** 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 quantity of dosage units authorized by the prescribing **provider** on the original **prescription order**, including refill.
- 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 90-day supply is dispensed.

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 drugs per prescription
- Amount of covered drugs 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 your provider prescribes a greater quantity of medication than what the dispensing limit allows, you can still get the medication. However, you will be responsible for the full cost of the prescription beyond what your coverage allows.

If you require a **prescription order** in excess of 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 faxed 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 quantity 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 medications in certain drug classes (e.g., medications for cancer, multiple sclerosis, lung disorders, etc.) or if you have not filled one of these medications within 120 days, you may only be able to receive a partial fill (14-15-day supply) of the medication for up to the first 3 months of therapy. This is to help see how the medication is working for you.

If you receive a partial fill, your **copayments** and/or **coinsurance** after your **deductible** will be adjusted to align with the quantity of medication dispensed.

If the medication is working for you and your **physician** or other **provider** wants you to continue on this medication, 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, visit our website at www.bcbstx.com/rx-drugs/pharmacy/pharmacy-programs.

Oncology Split Fill Program

If this is your first time using select drugs (e.g. cancer drugs) 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.

If you receive a partial fill, your **co-share** amount will be adjusted to align with the quantity of drug dispensed. If the drug is working for you and your **physician** or other 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, visit our website at www.bcbstx.com/rx-drugs/pharmacy/pharmacy-programs.

Prescription Contraceptives

Covered prescription contraceptives may be obtained as follows:

- An initial three-month supply at one time
- Up to a 12-month supply at one time for subsequent refills
- A maximum of 12-month supply during each 12-month period

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** or through **providers** that supply **preferred specialty drugs** 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 that 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, you and the **provider** will be notified and the drug will then be covered at the applicable payment levels shown on your **SUMMARY OF BENEFITS**.

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.

For **covered drugs** approved by the FDA for treatment of **serious mental illness** for participants 18 years or older, we will not require that you:

- 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 our **drug list**

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.

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** reasonably 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 Authorizations

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

- Safe
- Effective
- Part of a specific treatment plan

We also evaluate additional clinical information before covering select drugs. A list of the drugs which require **prior authorization** is available to you and your **provider** on our website at www.bcbstx.com/member/prescription-drug-plan-information/drug-lists.

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
- Drugs that:

- Have an FDA boxed warning for use.
- Must have specific **provider** assessment.
- Use in a manner other than the FDA approved use.

When you submit a **prescription order** to a **participating pharmacy** or through **providers** that supply **preferred specialty drugs** 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** 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.

Non-participating pharmacies do not file your claims electronically and, therefore, will not have 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.

Controlled Substances Limitations

If we determine that you may be receiving quantities of **controlled substance** drugs 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 and restrictions may include but not be limited to a certain **provider** and/or **pharmacy** of your choice and/or quantities and/or days' supply for the prescribing and dispensing of the **controlled substance** drug. If you do not choose such **provider** and/or **pharmacy** within a reasonable time, we will make the choice. Additional **copays**/**coinsurance** and any **deductible** may apply.

Right of Appeal

In the event that a requested **prescription order** is denied on the basis of **prior authorization** criteria, step therapy criteria, or quantity versus time dispensing limits with or without your authorized **provider** having submitted clinical documentation, you have the right to appeal as indicated under the **Review of Claim Determinations** subsection of this benefit booklet.

Limitations and Exclusions

Pharmacy benefits are not available for:

- Drugs which do not by law require a **prescription 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.
- Drugs/products which are not included on the **drug list** including new to market FDA approved drugs which have not been reviewed by the **plan** for inclusion on the **drug list**, unless specifically covered elsewhere in this **plan** and/or such coverage is required in accordance with applicable law or regulatory guidance.
- Pharmaceutical aids such as excipients found in the USP-NF (United States Pharmacopeia-National Formulary), including, but not limited to preservatives, solvents, ointment bases and flavoring coloring diluting emulsifying and suspending agents.

- Devices, technologies, and/or durable medical equipment of any type (even though such devices may require a **prescription order**) such as, but not limited to therapeutic devices, including support garments and other non-medicinal substances, artificial appliances, digital health technologies and/or applications, or similar devices (provided that disposable hypodermic needles and syringes for self-administered injections and those devices listed as diabetes supplies shall be specific exceptions to this exclusion).

  NOTE: Coverage for the rental or purchase of a manual, electric, or **hospital** grade breast pump and contraceptive devices is provided as indicated under the medical portion of this **plan**.
- Administration or injection of any drugs.
- Vitamins (except those vitamins which by law require a **prescription order** and for which there is no non-prescription alternative or as indicated under **Preventive Care** in **PHARMACY BENEFITS**).
- Drugs injected, ingested or applied in a **physician's** or authorized **provider's** office or during confinement while a patient is in a **hospital**, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.
- **Covered drugs**, devices, or other **pharmacy** services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
- **Covered drugs**, devices, or other **pharmacy** services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or the laws, regulations or established procedures of any county or municipality, or any prescription drug which may be properly obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law; provided, however, that the exclusions of this section shall not be applicable to any coverage held by the **participant** for prescription drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
- Any special services provided by the **pharmacy**, including but not limited to, counseling and delivery. Select vaccinations administered through participating pharmacies are an exception to this exclusion.
- **Covered drugs** for which the **pharmacy's** usual and customary charge to the general public is less than or equal to the **participant's** cost share determined under this **plan**.
- Non-prescription contraceptive materials, (**except** prescription contraceptive drugs which are **legend drugs**. Contraceptive drugs provided by a **participating pharmacy** will not be subject to **coinsurance**, **deductibles**, **copays** and/or dollar maximums as shown in **Preventive Care**.)
- Injectable infertility and fertility medications.
- Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations, except as required by the Affordable Care Act.
- 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 dispensed in quantities in excess of the day supply amounts stipulated in your **SUMMARY OF BENEFITS**, certain **covered drugs** exceeding the clinically appropriate predetermined quantity, or refills of any prescriptions in excess of the number of refills specified by the **physician** or authorized **provider** or by law, or any drugs or medicines dispensed more than one year following the **prescription order** date.
- Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), unless approved by the FDA for self-administration, intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting. NOTE: This exclusion does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases. This exception also does not apply to amino-acid based elemental formulas, regardless of the formula delivery method, used for the diagnosis and treatment of immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins, severe food protein-induced enterocolitis syndromes, eosinophilic disorders, as

evidenced by the results of biopsy and disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract. A **prescription order** from your **provider** is required.

- Any drugs 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.
- Drugs, that the use or intended use of which would be illegal, unethical, imprudent, abusive, not **medically necessary**, or otherwise improper.
- Drugs that are not considered **medically necessary** or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines.
- Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the **identification card**.
- Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under your **employer's** group health care **plan**, or for which benefits have been exhausted.
- Rogaine, minoxidil, or any other drugs, medications, solutions, or preparations used or intended for use in the treatment of hair loss, hair thinning, or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.
- 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.)
- Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
- **Prescription orders** for which there is an over-the-counter product available with the same active ingredient(s) in the same strength, unless otherwise determined by the **plan**.
- 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.
- Allergy serum and allergy testing materials.
- Injectable drugs, except self-administered **specialty drugs** or those approved by the FDA for self-administration.
- Self-administered drugs dispensed or administered by a **physician** in their office.
- Select medications may be excluded from the medical benefit when a self-administered formulation of the product is available.
- **Prescription orders** which do not meet the required step therapy criteria.
- **Prescription orders** which do not meet the required **prior authorization** criteria.
- Some drugs have therapeutic equivalents/therapeutic alternatives. In some cases, BCBSTX may limit benefits to only certain therapeutic equivalents/therapeutics alternatives. If you do not accept the therapeutic equivalents/therapeutic alternatives that are covered under you **plan**, the drug purchased will not be covered under any benefit level.
- Replacement of drugs or other items that have been lost, stolen, destroyed or misplaced.
- Shipping, handling or delivery charges.
- Institutional packs and drugs that are repackaged by anyone other than the original manufacturer.

- **Prescription orders** written by a member of your immediate family, or a self-prescribed **prescription order**.
- Nonsedating antihistamine drugs and combination medications containing a nonsedating antihistamine and decongestant.
- Depo-Provera (IMinjectable).
- Brand proton pump inhibitors.
- Drugs determined by the **plan** to have inferior efficacy or significant safety issues.
- Drugs that are not considered **medically necessary** or treatment recommendations that are not supported by evidence-based guidelines or clinical practiceguidelines.
- Drugs without superior clinical efficacy which have lower cost therapeutic equivalents or therapeutic alternatives.
- 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.

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 our medical policy and nationally recognized criteria.

Medical Necessity reviews may occur:

- Prior to care
- During care
- After care has been completed

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**. Pre-approval is also called **prior authorization**. This ensures that certain **covered services** will not be denied based on **medical necessity** or **experimental/investigational**.

Prior authorization does not guarantee payment of **benefits**. For additional information and a current list of health care services that require **prior authorization**, please visit our website at www.bcbstx.com.

Prior Authorization Responsibility

In-Network Provider Prior Authorization

When required, your **in-network provider** is responsible for obtaining **prior authorization**. If your **in-network provider** does not obtain **prior authorization** and the services are denied as not **medically necessary**, the **in-network provider** will be held responsible.

The **in-network provider** will not be able to bill you for the services you have received. We recommend you confirm with your **provider** if **prior authorization** has been obtained. For additional information about **prior authorization** for services outside of our **service area**, please refer to the BlueCard® Program section.

Note: Providers that **contract** with other Blue Cross and Blue Shield plans are not familiar with the **prior authorization** requirements of BCBSTX. Unless a provider contracts directly with BCBSTX as a participating **provider**, the **provider** is not responsible for being aware of this plan's **prior authorization** requirements, except as described in the section "The BlueCard® Program" in the **GENERAL PROVISIONS**.

Out-of-Network Prior Authorization

If an **out-of-network provider** recommends an admission or service that requires **prior authorization**, you are responsible for obtaining **prior authorization.**

If the service is determined to be **medically necessary**, **out-of-network benefits** will apply. However, if **prior authorization** is not obtained before services are received and determined to be not **medically necessary**, you may be responsible for the charges.

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 http://www.bcbstx.com/find-care/where-you-go-matters/utilization-management for the **recommended clinical review** list.

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** is sometimes 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**

Failure to Obtain Prior Authorization

If **prior authorization** is not obtained:

- You may be responsible for a penalty for certain **covered services**, if indicated on your **SUMMARY OF BENEFITS**.
- If we determine the treatment or service is not **medically necessary** or is **experimental/investigational**, **benefits** will be reduced or denied.
- We will review the **medical necessity** of your treatment or service prior to the final benefit determination.

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

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.

CLAIM FILING AND APPEALS PROCEDURES

Filing of Claims Required

When you receive care and **covered services** from an **in-network provider**, the **provider** will usually submit your claim directly to us, but it is your responsibility to make sure we receive your claim.

When you receive care and **covered services** from an **out-of-network provider**, you may be required to file your own claim.

The instructions for filing your own claim are in the charts below.

Filing a Medical Claim
Complete and submit a claim form and any additional information required. File each **participant's** expenses separately. **Deductibles** and **benefits** are applied to each **participant** separately. Include itemized bills from the **provider**, labs, etc., on their letterhead showing the services given, dates of service, charges, and **participant's** name.

Filing a Prescription Drug Claim	Requirement
Mail-Order Program	A completed mail service prescription drug claim form
Prescription Drug Claims	A completed Prescription Reimbursement Claim Form Include itemized bills from the **pharmacy** showing the name, address, and telephone number of the **pharmacy**, **participants** prescription drugs received, including the name and quantity of the drug, prescription number and date of purchase

Please mail completed claim forms to:

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

Our Receipt of Claims

A claim will be considered received by us for processing upon actual delivery to the 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.

For additional information and claim forms, please visit www.bcbstx.com.

Who Receives Payment

Benefit payments will be made directly to contracting **providers** when they bill us. If unpaid at your death, any

benefits payable to you will be paid to your beneficiary or your estate.

Except as provided in the **Assignment and Payment of Benefits** section**,** rights and benefits under the **plan** are not assignable before or after services and supplies are provided.

Benefit Payments to a Managing Conservator

Benefits for services provided to your minor **dependent child** may be paid to a third party if the third party is named in a court order as managing or possessory conservator of the **child**, and we have not already paid any portion of the claim.

For **benefits** to be payable to a managing or possessory conservator of a **child**, the managing or possessory conservator must submit:

- A claim form
- Proof of payment of the expenses
- A certified copy of the court order naming that person the managing or possessory conservator.

Any amounts we are owed may be deducted from our benefit payment. Payment to you or your **provider**, or deduction of amounts owed to us, will be considered in satisfaction of its obligations to you.

An explanation of benefits summary is sent to you so you will know what has been paid.

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. We will receive and review and process claims consistent with administrative practices and procedures established in writing between the us and the **plan administrator**.

You have the right to seek and obtain a full and fair review of your claim in accordance with the benefits and procedures detailed in your **health benefit plan**.

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, as described in this benefit booklet, for medical care or treatment and your **physician** determines that a delay in getting medical care or treatment could put your life or health at risk; or a 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.
- **Pre-Service Claim** means any non-urgent request for benefits that involves services you have not yet received and requires prior authorization.
- **Concurrent Care Claim** means a claim for a health benefit that we previously approved, but coverage was subsequently reduced or terminated (other than by **plan** amendment or termination) or a request to extend the course of the treatment beyond what was previously approved that is an Urgent Care Clinical Claim.

- **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 sex
  - 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.

The following table summarizes the applicable deadlines and extension periods for each type of claim:

Urgent Care Claim	
Deadline for initial determination	72 hours after claim is received (No extensions)
If additional information is needed	You must be notified 24 hours after claim is received. You must be given 48 hours to respond. You must be notified of the decision no later than 48 hours after the earlier of: Our receipt of the requested information; or the end of the prescribed response period.
Pre-Service Claims	
Deadline for initial determination	15 days after claim is received (15-day extension may be allowed)
If additional information is needed and an extension is necessary	The notice must specify the information needed. You must be given at least 45 days to respond. The running of time for the initial claims determination is suspended until the end of the prescribed response period or until the information is received, whichever is earlier. You must be notified of the decision no later than 15 days after we receive a response to the request for information or 15 days after the end of the deadline for you to provide the information, whichever is earlier. NOTE: If filed improperly, you will be notified on the failure within 5 days (within 24 hours in the case of an Urgent Care Claim). The notice may be oral, but you may also request a written notice

Post-Service Claims (Retrospective Review)

Deadline for initial determination	30 days after claim is received (15-day extension may be allowed)
If additional information is needed and an extension is necessary	The notice must specify the information needed. You must be given at least 45 days to respond. The running of time for the initial claims' determination is suspended until the end of the prescribed response period or until the information is received, whichever is earlier. You must be notified of the decision no later than 15 days after we receive a response to the request for information or 15 calendar days after the end of the deadline for you to provide the information, whichever is earlier.
Concurrent Care Claim	
Deadline for initial determination	You must have an opportunity to appeal and obtain a decision before the previously approved treatment is reduced or terminated. A request to extend an approved course of treatment that is an Urgent Care Clinical Claim will receive a response within 24 hours, if the request is made at least 24 hours prior to the expiration of the previously approved period or number of treatments. **Note:** If request for extension is not made at least 24 hours before the end of the approved period of time or number of treatments, then the claim will be handled as an Urgent Care Clinical Claim. If a request to extend a course of treatment is not an Urgent Care Clinical Claim, the request may be treated as a new Pre-Service or Post-Service claim. (No Extensions)

If a Claim Is Denied or Not Paid in Full

If the claim is denied in whole or in part, you will receive a written notice from us with the following information, if applicable:

- Reasons for the determination
- A reference to the benefit **plan** provisions on which the determination is based.
- A description of additional information necessary and why it is necessary.
- Information sufficient to identify the claim including:
  - Date of service
  - Health care **provider**
  - Claim amount (if applicable)
  - Denial codes with their meanings and the standards used.
  - Diagnosis/treatment codes with their meanings and the standards (upon request)
- An explanation of the internal review/appeals and external review processes (and how to initiate internal or external review and applicable time limits)
- Information on any voluntary appeal procedures offered by the **plan**, 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 and the timeframe within which such action must be filed.

- A statement in non-English language(s) that written notice of claim denials and certain other benefit information may be available (upon request) in such non-English language(s) (in certain situations)
- A statement in non-English language(s) that indicates how to access the language services provided by the **claim administrator** (in certain situations).
- Copies of all documents, records and other information relevant to the claim for (provided free of charge on request).
- Copy of internal rule, guideline, protocol or other similar criterion (provided free of charge upon request)
- An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances if the denial was based on **medical necessity**, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request.
- Urgent Care Clinical Claim:
  - Description of the expedited review procedures applicable
  - Decision may be provided orally, so long as a written notice is given to the claimant within three days of verbal notification.
- Contact information for any applicable office of health insurance consumer assistance or ombudsman.

Claim Appeal Procedures

Claim Appeal Procedures and Definitions

Adverse Benefit Determination means determination by the **claim administrator** that the health care services you have received, or may receive are:

- **Experimental/investigational**
- Not **medically necessary** or 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 the **claim administrator** or, if applicable, your **employer**, at the completion of the internal review/appeal process of an **adverse benefit determination** with respect to which the internal review/appeal process has been deemed exhausted.

Note: Expedited Internal Review of Urgent Care Claims

If your claim is an Urgent Care Claim, you have the right to an expedited review. You also have the right to request an expedited external review of your Urgent Care Claim at the same time you request expedited internal review.

How to Appeal an Adverse Benefit Determination

If you believe that we incorrectly denied all or part of your claim for **benefits**, you may have your claim reviewed. Your request for us to review an adverse determination is an appeal of an adverse determination.

You, or an authorized representative, may act on your behalf, and file an adverse benefit determination appeal.

In **urgent care clinical claim** circumstances, 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 authorized representative may call the **claim administrator** at the toll-free telephone number on the back of your **identification card**.

You must file an appeal within 180 calendar days from the time you receive a notice of an **adverse benefit determination**. You may call us at the toll-free telephone number on the back of your **identification card**, with your reason for making the appeal; or send your written appeal to:

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

The review of the **claim administrator's** 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 used to review your claim before the date a final decision on the appeal is made and you will have a chance to respond.	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
The appeal decision will be made by the **claim administrator**, a **physician** associated or contracted with the **claim administrator**, and/or by external advisors, who were not involved in the initial Adverse Benefit Determination.	During the review process
We will not consider the initial Adverse Benefit Determination.	During the review process
Pre-Service appeal decision, within	30 days upon receipt of the appeal
Post-Service appeal decision, within	60 days upon receipt of the appeal
Urgent Care appeal decision, within	72 hours upon receipt of the appeal

Note: This appeal process does not prohibit you from pursuing a civil action under the law. Before bringing any action to recover benefits you must complete the appeal process and raise all issues with respect to a claim.

Notice of Appeal Determination

We will provide written notice of the appeal determination to you, and, if a clinical appeal, to the **provider** who recommended the services involved in the appeal.

The written notice to you or your authorized representative will include:

- A reason for the determination
- A reference to the benefit **plan** provisions on which the determination is based, and the contractual, administrative or protocol for the determination.
- Information to identify the claim including:
    - Date of service
    - Health care **provider**
    - Claim amount (if applicable)
    - Denial codes with their meanings and the standards used.
    - Diagnosis/treatment codes with their meanings and the standards used (available upon request)
- An explanation of the external review processes (and how to initiate an external review)
- A statement of your right, if any, to bring a civil action under Section 502(a) of ERISA and the timeframe within which such action must be filed.
- A statement in non-English language(s) that written notice of claim denials and certain other benefit information may be available in such non-English language(s) (in certain situations)
- A statement in non-English language(s) that indicates how to access the language services provided by the **claim administrator** (in certain situations)
- Copies of all documents, records, and other information relevant to the claim for benefits (provided free of charge on request)
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination (provided free of charge on request)
- An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request.
- A description of the standard that was used in denying the claim.
- Health insurance consumer assistance or ombudsman contact information (as appropriate)

If your appeal is denied in whole 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 below under the **How to Appeal a Final Internal Adverse Determination to an Independent Review Organization (IRO)** section.

If You Need Assistance

If you have any questions about the claims procedures or the review procedure, please call us at 1-800-521-2227. Our Customer Service Helpline is available from 8:00 A.M. to 8:00 P.M. Monday through Friday.

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

If you need assistance with the internal claims and appeals or the external review processes, please call the toll-free telephone number on the back of your **identification card**. 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).

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 Procedures and Definitions

Adverse Benefit Determination means our determination, or the determination of our designated utilization review organization, that the admission, availability of care, continued stay, or other covered service has been reviewed and determined to be, or meet requirements for:

- **Experimental/ investigational**
- **Medically necessity**, appropriateness, health care setting, level of care, or effectiveness
- Entitlement to a reasonable alternative standard for a reward under a wellness program
- Compliant with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act.

An adverse determination includes the denial, reduction, or termination of a requested service.

Final internal adverse benefit determination means an adverse benefit determination that we confirmed after completing our internal review/appeal process.

You are entitled to an immediate appeal to an IRO if your request is based on the following:

- Life-threatening, **urgent care** circumstances
- If you were receiving prescription drugs or intravenous infusions and coverage was discontinued

You are not required to comply with our appeal of an adverse determination process if an immediate appeal to an IRO is requested.

If we deny your appeal of an adverse determination, you, your authorized representative, or **provider** may seek review of the decision by an IRO. We will send you a notice of adverse determination and describe the independent review process, including a copy of the request for an independent review form.

You must submit the request for independent review form to us within four (4) months after receipt of the adverse determination. In reaching a decision, the assigned IRO will not be bound by any decisions or conclusions reached during the our internal claims and appeals process. The assigned IRO will provide notice of their final decision no later than 72 hours after receipt of the expedited external review.

Preliminary Review

Within five (5) business days following the date of receipt of the external review request, the **claim administrator** must complete a preliminary review of the request to determine whether:

- You are, or were, covered under the **plan** at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the **plan** at the time the health care item or service was provided;
- The Adverse Benefit Determination or the Final Adverse Internal Benefit Determination does not relate to your failure to meet the requirements for eligibility under the terms of the **plan** (e.g., worker classification or similar determination);
- You have exhausted our internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the **Exhaustion** subsection below for additional information and exhaustion of the internal appeal process; and
- You or your authorized representative have provided all the information and forms required to process an external review.

You will be notified within one (1) business day after we complete the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the four (4) month external review request period (or 48 hours following receipt of the notice), whichever is later, to perfect the request for external review. If your claim is not eligible for external review, we will outline the reasons it is ineligible in the notice, and provide contact information for the Department of Labor's Employee Benefits Security Administration (toll-free number 1-866-444-EBSA (3272)).

In life-threatening, **urgent care** situations, denial of a step therapy exception request, or if you were receiving prescription drugs or intravenous infusions and coverage was discontinued you, your authorized representative, or **provider** may contact us by telephone to request the review and provide the required information.

- We will submit medical records, names of **providers**, and documentation related to the decision of the IRO
- We will comply with the decision by the IRO
- We will pay for the independent review

Upon request and without any cost to you, you or your authorized representative may have reasonable access to, and copies of, all documents, records, and other information regarding the claim or appeal, including:

- Information relied upon to make the decision
- Information submitted, considered, or generated while making the decision, and whether it was relied upon
- Descriptions of the administrative process and safeguards used to make the decision
- Records of any independent reviews conducted by us
- Medical judgments, including whether a particular service is **experimental/investigational** or not **medically necessary** or appropriate
- Expert advice and consultation obtained by us in connection with the denied claim, whether the advice was relied upon to make the decision

If the process for appeal and review places your health in serious jeopardy, you are not prohibited from pursuing

other appropriate remedies under the law, including, injunctive relief, a declaratory judgment, or other relief If your **plan** is governed by the Employee Retirement Income Security Act (ERISA), you have the right to bring a civil action under 502(a) of ERISA.

If You Need Assistance

If you need assistance with the internal claims and appeals or the external review processes, please call the toll-free telephone 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).

Actions Against Us

No lawsuit, or action in law, or equity, may be brought by you, or on your behalf, before the expiration of 60 days after a **proof of loss** has been filed in agreement with **plan** requirements; and no such action will be brought unless it is brought within three years after the expiration of 60 days when a **proof of loss** has been filed.

Proof of Loss means written evidence of a claim including:

- The form on which the claim is made
- Bills and statements reflecting services and items furnished to a **participant** and amounts charged for those services and items that are covered by the claim
- Correct diagnosis code(s) and procedure code(s) for the services and items

For additional information and claim forms, please visit www.BCBSTX.com.

Please Mail Completed Claim Forms to:

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

Exhaustion

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the Final Internal Adverse Benefit Determination.

For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

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

Except as described above, you must exhaust the mandatory levels of appeal before you request external review or seek other legal recourse.

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 the **claim administrator** 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

Agent

The **employer** is not the agent of the **claim administrator**.

Amendments

The **plan** may be amended or changed at any time by agreement between the **employer** and us.

The Claim Administrator's Ownership Interests

The **claim administrator** or its subsidiaries or affiliates may have ownership interests in certain **providers** who provide **covered services** to **participants**, and/or vendors or other third parties who provide **covered services** related to the benefits and requirements of this **plan** or provide services to certain **providers**.

Assignment and Payment of Benefits

Rights and benefits under the **plan** shall not be assignable, either before or after services and supplies are provided.

In the absence of a written agreement with a **provider**, we reserve the right to make benefit payments to the **provider** or the **employee**, as we elect. Payment to either party discharges the **plan's** responsibility to the **employee** or **dependents** for benefits available under the **plan**.

Claims Liability

BCBSTX, in its role as **claim administrator**, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Disclosure Authorization

If you file a claim for benefits, it will be necessary that you authorize any health care **provider**, insurance carrier, or other entity to furnish the **claim administrator** all information and records or copies of records relating to the diagnosis, treatment, or care of any individual included under your coverage. If you file claims for benefits, you and your **dependents** will be considered to have waived all requirements forbidding the disclosure of this information and records.

Identity Theft Protection

As a **participant**, BCBSTX makes available at no additional cost to you identity theft protection services, including credit monitoring, fraud detection, credit/identity repair and insurance to help protect your information. These identity theft protection services are currently provided by BCBSTX's designated outside vendor and acceptance or declination of these services is optional to the **participant**.

Participants who wish to accept such identity theft protection services will need to individually enroll in the program online at www.bcbstx.com or by calling the Customer Service Helpline. Services may automatically end when the person is no longer an eligible **participant**. Services may change or be discontinued at any time with reasonable notice. BCBSTX does not guarantee that a particular vendor or service will be available at any given time.

Medicare

Special rules apply when you are covered by this **plan** and by Medicare. Generally, this **plan** is a Primary **plan** if you are an active **employee**, and Medicare is a Primary **plan** if you are a retired **employee**.

Participant/Provider Relationship

The choice of a health care **provider** should be made solely by you or your **dependents**. The **claim administrator** does not furnish services or supplies but only makes payment for Eligible Expenses incurred by **participants**. The **claim administrator** is not liable for any act or omission by any health care **provider**. The **claim administrator** does not have any responsibility for a health care **provider's** failure or refusal to provide services or supplies to you or your **dependents**. Care and treatment received are subject to the rules and regulations of the health care **provider** selected and are available only for sickness or injury treatment acceptable to the health care **provider**.

The **claim administrator**, **network providers**, and/or other contracting **providers** are independent contractors with respect to each other. The **claim administrator** in no way controls, influences, or participates in the health care treatment decisions entered into by said **providers**. The **claim administrator** does not furnish medical, surgical, hospitalization, or similar services or supplies, or practice medicine or treat patients. The **providers**, their **employees**, their agents, their ostensible agents, and/or their representatives do not act on behalf of BCBSTX nor are they **employees** of BCBSTX.

Paper Check – Automatic Clearing House/Electronic Funds

BCBSTX 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.

Overpayment

If your **group health plan** or the **claim administrator** pays benefits for **eligible expenses** incurred by you or your **dependents** and it is found that the payment was more than it should have been, or it was made in error ("Overpayment"), your **group health plan** or the **claim administrator** has the right to obtain a refund of the Overpayment amount from: (i) the person to, or for whom, such benefits were paid, or (ii) any insurance company or **plan**, or (iii) any other persons, entities, or organizations, including, but not limited to **network providers** or **out-of-network providers**.

If no refund is received, your **group health plan** and/or Blue Cross and Blue Shield (in its capacity as insurer or administrator) has 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, whether for the same or a different **participant.**
- Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield administered ASO benefit program and/or Blue Cross and Blue Shield administered insured benefit program or policy, if the future **benefit** payment owed is to a **network provider.**
- Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield insured group benefit **plan** or individual policy, if the future benefit payment owed is to a **network provider.**
- Any future benefit payment, or other payment, made to any person or entity.
- Any future payment owed to one or more **network providers**.

Further, we have the right to reduce your **group health plan's** payment to a **network provider** by the amount necessary to recover another Blue Cross and Blue Shield's **plan** or policy overpayment to the same **network provider** and to remit the recovered amount to the other Blue Cross and Blue Shield **plan** or policy.

Rescission

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, or makes an intentional misrepresentation of material fact. A cancellation or discontinuance of coverage that has only prospective effect is not a rescission. A retroactive cancellation or discontinuance of coverage based on a failure to timely pay required premiums or contributions toward the cost of coverage (including COBRA premiums) is not a rescission. You will be given 30 days advance notice of rescission. A rescission is considered an Adverse Benefit Determination for which you may seek internal review and external review.

Subrogation

If the **plan** pays or provides benefits for you or your **dependents**, the **plan** is subrogated to all rights of recovery which you or your **dependent** have in contract, tort, or otherwise against any person, organization, or insurer for the amount of benefits the **plan** has paid or provided. That means the **plan** may use your rights to recover money through judgment, settlement, or otherwise from any person, organization, or insurer.

For the purposes of this provision, *subrogation* means the substitution of one person or entity (the **plan**) in the place of another (you or your **dependent**) with reference to a lawful claim, demand or right, so that the person who is substituted succeeds to the rights of the other in relation to the debt or claim, and its rights or remedies.

Right of Reimbursement

In jurisdictions where subrogation rights are not recognized, or where subrogation rights are precluded by factual circumstances, the **plan** will have a right of reimbursement.

If you or your **dependent** recover money from any person, organization, or insurer for an injury or condition for which the **plan** paid benefits, you or your **dependent** agree to reimburse the **plan** from the recovered money for the amount of benefits paid or provided by the **plan**. That means you or your **dependent** will pay to the **plan** the

amount of money recovered by you through judgment, settlement or otherwise from the third party or their insurer, as well as from any person, organization or insurer, up to the amount of benefits paid or provided by the **plan**.

Right to Recovery by Subrogation or Reimbursement

You or your **dependent** agree to promptly furnish to the **plan** all information which you have concerning your rights of recovery from any person, organization, or insurer and to fully assist and cooperate with the **plan** in protecting and obtaining its reimbursement and subrogation rights. You, your **dependent** or your attorney will notify the **plan** before settling any claim or suit so as to enable us to enforce our rights by participating in the settlement of the claim or suit. You or your **dependent** further agree not to allow the reimbursement and subrogation rights of the **plan** to be limited or harmed by any acts or failure to act on your part.

Coordination of Benefits

The availability of benefits specified in This **plan** is subject to Coordination of Benefits (COB) as described below. This COB provision applies to This **plan** when a **participant** has health care coverage under more than one **plan**.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this **plan** are determined before or after those of another **plan**. The benefits of This **plan** shall not be reduced when this **plan** determines its benefits before another **plan**; but may be reduced when another **plan** determines its benefits first.

Each contract or other arrangement for coverage is a separate **plan**. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate **plan**.

This **plan** means the part of this benefit booklet that provides benefits for health care expenses.

When there are more than two **plans** covering the **participant**, this **plan** may be a Primary **plan** as to one or more other **plans** and may be a Secondary **plan** as to a different **plan** or **plans**.

Order of Benefit Determination Rules

General Information

When there is a basis for a claim under this **plan** and another **plan**, this **plan** is a **secondary plan** which has its benefits determined after those of the other **plan**, unless:

- The other **plan** has rules coordinating its **benefits** with those of this **plan**.
- Both those rules and this **plan's** rules require that this **plan's** benefits be determined before those of the other **plan**.

If this benefit booklet contains any dental or vision benefits, the benefits provided by the health portion of this **plan** will be the **secondary plan**.

Rules

This **plan** determines its order of benefits using the first of the following rules which applies:

1. **Non-Dependent/Dependent**

   The benefits of the **plan** which covers the **participant** as an **employee**, member or subscriber are determined before those of the **plan** which covers the **participant** as a **dependent**. However, if the **participant** is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

   - Secondary to the **plan** covering the **participant** as a **dependent**
   - Primary to the **plan** covering the **participant** as other than a **dependent** (e.g., a retired **employee**), then the benefits of the **plan** covering the **participant** as a **dependent** are determined before those of the **plan** covering that **participant** other than a **dependent**.

2. **Dependent Child/Parents Not Separated or Divorced**

   Except as stated below, when this **plan** and another **plan** cover the same child as a **dependent** of different parents:

   - The benefits of the **plan** of the parent whose birthday falls earlier in a **calendar year** are determined before those of the **plan** of the parent whose birthday falls later in that **calendar year**
   - If both parents have the same birthday, the benefits of the **plan** which covered one parent longer are determined before those of the **plan** which covered the other parent for a shorter period of time.

   However, if the other **plan** does not have the rule described below, but instead has a rule based on gender of the parent, and if, as a result, the **plans** do not agree on the order of benefits, the rule in the other **plan** will determine the order of benefits.

3. **Dependent Child/Parents Separated or Divorced**

   If two or more **plans** cover a **participant** as a **dependent** child of divorced or separated parents, benefits for the child are determined in this order:

   - First, the **plan** of the parent with custody of the child
   - Then, the **plan** of the spouse of the parent with custody, if applicable
   - Finally, the **plan** of the parent not having custody of the child.

   However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the **plan** of that parent has actual knowledge of those terms, the benefits of that **plan** are determined first. The **plan** of the other parent shall be the **secondary plan**. This paragraph does not apply with respect to any **calendar year** during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. **Joint Custody**

   If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the **plans** covering the child shall follow the order of benefit determination rules.

5. **Active/Inactive Employee**

   The benefits of a **plan** which covers a **participant** as an **employee** who is neither laid off nor retired are determined before those of a **plan** which covers that **participant** as a laid off or retired **employee**. The same would hold true if a **participant** is a **dependent** of a person covered as a retired **employee** and an

employee. If the other **plan** does not have this rule, and if, as a result, the **plans** do not agree on the order of benefits, this rule shall not apply.

6. **Continuation Coverage**

   If a **participant** whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another **plan**, the following shall be the order of benefit determination:

   - First, the benefits of a **plan** covering the **participant** as an **employee**, member or subscriber (or as that **participant's dependent**);
   - Second, the benefits under the continuation coverage

   If the other **plan** does not have this rule, and if, as a result, the **plans** do not agree on the order of benefits this rule does not apply.

7. **Longer/Shorter Length of Coverage**

   If none of the above rules determine the order of benefits, the benefits of the **plan** which covered an **employee**, member or subscriber longer are determined before those of the **plan** which covered that **participant** for the shorter period of time.

Effect on the Benefits of This Plan

When This Section Applies

This section applies when this **plan** is the Secondary **plan** in accordance with the order of benefits determination outlined above. In that event, the benefits of this **plan** may be reduced under this section.

Reduction in this Plan's Benefits

The benefits of this **plan** will be reduced when the sum of:

- The benefits that would be payable for the Allowable Expense under this **plan** in the absence of this COB provision
- The benefits that would be payable for the **allowable expense** under the other **plans**, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made exceeds those **allowable expenses** in a claim determination period.

In that case, the benefits of this **plan** will be reduced so that they and the benefits payable under the other **plans** do not total more than those **allowable expenses**. When the benefits of this **plan** are reduced as previously described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this **plan**.

Right to Receive and Release Needed Information

We assume no obligation to discover the existence of another **plan**, or the benefits available under the other **plan**, if discovered. We have the right to decide what information we need to apply these COB rules. We may get needed information from or release information to any other organization or person without telling, or getting the consent of, any person. Each person claiming benefits under this **plan** must give us any information concerning the existence of other **plans**, the benefits thereof, and any other information needed to pay the claim.

Facility of Payment

A payment made under another **plan** may include an amount that should have been paid under this **plan**. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this **plan**. We will not have to pay that amount again.

Right to Recovery

If the amount of the payments We make is more than We should have paid under this COB provision. We may recover the excess from one or more of:

- The persons we have paid or for whom we have paid
- Insurance companies
- **Hospitals**, **physicians**, or **other providers**
- Any other person or organization

Termination of Coverage

Termination of Individual Coverage

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

- Your contribution for coverage under the **plan** is not received timely by the **plan administrator.**
- You no longer satisfy the definition of an **employee** as defined in this benefit booklet, including termination of employment.
- The **plan** is terminated or the **plan** is amended, at the direction of the **plan administrator**, to terminate 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 **Continuation of Group Coverage - Federal** in the **GENERAL PROVISIONS** section of this benefit booklet.

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

Coverage for a child of any age who is medically certified as **disabled** and dependent on the parent will not terminate upon reaching the limiting age shown in your **SUMMARY OF BENEFITS** if the child continues to be both:

- Disabled
- Dependent upon you for more than one-half of their support as defined by the Internal Revenue Code of the United States

Disabled means any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. The disability must begin while the child is covered under the **plan** and before the child attains the limiting age. You must submit satisfactory proof of the disability and dependency through your **plan administrator** to the **claim administrator** within 31 days following the child's attainment of the limiting age. As a condition to the continued coverage of a child as a disabled **dependent** beyond the limiting age, the **claim administrator** may require periodic certification of the child's physical or mental condition but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Termination of the Group

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

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

Allowable Expense means a necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part by one or more **plans** covering the **participant** for whom claim is made.

Claim Determination Period means a **calendar year**. However, it does not include any part of a year during which a **participant** has no coverage under this **plan**, or any part of a year before the date this COB provision or a similar provision takes effect.

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.

Plan means any group insurance or group-type coverage, whether insured or uninsured. This includes:

- Group or blanket insurance
- Franchise insurance that terminates upon cessation of employment
- Group **hospital** or medical service **plans** and other group prepayment coverage
- Any coverage under labor-management trustee arrangements, union welfare arrangements **employer** organization arrangements
- Governmental **plans**, or coverage required or provided by law

Plan does not include:

- Any coverage held by the **participant** for hospitalization and/or **medical-surgical expenses** which is written as a part of or in conjunction with any automobile casualty insurance policy
- A policy of health insurance that is individually underwritten and individually issued
- school accident type coverage
- A state **plan** under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended)

Primary Plan/Secondary Plan means the order of benefit determination rules state whether this **plan** is a Primary **plan** or Secondary **plan** covering the participant. A primary **plan** is a **plan** whose benefits are determined before those of the other **plan** and without considering the other plan's benefit. A *Secondary* **plan** is a **plan** whose benefits are determined after those of a Primary **plan** and may be reduced because of the other **plan's benefits**.

GLOSSARY

Allowable Amount means the maximum amount determined by the **claim administrator** (BCBSTX) to be eligible for consideration of payment for a particular covered service, covered supply, or procedure.

- For **hospitals** and **facility other providers**, **physicians**, and **professional other providers** contracting with the **claim administrator** in Texas or any other Blue Cross and Blue Shield **plan** - The **allowable amount** is based on the terms of the **provider** contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis-related groups (DRG), fee schedule, package pricing, global pricing, per diems, case-rates, discounts, or other payment methodologies.
- For **hospitals** and **facility other providers**, **physicians**, **professional other providers**, and any **other provider** not contracting with the **claim administrator** in Texas - The **allowable amount** will be the lesser of: (i) the **provider's** billed charges, or; (ii) the BCBSTX non-contracting **allowable amount**. Except as otherwise provided in this section, the non-contracting **allowable amount** is developed from base Medicare Participating reimbursements adjusted by a predetermined factor established by the **claim administrator**. Such factor shall be not less than 75% and will exclude any Medicare adjustment(s) which is/are based on information on the claim.
- Notwithstanding the preceding sentence, the non-contracting **allowable amount** for **home health care** is developed from base Medicare national per visit amounts for low utilization payment adjustment, or LUPA, episodes by Home Health discipline type adjusted for duration and adjusted by a predetermined factor established by the **claim administrator**. Such factor shall be not less than 75% and shall be updated on a periodic basis.
- When a Medicare reimbursement rate is not available or is unable to be determined based on the information submitted on the claim, the **allowable amount** for non-contracting **providers** will represent an average contract rate in aggregate for **network providers** adjusted by a predetermined factor established by the **claim administrator**. Such factor shall be not less than 75% and shall be updated not less than every two years.
- The **claim administrator** will utilize the same claim processing rules and/or edits that it utilizes in processing **network provider** claims for processing claims submitted by non-contracted **providers** which may also alter the **allowable amount** for a particular service. In the event the **claim administrator** does not have any claim edits or rules, the **claim administrator** may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The **allowable amount** will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including, but not limited to, disproportionate share and graduate medical education payments.
- Any change to the Medicare reimbursement amount will be implemented by the **claim administrator** within ninety (90) days after the **effective date** that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.
- The non-contracting **allowable amount** does not equate to the **provider's** billed charges and **participants** receiving services from a non-contracted **provider** will be responsible for the difference between the non-contracting **allowable amount** and the non-contracted **provider's** billed charge, and this difference may be considerable. To find out the BCBSTX non-contracting **allowable amount** for a particular service, **participants** may call customer service at the number on the back of your BCBSTX **identification card**.
- **For multiple surgeries.** The **allowable amount** for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest **allowable amount** plus a determined percentage of the **allowable amount** for each of the other covered procedures performed.
- **For procedures, services, or supplies provided to Medicare recipients** - The **allowable amount** will not exceed Medicare's limiting charge.
- **For covered drugs as applied to Participating and non-Participating Pharmacies -** The **allowable**

amount for Participating Pharmacies and the mail-order program will be based on the provisions of the contract between the **claim administrator** and the **participating pharmacy** or **pharmacy** for the mail-order program in effect on the date of service. The **allowable amount** for non-Participating Pharmacies will be based on the average wholesale price.

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 BCBSTX in assessing **experimental/investigational** status but will not be determinative.

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

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.

Average Wholesale Price means any one of the recognized published averages of the prices charged by wholesalers in the United States for the drug products they sell to a **pharmacy**.

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 **professional other provider** who renders services for mental and **behavior health** 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 **copay** obligations from generic to brand name.

Brand Name Drug (Non-Preferred) means a **brand name drug** which appears on the applicable drug list as a non-preferred brand name drug. You can access this drug list at www.bcbstx.com.

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

Calendar Year means the period commencing on January 1 and ending on the next succeeding December 31, inclusive.

Chiropractic Services means any of the following services, supplies or treatment provided by or under the direction of a Doctor of Chiropractic acting within the scope of their license: general office services, general services provided in an outpatient facility setting, x-rays, supplies, and physical treatment. Physical treatment includes functional occupational therapy, physical/mechano therapy, muscle manipulation therapy and hydrotherapy.

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 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.

Contracting Facility means a **hospital**, a **facility other provider**, or any other facility or institution with which the **claim administrator** has executed a written contract for the provision of care, services, or supplies furnished within the scope of its license for benefits available under the **plan**. A **contracting facility** shall also include a **hospital** or **facility other provider** located outside the State of Texas, and with which any other Blue Cross **plan** has executed such a written contract; provided, however, any such facility that fails to satisfy each and every requirement contained in the definition of such institution or facility as provided in the **plan** shall be deemed a **non-contracting facility** regardless of the existence of a written contract with another Blue Cross **plan**.

Controlled Substance means an abusable volatile chemical as defined in the Texas Health and Safety Code, or a substance designated as a **controlled substance** in the Texas Health and Safety Code

Copayment or Copay means the set amount you pay each time you receive a certain service.

Co-Share Amount means the dollar amount of **eligible expenses** including **deductible(s)** and **copays** incurred by a **participant** during a **calendar year** that exceeds benefits provided under the **plan**. Refer to **Co-Share Stop-Loss Amount** in **HOW THE PLAN WORKS** of the benefit booklet for additional information.

Covered Drugs means any prescription drug:

- Which is included on the applicable **drug list**
- Which is **medically necessary** and is ordered by an authorized **provider** naming a **participant** as the recipient
- For which a written or verbal **prescription order** is provided by an authorized **provider**
- 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**)

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

Custodial Care means any service primarily for personal comfort for convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. **Custodial care** Services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (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, if any, you must pay before we start paying **contract benefits**. You do not send this amount to us. We subtract this amount from covered expenses on claims you and health care professionals send us. Some services can be covered before the **deductible** is met. Refer to your **SUMMARY OF BENEFITS** for any **deductibles** applicable to your coverage.

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 stepchild
- 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

Domestic Partner means a person with whom you have entered into a **domestic partnership** in accordance with the **employer's plan** guidelines. Note: **domestic partner** coverage is available at your **employer's** discretion. Contact your **employer** for information on whether **domestic partner** coverage is available under your **plan**.

Note: A **domestic partner** is not recognized as a spouse for certain federally regulated programs, such as COBRA Continuation Coverage and Medicare.

Note: Domestic partner coverage is available at your **employer's** discretion. Contact your **employer** for information on whether **domestic partner** coverage is available under your **plan**.

Domestic Partnership means, for purposes of this **plan**, a committed relationship of mutual caring and support between two people who are jointly responsible for each other's common welfare and share financial obligations and who have executed an affidavit or certification of **domestic partnership** form provided by the **plan**.

Drug List means a list of all 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.

Effective Date means the date the coverage for a **participant** begins.

Eligible Expenses mean **inpatient hospital expenses**, **medical-surgical expenses**, **extended care expenses**, **Special Provisions Expenses** as described in this benefit booklet.

Emergency Care means health care services provided in a **hospital** emergency facility (emergency room) or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate care could result in:

- Placing the patient's health in serious jeopardy
- Serious impairment of bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement
- In the case of a pregnant individual, 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.

If applicable to your **plan**, **employees** who have retired under the large **employer's** established procedures whether by either individual selection by the **employer** or the **employee** to be included in a retiree classification, may continue coverage under this **contract**.

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**, BCBSTX utilizes 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 drugs** are shown on the **drug list** which is available by accessing the BCBSTX website at www.bcbstx.com. You may also contact the Customer Service Helpline number shown on your **identification card** for more information.

Generic Drug (Non-Preferred) means a generic drug which appears on the applicable drug list as a non-preferred generic drug. The drug list is available by accessing the website at www.bcbstx.com.

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

Group Health Care Plan (GHP) as applied to this benefit booklet means a self-funded **employee** welfare benefit **plan**. For additional information, refer to the definition of **plan administrator**.

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 benefits for health care services. The term does not include:

- Accident only or disability income insurance, or a combination of accident-only and disability income insurance
- Credit-only insurance
- Disability insurance coverage
- Coverage for a specified disease or illness
- Medicare services under a federal contract
- Medicare supplement and Medicare Select policies regulated in accordance with federal law;
- Long-term care coverage or benefits, **home health care** coverage or benefits, nursing home care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits
- Coverage that provides limited-scope dental or vision benefits
- Coverage provided by a single service health maintenance organization
- Coverage issued as a supplement to liability insurance
- Workers' compensation or similar insurance
- Automobile medical payment insurance coverage
- Jointly managed trusts authorized under 29 U.S.C. Section 141, et seq., that contain a **plan** of benefits for **employees**; is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the **employees**; and is authorized under 29 U.S.C. Section 157
- **Hospital** indemnity or other fixed indemnity insurance
- Reinsurance contracts issued on a stop-loss, quota-share, or similar basis
- Short-term major medical contracts
- Liability insurance, including general liability insurance and automobile liability insurance
- Other coverage that is:
    - similar to the coverage described by this subdivision under which benefits for medical care are secondary or incidental to other insurance benefits; and
    - specified in federal regulations;
- Coverage for onsite medical clinics; or
- Coverage that provides other limited benefits specified by federal regulations.

Hospital means a short-term acute care facility which:

- Is duly licensed as a **hospital** by the state in which it is located and meets the standards established for such licensing, and is either accredited by the Joint Commission on Accreditation of Healthcare Organizations or is certified as a **hospital provider** under Medicare
- Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of **physicians** or **behavioral health practitioners** for compensation from its patients
- Has organized departments of medicine and major surgery, either on its premises or in facilities available to the **hospital** on a contractual prearranged basis, and maintains clinical records on all patients
- Provides 24-hour nursing services by or under the supervision of a Registered Nurse
- Has in effect a **hospital** utilization review **plan**

Hospital Admission means the period between the time of a **participant's** entry into a **hospital** or a Substance Use Treatment Center as a *Bed patient* and the time of discontinuance of bed-patient care or discharge by the admitting **physician**, **behavioral health practitioner** or **professional other provider**, whichever first occurs. The day of entry, but not the day of discharge or departure, shall be considered in determining the length of a **hospital admission**.

Bed Patient means confinement in a bed accommodation of a Substance Use Treatment Center on a 24-hour basis or in a bed accommodation located in a portion of a **hospital** which is designed, staffed, and operated to provide acute, short-term **hospital** care on a 24-hour basis; the term does not include confinement in a portion of the **hospital** (other than a Substance Use Treatment Center) designed, staffed, and operated to provide long-term institutional care on a residential basis.

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

In-Network Benefits means the benefits available under the **plan** for services and supplies that are provided by an **in-network provider** or an **out-of-network provider** when acknowledged by the **claim administrator**.

In-Network Provider means a hospital, physician, behavioral health provider or other professional provider who has entered into an agreement with us (and in some instances with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care provider.

Inpatient Hospital Expense means the **allowable amount** incurred for the **medically necessary** items of service or supply listed below for the care of a **participant**, provided that such items are:

- Furnished at the direction or prescription of a **physician**, **behavioral health practitioner** or **professional other provider**; and
- Provided by a **hospital** or a **substance use disorder treatment center**; and
- Furnished to and used by the **participant** during an inpatient **hospital admission**.

An expense shall be deemed to have been incurred on the date of provision of the service for which the charge is made. **Inpatient hospital expense** shall include:

- Room accommodation charges. If the **participant** is in a private room, the amount of the room charge in excess of the **hospital's** average semiprivate room charge *is not* an Eligible Expense.
- All other usual **hospital** services, including drugs and medications, which are **medically necessary** and consistent with the condition of the **participant**. Personal items *are not* an Eligible Expense.

Medically Necessary **mental health care** or treatment of **serious mental illness** in a Crisis Stabilization Unit or Facility, Residential Treatment Center, or a Residential Treatment Center for Children and Adolescents, in lieu of hospitalization, shall be **inpatient hospital expense**.

An **employee** or a **dependent** is *not* a **late enrollee** if:

1. The individual:
    a. Was covered under another **health benefit plan** or self-funded **health benefit plan** at the time the individual was eligible to enroll; and
    b. Declines in writing, at the time of initial eligibility, stating that coverage under another **health**

benefit plan or self-funded **health benefit plan** was the reason for declining enrollment; and

c. Has lost coverage under another **health benefit plan** or self-funded **health benefit plan** as a result of:

(1) Termination of employment;

(2) Reduction in the number of hours of employment;

(3) Termination of the other **plan**'s coverage;

(4) Termination of contributions toward the premium made by the **employer**;

(5) COBRA coverage has been exhausted;

(6) Cessation of **dependent** status;

(7) The **plan** no longer offers any benefits to the class of similarly situated individuals that include the individual; or

(8) In the case of coverage offered through an HMO, the individual no longer resides, lives, or works in the service area of the HMO and no other benefit option is available; and

d. Requests enrollment not later than the 31st day after the date on which coverage under the other **health benefit plan** or self-funded **health benefit plan** terminates or in the event of the attainment of a lifetime limit on all benefits, the individual must request to enroll not later than 31 days after a claim is denied due to the attainment of a lifetime limit on all benefits.

2. The request for enrollment is made by the individual within the 60th day after the date on which coverage under Medicaid or CHIP terminates.
3. The individual is employed by an **employer** who offers multiple **health benefit plans** and the individual elects a different **health benefit plan** during an **open enrollment period**.
4. A court has ordered coverage to be provided for a spouse under a covered **employee's plan** and the request for enrollment is made not later than the 31st day after the date on which the court order is issued.
5. A court has ordered coverage to be provided for a child under a covered **employee's plan** and the request for enrollment is made not later than the 31st day after the date on which the **employer** receives notice of the court order.
6. A **dependent** child is not a **late enrollee** if the child:

a. Was covered under Medicaid or the Children's Health Insurance Program (CHIP) at the time the child was eligible to enroll;

b. The **employee** declined coverage for the child in writing, stating that coverage under Medicaid or CHIP was the reason for declining coverage;

c. The child has lost coverage under Medicaid or CHIP; and

d. The request for enrollment is made within the 60th day after the date on which coverage under Medicaid or CHIP terminates.

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 test 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**, their **physician**, **behavioral health practitioner**, 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**. 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. BCBSTX does 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**, their **physician**, **behavioral health practitioner**, the **hospital**, or the **other provider**.

  The medical staff of the **claim administrator** 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 practitioner** or **professional 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.

Negotiated National Account Arrangement means an agreement negotiated between one or more Blue Cross and/or Blue Shield **plans** for any national account that is not delivered through the BlueCard Program.

Network means identified **physicians**, **behavioral health practitioner**, **professional other providers**, **hospitals**, and other facilities that have entered into agreements with BCBSTX (and in some instances with other participating Blue Cross and/or Blue Shield **plans**) for participation in a managed care arrangement.

Network Provider means a **hospital**, **physician**, **behavioral health practitioner**, or **other provider** who has entered into an agreement with BCBSTX (and in some instances with other participating Blue Cross and/or Blue Shield **plans**) to participate as a managed care **provider**.

Other Provider or Other Facility Provider means a person or entity, other than a **hospital** or **physician**, that is licensed where required to furnish to a **participant** an item of service or supply. **Other provider** shall include:

- Substance Use Treatment Center
- Crisis Stabilization Unit or Facility
- Durable Medical Equipment **provider**
- Home Health Agency
- Home **infusion therapy provider**
- **Hospice**
- Imaging Center
- Independent Laboratory
- Prosthetics/Orthotics **provider**
- **Psychiatric Day Treatment Facility**

- Renal Dialysis Center
- Residential Treatment Center for Children and Adolescents
- **Skilled Nursing Facility**
- Therapeutic Center

Other Professional Provider - a person or practitioner, when acting within the scope of their license and who is appropriately certified, only as listed:

- Advanced Practice Nurse
- Doctor of Chiropractic
- Doctor of Dentistry
- Doctor of Optometry
- Doctor of Podiatry
- Doctor in Psychology
- Licensed Acupuncturist
- Licensed Audiologist
- Licensed Substance Use Counselor
- Licensed Dietitian
- Licensed Hearing Instrument Fitter and Dispenser
- Licensed Marriage and Family Therapist
- Licensed Clinical Social Worker
- Licensed Occupational Therapist
- Licensed Physical Therapist
- Licensed Professional Counselor
- Licensed Speech-Language Pathologist
- Licensed Surgical Assistant
- Nurse First Assistant
- **Physician** Assistant
- Psychological Associates who work under the supervision of a Doctor in Psychology

In states where there is a licensure requirement, **other providers** must be licensed by the appropriate state administrative agency.

Out-of-Network Benefits means the benefits available under the **plan** for services and supplies that are provided by an **out-of-network provider**.

Out-of-Network Provider means a **hospital**, **physician**, **behavioral health practitioner**, or **other provider** who has not entered into an agreement with BCBSTX (or other participating Blue Cross and/or Blue Shield **plan**) as a managed care **provider**.

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

Participating Pharmacy means an independent retail **pharmacy**, chain of retail pharmacies, mail-order **pharmacy** or **specialty drug pharmacy** which has entered into an agreement to provide pharmaceutical services

to **participants** under the **plan**. A retail **participating pharmacy** may or may not be a **select participating pharmacy** as that term is used in the **Select Vaccinations Obtained through Participating Pharmacies** subsection above.

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 in which the pharmacist practices.

Pharmacy Vaccine Network means the network of select Participating Pharmacies which have a written agreement with BCBSTX to provide certain vaccinations to participants under this plan.

Preferred Participating Pharmacy means a **participating pharmacy** which has a written agreement with BCBSTX to provide pharmaceutical services to **participants** under this **plan** or an entity chosen by BCBSTX to administer its **pharmacy** benefit program that has been designated as a preferred **pharmacy**.

Prescription Order means a written or verbal order from an authorized provider to a pharmacist for a drug or device to be dispensed. Orders written by an authorized provider located outside the United States to be dispensed in the United States are not covered under the **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 a program of health and welfare benefits established for the benefit of its **participants** whether the **plan** is subject to the rules and regulations of the Employee's Retirement and Income Security Act (ERISA) or, for government and/or church **plans**, where compliance is voluntary.

Plan Administrator means a named administrator of the **group health plan** (GHP) having fiduciary responsibility for its operation. BCBSTX is not the **plan administrator**.

Service Area means the geographical area or areas in which a Network of **providers** is offered and available and is used to determine eligibility for **Managed Health Care plan** benefits.

Primary Care Provider or PCP means a **physician** or **professional other provider** who has entered into an agreement with **claim administrator** (and in some instances with other participating Blue Cross and/or Blue Shield **plans**) to participate as a managed care **provider** of a family practitioner, obstetrician/gynecologist, pediatrician, **behavioral health practitioner**, an internist or a **physician** Assistant or Advanced Practice Nurse who works under the supervision of one of these.

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

Prosthetic Appliances means artificial devices including limbs or eyes, braces or similar prosthetic or orthopedic devices, which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). For purposes of this definition, a wig or hairpiece is not considered a **prosthetic appliance**.

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

Specialty Drug means specialty medication that are used to treat complex medical conditions and 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.

To determine which drugs are **specialty drugs**, you may contact the Customer Service Helpline number shown on your **identification card**.

Specialty Drug (Non-Preferred) means a specialty drug which appears on the applicable drug list as a non-preferred specialty drug. The drug list is available by accessing the website at www.bcbstx.com.

Specialty Drug (Preferred) means a specialty drug which appears on the applicable drug list as a preferred specialty drug. The drug list is available by accessing the website at 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 you.

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.

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 **facility other provider** in which they were performed; and
- The **physician** or **professional other provider** has had the appropriate training and experience to provide the treatment or procedure.

The claim administrator for the plan shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is **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.

Although a physician or professional other provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, the claim administrator 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**.

Continuation of Group Coverage – Federal

COBRA Continuation - Federal

Under the provisions of the 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 **employer** is exempt from the provisions of COBRA.

Minimum Size of Group

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

Loss of Coverage

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

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

- Divorce from the covered **employee**,
- Death of the covered **employee**,
- The covered **employee** becomes eligible for Medicare, or
- A covered **dependent** child no longer meets the **dependent** eligibility requirements.

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

- The last day of the eighteen (18) month period for events which have a maximum continuation period of eighteen (18) months.
- The last day of the thirty-six (36) month period for events which have a maximum continuation period of thirty-six (36) months.
- The first day for which timely payment of contribution is not made to the **plan** with respect to the qualified beneficiary.
- The **group health plan** is canceled.
- The date, after the date of the election, upon which the qualified beneficiary first becomes covered under any other **group health plan**.
- The date, after the date of the election, upon which the qualified beneficiary first becomes entitled to Medicare benefits.

Extension of Coverage Period

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 initial qualifying event.

If a **participant** 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, coverage may be extended up to an additional eleven (11) months for a total of twenty-nine (29) months. 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.

Notice of COBRA Continuation Rights

The **employer** is responsible for providing the necessary notification to **participants** as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986.

For additional information regarding your rights under COBRA continuation, refer to the Continuation Coverage Rights Notice in the **NOTICES** section of this benefit booklet.

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 **plan administrator** will furnish summary **plan** descriptions, annual reports, and summary annual reports to you and other **plan participants** and to the government as required by ERISA and its regulations.
- The **claim administrator** will furnish the **plan administrator** with this benefit booklet as a description of benefits available under this **health benefit plan**. Upon written request by the **plan administrator**, the **claim administrator** will send any information which the **claim administrator** has that will aid the **plan administrator** in making its annual reports.
- Claims for benefits must be made in writing on a timely basis in accordance with the provisions of this **health benefit plan**. Claim filing and claim review health procedures are found in the **CLAIM FILING AND APPEALS PROCEDURES** section of this benefit booklet.
- BCBSTX, as the **claim administrator**, is 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 **plan administrator** has given the **claim administrator** the authority and discretion to interpret the **health benefit plan** provisions and to make eligibility and benefit determinations. The **plan administrator** has full and complete authority and discretion to make decisions regarding the **health benefit plan's** provisions and determining questions of eligibility and benefits. Any decisions made by the **plan administrator** shall be final and conclusive.

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:

I. 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 PCPs, 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).

II. 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**.

III. Continuity of Care

If You are under the care of a Participating **provider** as defined in the Certificate 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.

IV. 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 both the Certificate and this Amendment, those terms will apply only to their use in the Certificate or this Amendment, respectively.

"Air Ambulance Services" means, for purposes of this Amendment only, medical transport by helicopter or airplane for patients.

"Emergency Medical Condition" means, for purposes of this Amendment 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 woman her 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 Amendment 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; and
- Covered Services You receive from a Non-Participating **provider** during the same visit after Your Emergency Medical Condition has stabilized unless:
    1. Your Non-Participating **provider** determines You can travel by non-medical or non-emergency transport;
    2. Your Non-Participating **provider** has provided You with a notice to consent form for balance billing of services; and
    3. You have provided informed consent.

"**Non-Participating Provider**" means, for purposes of this Amendment 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** to which this Amendment is attached.

"**Non-Participating Emergency Facility**" means, for purposes of this Amendment 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** to which this Amendment is attached.

"**Participating Provider**" means, for purposes of this Amendment 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** to which this Amendment is attached 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 Amendment 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** to which this Amendment is attached. 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 Amendment only, a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

"**Recognized Amount**" means, for purposes of this Amendment 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. <u>Federal No Surprises Act Surprise Billing Protections</u>

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 **provider** 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 **provider**, if the services would be covered if received from a Participating **provider**.

b. <u>Claim Payments</u>

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 **provider** 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 your 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

NOTICE

Other Blue Cross and Blue Shield Plans Separate Financial Arrangements with Providers

Out-of-Area Services

Blue Cross and Blue Shield of Texas (BCBSTX) has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of BCBSTX service area, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard Program, and may include negotiated National Account arrangements available between BCBSTX and other Blue Cross and Blue Shield Licensees.

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 healthcare **providers**. Our payment practices in both instances are described below.

A. BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare **providers**.

For inpatient facility services received in a **hospital**, the Host Blue's participating **provider** is required to obtain **prior authorization**. If **prior authorization** is not obtained, the participating **provider** will be sanctioned based on the Host Blue's contractual agreement with the **provider**, and the **participant** will be held harmless for the **provider** sanction.

Whenever you access covered healthcare services outside BCBSTX's service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare **provider**. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare **provider** or **provider** group that may include types of settlements, incentive payments, and/or other credits 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, going forward, also take into account adjustments to correct for over-or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

B. Negotiated (non-BlueCard Program) National Account Arrangements

As an alternative to the BlueCard Program, your claims for covered healthcare services may be processed through a negotiated National Account arrangement with a Host Blue.

The amount you pay for covered healthcare services under this arrangement will be calculated based on the lower of either billed covered charges or negotiated price (Refer to the description of negotiated price under Section A., BlueCard Program) made available to us by the Host Blue.

C. Non-Participating Healthcare Providers Outside BCBSTX Service Area

1. In General

When Covered Services are provided outside of the **plan's** service area by non-participating healthcare **providers**, the amount(s) you pay for such services will be calculated using the methodology described in the benefit booklet for non-participating healthcare **providers** located inside our service area. You may be responsible for the difference between the amount that the non-participating healthcare **provider** bills and the payment the **plan** will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

2. Exceptions

In some exception cases, the **plan** may, but is not required to, in its sole and absolute discretion negotiate a payment with such non-participating healthcare **provider** on an exception basis. If a negotiated payment is not available, then the **plan** may make a payment based on the lesser of:

a. the amount calculated using the methodology described in the benefit booklet for non-participating healthcare **providers** located inside your service area (and described in Section C(a)(1) above); or

b. The following:

   1. For professional **providers**, an amount equal to the greater of the minimum amount required in the methodology described in the benefit booklet for non-participating healthcare **providers** located inside your service area; or an amount based on publicly available **provider** reimbursement data for the same or similar professional services, adjusted for geographical differences where applicable, or

   2. For **hospital** or facility **providers**, an amount equal to the greater of the minimum amount required in the methodology described in the benefit booklet for non-participating healthcare **providers** located inside your service area; or an amount based on publicly available data reflecting the approximate costs that **hospitals** or facilities have incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the **hospital** or facility.

In these situations, you may be liable for the difference between the amount that the non-participating healthcare **provider** bills and the payment Blue Cross and Blue Shield of Texas will make for the Covered Services as set forth in this paragraph.

D. Value-Based Programs BlueCard® Program

If you receive Covered Services under a **value-based program** inside a Host Blue's service area, you will not bear any portion of the **provider incentives**, risk-sharing, and/or Care Coordinator Fees of such arrangement, except when a Host Blue passes these fees to Blue Cross and Blue Shield of Texas through average pricing or fee schedule incentive adjustments.

Under the Agreement, **employer** has with Blue Cross and Blue Shield of Texas, Blue Cross and Blue Shield of Texas and **employer** will not impose cost sharing for Care Coordinator Fees.

Care Coordinator Fee means a fixed amount paid by a Blue Cross and/or Blue Shield plan to providers periodically for care coordination under a Value-Based Program.

Value-Based Program means an outcome-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.

E. Blue Cross Blue Shield Global Core Program

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of the Blue Cross Blue Shield Global Core Program when accessing Covered Services. The Blue Cross Blue Shield Global Core Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core Program 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 BlueCard service area, 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 BlueCard service area, 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, can arrange a physician appointment or hospitalization, if necessary.

NOTICE

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 the plan to obtain prior authorization for non-emergency inpatient services.

Outpatient Services

Outpatient Services are available for emergency care. Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area 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 BlueCard service area, 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 with 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 plan, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, 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.

NOTICE

The Women's Health and Cancer Rights Act of 1998 requires this notice. This Act is effective for plan year anniversaries on or after October 21, 1998. This benefit may already be included as part of your coverage.

In the case of a covered person receiving benefits under their plan in connection with a mastectomy and who elects breast reconstruction, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

1. Reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Deductibles, **coinsurance** and **copays** will be the same as those applied to other similarly covered medical services, such as surgery and prostheses.

NOTICE

ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE **PROVIDER** NETWORK USED BY YOUR **HEALTH BENEFIT PLAN**, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY **PHYSICIANS** AND OTHER HEALTH CARE PRACTITIONERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR **HEALTH BENEFIT PLAN**.

NOTICE

CONTINUATION COVERAGE RIGHTS UNDER COBRA

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE AFTERTERMINATION (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

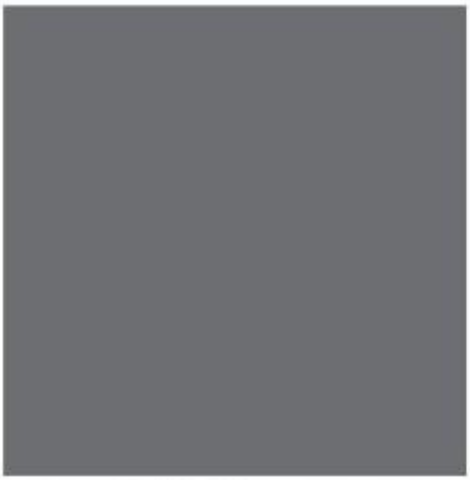
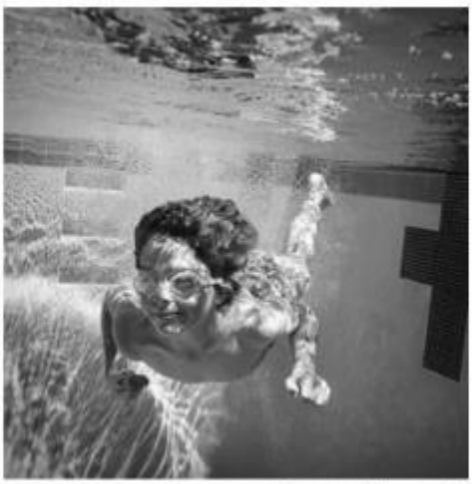
Questions concerning your **plan** or your COBRA continuation coverage rights, should be addressed to your **plan administrator**. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting **group health plan**s, 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.)

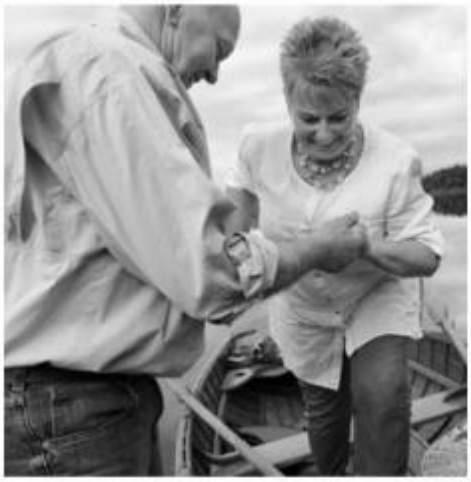
KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

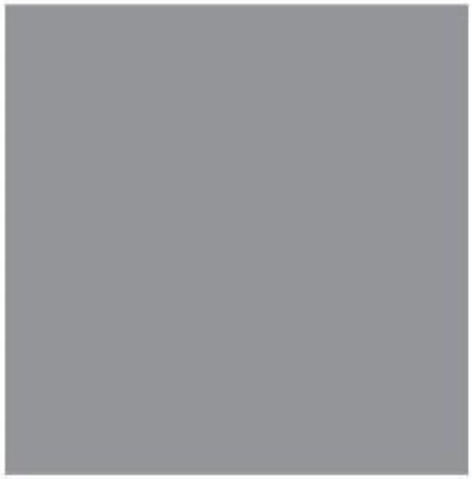
In order to protect your family's rights, you should keep the **plan administrator** informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the **plan administrator**.

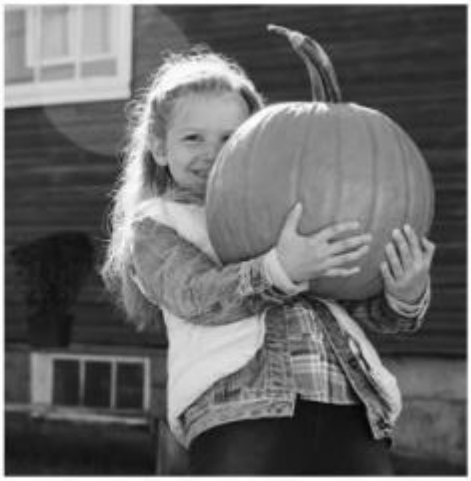
PLAN CONTACT INFORMATION

Contact your **employer** for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.





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