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BlueCross BlueShield of Texas

Your Health Care Benefits Program

Blue Advantage HMO[SM]

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

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

1001 East Lookout Drive
Richardson, Texas 75080
1-877-299-2377
www.bcbstx.com

CERTIFICATE OF COVERAGE

This Certificate of Coverage ("Certificate") is part of the Group Agreement ("Group Agreement") between the Group and Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation (HMO). The Group Agreement determines the terms and conditions of coverage. Provisions of this Certificate include the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** and any amendments, Riders, or attachments, which may be delivered with the Certificate or added later.

HMO agrees to provide You coverage for benefits in keeping with the conditions, rights, and privileges set forth in this Certificate. Your coverage under this Certificate is subject to all the conditions and provisions of the Group Agreement.

This Certificate describes Your covered health care benefits. Coverage for services or supplies is provided only if furnished while You are a Member and this coverage is in force. Except as shown in **GENERAL PROVISIONS; COBRA Continuation Coverage** and **State Continuation Coverage**, coverage is not provided for any services received before coverage starts or after coverage ends.

Certain words have specific meanings in this Certificate. Defined terms are capitalized and shown in the appropriate provision or in the **DEFINITIONS** section and in the amendments or attachments to this Certificate, if applicable.

The Group Agreement relating to this Certificate is not a workers' compensation insurance policy. Ask Your employer if they subscribe to the workers' compensation system. This Certificate is governed by applicable federal law and the laws of Texas. Any reference to "applicable law" will include applicable laws and rules, including but not limited to statutes, ordinances, administrative decisions and regulations.

This Certificate may be delivered to You electronically, but a paper copy is available upon request. Please read this entire Certificate carefully, as it describes Your rights and obligations and those of the HMO. It is Your Group's and Your responsibility to understand these terms and conditions, because in some circumstances, certain medical services are not covered or may require Prior Authorization by HMO.

No services are covered by this Certificate if current Premiums have not been paid. If the Group Agreement is terminated for nonpayment of Premium, You are responsible for the cost of services received during the Grace Period described in **HOW THE PLAN WORKS.**

This Certificate applies only to Your HMO coverage. It does not limit Your ability to receive health care services that are not Covered Services.

No Participating Provider or other Provider, institution, facility or agency is an agent or employee of HMO.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the Guide to Health Insurance for people with Medicare available from BCBSTX.

Have a complaint or need help?

If You have a problem with a claim or Your Premium, call your insurance company or HMO first. If You can't work out the issue, the Texas Department of Insurance may be able to help.

Even if You file a complaint with the Texas Department of Insurance, You should also file a complaint or appeal through Your insurance company or HMO. If You don't, You may lose Your right to appeal.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation,
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To get information or file a complaint with Your insurance company or HMO:

Call: Blue Cross and Blue Shield of Texas
Toll-Free: 1-877-299-2377
Email: BCBSTXComplaints@bcbstx.com
Mail: P. O. Box 660044, Dallas, TX 75266-0044

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: Consumer Protection, MC:CO-CP
Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation,
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Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Blue Cross and Blue Shield of Texas
Teléfono gratuito: 1-877-299-2377
Correo electrónico: BCBSTXComplaints@bcbstx.com
Dirección postal: P. O. Box 660044, Dallas, TX 75266-0044

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: Consumer Protection, MC: CO-OP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-20230

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SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS

BlueCross BlueShield of Texas

Blue Advantage Gold HMO℠ 822

Blue Advantage HMO℠ Network

The following chart summarizes the coverage available under Your HMO Certificate. For details, refer to **COVERED SERVICES AND BENEFITS**. All Covered Services (except in emergencies) must be provided by or through Your Participating Primary Care Physician/Practitioner, who may refer You for further treatment by Providers in the applicable network of Participating Specialists and Hospitals. Urgent Care, Retail Health Clinics, Outpatient Professional Behavioral Health, and Virtual Visits do not require Primary Care Physician/Practitioner Referral. Some services may require Prior Authorization by HMO.

A Copayment for Covered Services shall not exceed fifty percent (50%) of the total cost of the services provided. Out-of-pocket maximums paid by You or on Your behalf in a Calendar Year for Covered Services shall not exceed two hundred percent (200%) of the total annual Premium. HMO will determine when maximums have been reached based on information provided to HMO by You and Participating Providers to whom You have made Copayments. Once You reach the maximum, You are not required to make additional Copayments for Covered Services or Covered Drugs for the remainder of the Calendar Year.

IMPORTANT NOTE: Copayments shown below indicate the amount You are required to pay, are expressed as either a fixed dollar amount or a percentage of the Allowable Amount and will be applied for each occurrence unless otherwise indicated. You will not be liable for any Copayments once applicable out-of-pocket maximums have been met. Copayments and out-of-pocket maximums may be adjusted for various reasons as permitted by applicable law.

MEDICAL BENEFITS	Your In-Network Cost
Calendar Year Out-of-Pocket Maximum for Medical/Pharmacy Benefits	
Individual Maximum	$7,500
Family Maximum	$15,000
General Payment Amounts	
General Copay (Dollar)	$0 Copay
Medical visits and services that cost the **General Copay (Dollar)** amount: • Chemotherapy • Dialysis • Home Health Care (up to 60 visits per Calendar Year) • Hospice Services (Inpatient Hospital Services costs will apply if Hospice Care provided in a hospital) • Outpatient Infusion Therapy: Non-Maintenance Drugs • Outpatient Surgery Physician • Radiation Therapy • Speech and Hearing Services (benefits for Autism Spectrum Disorder will not apply towards and are not subject to any speech services visit maximum) • Any service listed above related to Mental Health and Substance Use Disorder	
General Copay (Percent)	20% of Allowable Amount

SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS

BlueCross BlueShield of Texas

MEDICAL BENEFITS	Your In-Network Cost
Medical visits and services that cost the **General Copay (Percent)** amount: • Diabetes Equipment and Supplies (certain supplies are covered under **Pharmacy Benefits**) • Prosthetic Appliances and Orthotic Devices • Cochlear Implants (limit one per ear, with replacements as Medically Necessary) • Durable Medical Equipment • Hearing Aids • Any service listed above related to Mental Health and Substance Use Disorder	
Benefit-Specific Payment Amounts **Note**: the below benefits include, at the costs listed below, any services related to Mental Health or Substance Use Disorder.	
Preventive Care Services See **COVERED SERVICES AND BENEFITS, Health Maintenance and Preventive Services** for a list of no-cost preventive services.	$0 Copay
Office Visits • Primary Care Visit • Specialist Visit	 $70 Copay $140 Copay
Medical visits and services that cost the **Office Visit** amount(s): • Retail Health Clinic Visit • Telehealth and Telemedicine Services • Virtual Visit • Prenatal and Postnatal Maternity Care Office Visit (first visit only; subsequent visits are fully covered) • Infertility and Family Planning Services (if not covered as a no-cost preventive service) • Eye and Ear Screenings (limit1 per year until age 18 (additional benefits available in **PEDIATRIC VISION CARE BENEFITS**), then 1 per 2 years) • Early Detection Test for Ovarian Cancer (limit 1 per year) • Exam for Prostate Cancer (limit 1 per year) • Diabetes Self-Management Training Visit • Any **Office Visit** related to Mental Health or Substance Use Disorder	
Inpatient Hospital Services (per admission)	$2,750 Copay
Medical visits and services that cost the **Inpatient Hospital Services** amount: • Inpatient Rehabilitation and Habilitation Services • Inpatient Maternity Visits • Inpatient Vasectomy Services • Inpatient Dental Surgical Procedures (limited Covered Services) • Inpatient Cosmetic, Reconstructive, or Plastic Surgery (limited Covered Services) • Any **Inpatient Hospital Services** related to Mental Health or Substance Use Disorder	

MEDICAL BENEFITS	Your In-Network Cost
Outpatient Surgery Services • Outpatient Surgery Facility	$1,750 Copay
Medical visits and services that cost the **Outpatient Surgery** amount(s): • Outpatient Vasectomy Services • Outpatient Dental Surgical Procedures (limited Covered Services) • Outpatient Cosmetic, Reconstructive, or Plastic Surgery (limited Covered Services) • Any **Outpatient Surgery** related to Mental Health or Substance Use Disorder	
Imaging Services • Advanced Imaging (CT, PET Scan, MRI, etc.) • X-Rays and Other Diagnostic Imaging	$450 Copay $100 Copay
Medical visits and services that cost the **Advanced Imaging** amount: • Advanced imaging for prostate exams • Advanced imaging for ovarian cancer screenings • Advanced imaging for urgent care • CT scans for cardiovascular tests • Any **Advanced Imaging** related to Mental Health or Substance Use Disorder	
Medical visits and services that cost the **X-Ray and Other Diagnostic Imaging** amount: • X-Rays or other diagnostic imaging for prostate exams • X-Rays or other diagnostic imaging for ovarian cancer screenings • X-Rays or other diagnostic imaging for urgent care • Ultrasonography for cardiovascular tests • Any **X-Ray or Other Diagnostic Imaging** related to Mental Health or Substance Use Disorder	
Outpatient Infusion Therapy • Infusion Maintenance Drugs: Home, Office, Infusion Suite • Infusion Maintenance Drugs: Other Facility	$50 Copay $500 Copay
Emergency Room Services If admitted, use **Inpatient Hospital Services** amount instead.	$1,000 Copay
Urgent Care Services	$50 Copay

MEDICAL BENEFITS	Your In-Network Cost
Outpatient Rehabilitation and Habilitation Services (Speech, Physical, Occupational Therapy) Up to 35 visits for Rehabilitation and 35 visits for Habilitation; visit limits do not apply to services associated with Autism Spectrum Disorder, Acquired Brain Injury, or Behavioral Health Services.	$100 Copay
Emergency Transport (Ambulance Services)	$150 Copay
Skilled Nursing Facility Services (per day, up to 25 days per Calendar Year)	$100 Copay
Allergy Care	50% of Allowable Amount
Speech and Hearing Services	$100 Copay

SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS

BlueCross BlueShield of Texas

PHARMACY BENEFITS	Participating Pharmacy	
	Preferred	**Participating**
Retail Pharmacy Cost shares are based the day supply a prescription dispenses (1-30 days, 31-60 days, 61-90 days). Maximum supply is typically 30 days but can increase to 90 days under the Extended Prescription Drug Supply Program.		
Pharmacy Tier 1 (Retail)	$5 Copay	$15 Copay
Pharmacy Tier 2 (Retail)	$15 Copay	$25 Copay
Pharmacy Tier 3 (Retail)	$50 Copay	$70 Copay
Pharmacy Tier 4 (Retail) **Out-of-Area Drugs**	$100 Copay	$120 Copay
Mail-Order Pharmacy Cost shares are based the day supply a prescription dispenses (1-30 days, 31-60 days, 61-90 days). Maximum supply is 90 days.		
Pharmacy Tier 1 (Mail)	$15 Copay	
Pharmacy Tier 2 (Mail)	$45 Copay	
Pharmacy Tier 3 (Mail)	$150 Copay	
Pharmacy Tier 4 (Mail)	$300 Copay	
Specialty Drugs obtained through the Specialty Pharmacy Program Cost shares are based the day supply a prescription dispenses (1-30 days, 31-60 days, 61-90 days). Maximum supply is 30 days, but You can exceed 30 days for Specialty Drugs with FDA-approved dosing regimens above the 30-day supply limit, if Your plan allows.		
Pharmacy Tier 5	$150 Copay	
Pharmacy Tier 6	$250 Copay	
Select Vaccinations obtained through the Pharmacy Vaccine Network		
Vaccinations	$0 Copay	

*The Copayment for insulin included in the Drug List will not exceed $25 per prescription for a 30-day supply, regardless of the amount or type of insulin needed to fill the prescription.

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

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.

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Select Covered drugs, determined by the HMO, may be available at no cost, to make these medications more affordable to Members.

For additional information regarding the applicable Drug List, please call customer service or visit the website at www.bcbstx.com/rx-drugs/pharmacy/pharmacy-programs.

DEFINITIONS

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.

Advanced Practice Nurse (APN) means a registered nurse approved by the Texas Board of Nursing to practice as an Advanced Practice Nurse based on completing an advanced educational program acceptable to the Board. The term includes a nurse practitioner, nurse-midwife, nurse anesthetist, and a clinical nurse specialist. An Advanced Practice Nurse is prepared to practice in an expanded role to provide health care to individuals, families, and/or groups in a variety of settings including but not limited to homes, Hospitals, institutions, offices, industry, schools, community agencies, public and private clinics, and private practice. An Advanced Practice Nurse acts independently and/or in collaboration with other Health Care Professionals in the delivery of health care services.

Allowable Amount means the maximum amount determined by HMO to be eligible for consideration of payment for a particular service, supply or procedure rendered by a Participating Provider. The Allowable Amount is based on the provisions of the Participating Provider contract and the payment methodology in effect on the date of service, whether diagnostic related grouping (DRG), capitation, relative value, fee schedule, per diem or other.

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition. The trial must be:

A. conducted under an investigational new drug application reviewed by the United States Food and Drug Administration;
B. exempt from obtaining an investigational new drug application; or
C. approved or funded by:

    1. the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, or a cooperative group or center of any of the foregoing entities;
    2. a cooperative group or center of the United States Department of Defense or the United States Department of Veterans Affairs;
    3. a qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support groups; or
    4. the United States Departments of Veterans Affairs, Defense, or Energy if the study or investigation has been reviewed and approved through a system of peer review determined by the United States Secretary of Health and Human Services to:

        a. be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
        b. provide unbiased scientific review by individuals who have no interest in the outcome of the review.

D. conducted and approved by an institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

Autism Spectrum Disorder means a Neurobiological Disorder that includes autism, Asperger's syndrome, or pervasive developmental disorder-not otherwise specified. “Neurobiological Disorder” means an illness of the nervous system caused by genetic, metabolic, or other biological factors.

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.

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

Chemical Dependency means the abuse of or psychological or physical dependence on or addiction to alcohol or a Controlled Substance.

Chemical Dependency Treatment Center means a facility that provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved by HMO or its designated behavioral health administrator. The facility must be:

- affiliated with a Hospital under a contractual agreement with an established system for patient Referral;
- accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations;
- licensed, certified or approved as a Chemical Dependency treatment program or center by an agency of the state of Texas having legal authority to so license, certify or approve; or
- if outside Texas, licensed, certified or approved as a Chemical Dependency treatment program or center by the appropriate agency of the state in which it is located having the legal authority to so license, certify or approve.

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); or
- sublingual provocative testing (droplets of allergenic extracts are placed in mouth).

Complications of Pregnancy means conditions, requiring Hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and 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.

Contract Month means the period of each succeeding month beginning on the Group Agreement effective date.

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 dollar amount or percentage amount required to be paid by You or on Your behalf at the time of service to a Participating Provider in connection with Covered Services provided as described in C**OVERED SERVICES AND BENEFITS**.

Cosmetic, Reconstructive or Plastic Surgery means surgery that can be expected or is intended to improve Your physical appearance, is performed for psychological purposes, or restores form but does not correct or materially restore a bodily function.

Covered Services means those Medically Necessary health services specified and described in **COVERED SERVICES AND BENEFITS.**

Crisis Stabilization Unit means a twenty-four (24) hour residential program that is usually short-term in nature and provides intensive supervision and highly structured activities to Members who show signs of an acute demonstrable psychiatric crisis of moderate to severe proportions.

Custodial Care means any service primarily for personal comfort or 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.).

Dependent(s) means the Subscriber's family members who meet the eligibility requirements of this Certificate and have been enrolled by the Subscriber.

Dietary and Nutritional Services means Your education, counseling, or training (including printed material) regarding diet, regulation or management of diet, or the assessment or management of nutrition.

Domestic Partner means a person with whom You have entered into a Domestic Partnership in accordance with the Group's guidelines and who has been determined eligible for coverage by HMO. 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 and if COBRA-like benefits are available.

Durable Medical Equipment (DME) means equipment that can withstand repeated use, is primarily and usually used to serve a medical purpose, is generally not useful to a person in absence of illness or injury and is appropriate for use in the home.

Effective Date of Coverage means the commencement date of coverage under this Certificate as shown on the records of HMO.

Emergency Care means health care services provided in a Hospital emergency facility, freestanding emergency medical care facility, or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that their condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the patient's health in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part;
- serious disfigurement; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Environmental Sensitivity means the inpatient or outpatient treatment of allergic symptoms by controlling environment, sanitizing the surroundings (removal of toxic materials), or use of special nonorganic, nonrepetitive diet techniques.

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 or 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 HMO in assessing Experimental/Investigational status but will not be determinative. 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 Participating Provider; and
- the Health Care Professional has had the appropriate training and experience to provide the treatment or procedure.

HMO 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. Prescription drugs that are approved by the FDA through the accelerated approval program may be considered Experimental/Investigational.

Although a Health Care Professional may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, such services or supplies still may be considered to be Experimental/Investigational within this definition. Treatment provided as part of a clinical trial or a research study is Experimental/Investigational.

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.

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.

Grace Period means a period of thirty (30) days after all but the first Premium due date, or such other grace period, if any, permitted by applicable law or regulatory guidance, during which period Premiums may be paid to HMO without lapse of coverage occurring. If payment is not received within thirty (30) days, or such other grace period, if any permitted by applicable law or regulatory guidance, coverage will be terminated after the 30th day and You will be liable for the cost of services received during the Grace Period.

Group means the employer or party that has entered into a Group Agreement with HMO under which HMO will provide for or arrange health services for eligible Members of the Group who enroll.

Group Open Enrollment Period means those periods of time (at least thirty-one (31) days) established by Group and HMO from time to time, but no less frequently than once in any twelve (12) consecutive months, during which eligible persons who have not previously enrolled with HMO may do so.

Habilitation Services means health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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.

Health Care Professional(s) means Physicians, nurses, audiologists, Physician Assistants, Advanced Practice Nurses, nurse first assistants, acupuncturists, clinical psychologists, pharmacists, occupational therapists, physical therapists, speech and language pathologists, surgical assistants and other professionals engaged in the delivery of health services who are licensed, practice under an institutional license, or certified, or practice under authority of a Physician or legally constituted professional association, or other authority consistent with state law.

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

Hospice means an organization, licensed by appropriate regulatory authority or certified by Medicare as a supplier of Hospice care, which has entered into an agreement with HMO to render Hospice care to Members.

Hospital means an acute care institution which:

- is duly licensed by the state in which it is located and must be accredited by the Joint Commission on Accreditation of Healthcare Organizations or certified under Medicare;
- is primarily engaged in providing, on an inpatient basis, medical care and treatment of sick and injured persons through medical, diagnostic, and major surgical facilities;
- provides all services on its premises under the supervision of a staff of Physicians;
- provides twenty-four (24) hour a day nursing and Physician service; and
- has in effect a Hospital utilization review plan.

Hospital Services (except as expressly limited or excluded in this Certificate) means those Medically Necessary Covered Services that are generally and customarily provided by acute general Hospitals; and prescribed, directed or authorized by the PCP.

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

In Home Health Assessment means a Covered Service, which may include, but is not limited to, health history and blood pressure and blood sugar level screening. The assessment is designed to provide You with information regarding Your health that can be discussed with Your health care Provider, and is not a substitute for diagnosis, management and treatment by Your health care Provider.

Infertility means the condition of a presumably healthy Member who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual sexual intercourse. This does not include conditions

for male Members when the cause is a vasectomy or orchiectomy or for female Members when the cause is a tubal ligation or hysterectomy.

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

Infusion Therapy involves 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.

Life-Threatening Disease or Condition means, for the purposes of a clinical trial, any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Marriage and Family Therapy means the provision of professional therapy services to individuals, families, or married couples, singly or in groups, and involves the professional application of family systems theories and techniques in the delivery of therapy services to those persons. The term includes the evaluation and remediation of cognitive, affective, behavioral, or relational dysfunction within the context of marriage or family systems.

Medical Director means a Physician of HMO, or their designee, who is responsible for monitoring the provision of Covered Services to Members.

Medical Social Services means those social services relating to the treatment of a Member's medical condition. Such services include, but are not limited to assessment of the:

- social and emotional factors related to Member's illness, need for care, response to treatment and adjustment to care; and
- relationship of Member's medical and nursing requirements to the home situation, financial resources, and available community resources.

Medically Necessary means services or supplies (except as limited or excluded herein) that 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 consistent with generally accepted standards of medical practice in the United States;
- not primarily for Your convenience, or the convenience of Your Participating Provider; and
- the most economical supplies or levels of service appropriate for Your safe and effective treatment.
- If more than one health intervention meets the requirements listed above, Medically Necessary means the most cost effective in terms of type of intervention or settings, frequency, extent, or duration, which is safe and effective for the patient's illness, injury or disease and supports improved health

When applied to hospitalization, this further means that You require acute care as an inpatient due to the nature of the services rendered or Your condition, and You cannot receive safe or adequate care as an outpatient. In determining whether a service is Medically Necessary, HMO may consider the views of the state and national medical communities and the guidelines and practices of Medicare, Medicaid, or other government-financed programs and peer reviewed literature. Although a Participating Provider may have prescribed treatment, such treatment may not be Medically Necessary within this definition. This definition applies only to the HMO's determination of whether health care services are Covered Services under this Certificate. HMO does not determine Your course of treatment or whether You receive particular health care services. The decision regarding the course of treatment and receipt of particular health care service is entirely between You and Your Participating Provider. HMO's determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization, outpatient service or other health care service is Medically Necessary under this Certificate.

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

Member means a Subscriber or Dependent(s) covered under HMO. This Certificate may refer to a Member as You or Your.

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

1. 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 HMO or its designated behavioral health administrator, whether or not the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin;
2. The diagnosis or treatment of any symptom, condition, disease, or disorder by a Participating Provider when the Covered Service is:
    - individual, group, family, or conjoint psychotherapy;
    - counseling;
    - psychoanalysis;
    - psychological testing and assessment;
    - the administration or monitoring of psychotropic drugs; or
    - Hospital visits (if applicable) or consultations in a facility listed in **item 5**, below;
3. Electroconvulsive treatment;
4. Psychotropic drugs;
5. Any of the services listed in **items 1-4**, above, performed in or by a Hospital (if applicable), or other licensed facility or unit providing such care.

Mental Health Treatment Facility means a facility that:

- meets licensing standards;
- mainly provides a program for diagnosis, evaluation and treatment of acute mental or nervous disorders;
- prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs;
- provides all normal infirmary level medical services or arranges with a Hospital for any other medical services that may be required;
- is under the supervision of a psychiatrist; and
- provides skilled nursing care by licensed nurses who are directed by a registered nurse.

Minimum Essential Coverage means health insurance coverage that is recognized as coverage that meets substantially all requirements under federal law pertaining to adequate individual, Group or government health insurance coverage. For additional information on whether particular coverage is recognized as "Minimum Essential Coverage", please call the customer service telephone number shown on the back of Your identification card or visit www.cms.gov.

Obstetrician/Gynecologist means a Participating Physician contracted by HMO as an Obstetrician and/or Gynecologist who may be selected by a Member to provide:

- well-woman exams;
- obstetrical care;
- care for all active gynecological conditions; and
- diagnosis, treatment, and Referral for any disease or condition within the scope of the professional practice of the Obstetrician/Gynecologist.

Out-of-Area means not within the Service Area.

Participating means a Provider that has entered into a contractual agreement with HMO for the provision of Covered Services to Members.

Physician means a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is properly licensed or certified to provide medical care (within the scope of their license) under the laws of the state where the individual practices.

Physician Assistant (PA) means a Physician assistant licensed under Texas Occupations Code Chapter 204.

Post-Delivery Care means postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments, including parent education, assistance and training in breast and bottle feeding, and the performance of necessary and appropriate clinical tests.

Post-Service Medical Necessity Review means a review, sometimes referred to as a retrospective medical necessity review, is the process of determining coverage after treatment has already occurred and is based on Medical Necessity guidelines.

Premium means the amount the Group or You are required to pay to HMO to continue coverage.

Primary Care Physician/Practitioner or PCP means the Participating Physician, Physician Assistant or Advanced Practice Nurse who is primarily responsible for providing, arranging and coordinating all aspects of Your health care. You and Your Dependents must each select a PCP from those listed by HMO to provide primary care services. You may choose a PCP who is a family practitioner, internist, pediatrician and/or Obstetrician/Gynecologist. The PA or APN must work under the supervision of a Participating family practitioner, internist, pediatrician and/or Obstetrician/Gynecologist in the same HMO network.

Prior Authorization means a determination by HMO that health care services proposed to be provided to a patient are Medically Necessary and appropriate. Prior Authorization processes will be conducted in accordance with Texas Insurance Code chapter 843, or in accordance with the laws in the state of Texas.

Professional Services means those Medically Necessary Covered Services rendered by Physicians and other Health Care Professionals in accordance with this Certificate. All services must be performed, prescribed, directed, or authorized in advance by the PCP.

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 (dental appliances and the replacement of cataract lenses are not considered Prosthetic Appliances).

Provider means any duly licensed institution, Physician, Health Care Professional or other entity which is licensed to provide health care services.

Psychiatric Day Treatment Facility means an institution that 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 Serious Mental Illness services to Members for periods of time not to exceed eight hours in any 24-hour period. Any treatment in such facility must be certified in writing by the attending Physician to be in lieu of hospitalization.

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

Referral means specific directions or instructions from Your PCP, in conformance with HMO's policies and procedures that direct You to a Participating Provider for Covered Services.

Rehabilitation Services means Rehabilitative services, including devices, are provided to help a person regain, maintain, or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury, or disabling condition.

Research Institution means an institution or Provider (person or entity) conducting a phase I, phase II, phase III, or phase IV clinical trial.

Residential Treatment Center means a facility setting (including a Residential Treatment Center for Children and Adolescents) offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, wilderness programs, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities. Patients are medically monitored with 24 hour medical availability and 24 hour onsite nursing service for Mental Health Care and/or treatment of Chemical Dependency. HMO requires that any Mental Health Treatment Facility, Residential Treatment Center and/or Chemical Dependency Treatment Center must be licensed in the state where it is located or accredited by a national organization that is recognized by HMO as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

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

Retail Health Clinic means a Participating Provider that has entered into a contractual agreement with HMO to provide treatment of uncomplicated minor illnesses. Retail Health Clinics are typically located in retail store s and are typically staffed by Advanced Practice Nurses or Physician Assistants.

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

Routine Patient Care Costs means the costs of any Medically Necessary health care service for which benefits are provided under the Health Benefit Plan, without regard to whether the Member is participating in a clinical trial.

Routine patient care costs do not include:

- the cost of an investigational new drug or device that is not approved for any indication by the United States Food and Drug Administration, including a drug or device that is the subject of the clinical trial;
- the cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in a clinical trial;
- the cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- the cost associated with managing a clinical trial; or
- the cost of a health care service that is specifically excluded from coverage under the HMO.

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

- schizophrenia; paranoid and other psychotic disorders;
- bipolar disorders (hypomanic, manic, depressive and mixed);
- major depressive disorders (single episode or recurrent);
- schizo-affective disorders (bipolar or depressive);
- obsessive-compulsive disorders;
- depression in childhood or adolescence.

Service Area means the geographical area served by HMO and approved by state regulatory authorities. The applicable Service Area includes the area shown and described in **SERVICE AREA**.

Skilled Nursing Facility means an institution or distinct part of an institution that is licensed or approved under state or local law, and primarily provides skilled nursing care and related services as a Skilled Nursing Facility, extended care facility or nursing care facility approved by the Joint Commission on Accreditation of Health Care Organizations, the Bureau of Hospitals of the American Osteopathic Association or as otherwise determined by HMO to meet the reasonable standards applied by either of those authorities.

Specialist means a duly licensed Physician, other than a PCP.

Subscriber means a person who meets all applicable eligibility and enrollment requirements of this Certificate, and whose enrollment application and Premium payment have been received by HMO.

Teledentistry Dental Services means a health care 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 than the Dentist or health professional using telecommunications or information technology.

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

Tobacco User means a person who is permitted under state and federal law to legally use tobacco, with tobacco use (other than religious or ceremonial use of tobacco), occurring on average four or more times per week that last occurred within the past six months (or such other meaning required or permitted by applicable law). Tobacco includes, but is not limited to, cigarettes, cigars, pipe tobacco, smokeless tobacco, snuff, etc. For additional

information, please call customer service at the toll-free number on the back of Your identification card or visit the website at www.bcbstx.com.

Urgent Care means medical or health care services provided in a situation other than an emergency that are typically provided in a setting such as an Urgent Care Provider's office or Participating Urgent Care center, as a result of an acute injury or illness that is severe or painful enough to lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the person's condition, illness, or injury is of such a nature that failure to obtain treatment within a reasonable period of time would result in serious deterioration of the condition of the person's health.

Urgent Care Provider means a Participating Provider that has entered into a contractual agreement with HMO for the provision of Covered Services for Urgent Care to Members.

Virtual Network Provider means a licensed Participating Provider that has entered into a contractual agreement with HMO to provided diagnosis and treatment of injuries and illnesses through either (i) interactive audio communication (via telephone or other similar technology), or (ii) 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 **COVERED SERVICES AND BENEFITS.**

You and **Your** means any Member, including Subscriber and Dependents.

Eligibility

No eligibility rules or variations in Premium will be imposed based on Your health status, medical condition, claims experience, receipt of care, medical history, genetic information, evidence of insurability, disability, or other health status related factor. Coverage under this Certificate is provided regardless of Your race, color, national origin, disability, age, sex, gender identity, sexual orientation, political affiliation or expression. Coverage under this Certificate 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 Certificate. Variations in the administration, processes or benefits of this Certificate are based on clinically indicated, reasonable medical management practices, or are part of permitted wellness incentive; disincentives and/or other programs do not constitute discrimination.

Subscriber Eligibility. To be eligible to enroll as a Subscriber, a person must:

1. reside, live or work in the Service Area; and
2. be a bona fide employee of Group entitled to participate in the health care benefit program arranged by Group or be entitled to coverage under a trust agreement or employment contract; and
3. satisfy any probationary or waiting period requirements established by Group.

Note: No such waiting period may exceed 90 days unless permitted by applicable law. If our records show that Your Group has a waiting period that exceeds the time period permitted by applicable law, then HMO reserves the right to begin Your coverage on a date that we believe is within the required period. Regardless of whether we exercise that right, Your Group is responsible for Your waiting period**.** If You have questions about Your waiting period, please contact Your Group.

Dependent Eligibility. To be eligible to enroll as a Dependent, a person must:

1. reside in the Service Area or permanently reside with a Subscriber who works in the Service Area, except as provided in **item 6**, below; and
2. meet all Dependent eligibility criteria established by Group; and
3. be Subscriber's spouse or Domestic Partner. Subscriber may be required to submit a certified copy of a marriage license or declaration of informal marriage with Dependent's enrollment application/change form before coverage will be extended; or
4. be a Dependent child, which hereafter means a natural child, eligible foster child, a stepchild, an adopted child (including a child for who the Subscriber or Subscriber's spouse is a party in a suit in which the adoption of the child is sought) or a Dependent child of a Domestic Partner under twenty-six years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage or any combination of those factors. To be eligible for coverage, a child of a Subscriber's child must also be dependent upon Subscriber for federal income tax purposes at the time application for coverage is made.

   In addition, a Dependent shall include a child for whom Subscriber or Subscriber's spouse or Domestic Partner is a court-appointed legal guardian, provided proof of such guardianship is submitted with the prospective Dependent's enrollment application/change form; or
5. be a child of any age, as defined in **item 4** above, who is and continues to be incapable of sustaining employment by reason of mental retardation or physical handicap and is chiefly dependent upon Subscriber for economic support and maintenance. Subscriber must provide HMO with a Dependent Child's Statement of Disability form, including a medical certification of disability, within thirty-one (31) days of the date of such medical certification and subsequently as may be required by HMO, but not more often than once per year. HMO's determination of eligibility shall be conclusive; or
6. have a court order for coverage to be provided for a spouse or minor child under Subscriber's Health Benefit Plan and a request for enrollment shall be made within thirty-one (31) days after issuance of the court order.

Coverage of Subscriber shall be a condition precedent to coverage of eligible Dependents, and no Dependent shall be covered hereunder prior to Subscriber's Effective Date of Coverage.

Loss of Eligibility. You must notify HMO of any changes that will affect Your eligibility, or that of Your Dependents, for services or benefits under this Certificate within thirty-one (31) days of the change.

Enrollment and Effective Date of Coverage

No person meeting Subscriber or Dependent eligibility requirements will be refused enrollment or re-enrollment by HMO because of health status, age, requirements for health services, or the existence of a pre-existing physical or mental condition, including pregnancy. No person, however, is eligible to re-enroll who had coverage terminated under **GENERAL PROVISIONS, Termination of Coverage.** Your coverage shall not be terminated by HMO due to health status or health care needs.

Initial Enrollment. Each eligible employee of Group shall be entitled to apply for coverage for himself and eligible Dependents during the initial Group Open Enrollment Period. All persons included for coverage must be listed on the enrollment application/change form. No proof of insurability is required. The Effective Date of Coverage is the first day of the month after the enrollment period, unless otherwise specified and agreed upon by Group and HMO.

Group Open Enrollment Period. A Group Open Enrollment Period will be held at least annually at which time eligible employees and/or Dependents may enroll as Members of HMO. No proof of insurability shall be required. The Effective Date of Coverage is the first day of the month after the enrollment period, unless otherwise specified and agreed upon by Group and HMO.

Other Enrollment Events. Coverage under this Certificate for persons becoming eligible at times other than initial enrollment or the Group Open Enrollment Period will become effective as stated in **items 1-6** below, only if HMO receives completed enrollment application/change form and applicable Premium payments timely. "Timely" means within thirty-one (31) days from the date of the event, unless otherwise specified and agreed upon by Group and HMO.

1. **Newly Eligible Employee**. Each new employee of Group who becomes eligible for coverage at a time other than the initial enrollment or Group Open Enrollment Period may enroll himself and eligible Dependents. If application is not made Timely, the newly eligible employee may not be added until the next Group Open Enrollment Period. The Effective Date of Coverage is the first day of the month following the date employee becomes eligible, unless otherwise specified and agreed upon by Group and HMO.
2. **Newly Eligible Dependents.** Subscriber may enroll any person who becomes newly eligible as a Dependent by completing and submitting to HMO an enrollment application/change form within thirty-one (31) days after attaining eligibility. No proof of insurability shall be required. The Effective Date of Coverage will be the date of the event, i.e., marriage, entry into a Domestic Partnership, birth, adoption, becoming a party in a suit for adoption or guardianship, unless otherwise specified and agreed upon by Group and HMO. Newly eligible Dependents not added to coverage within thirty-one (31) days after the event will become effective in accordance with the provisions for late enrollees.
3. **Newborn Children Coverage**. Coverage will be automatic for Subscriber or Subscriber's spouse's or Domestic Partner's newborn child for the first sixty (60) days following the date of birth. Coverage will continue beyond the sixty (60) days only if the child is an eligible Dependent and You notify HMO (verbally or in writing) or submit an enrollment application/change form to HMO Timely and make or agree to make any additional Premium payments in accordance with this Certificate. The Effective Date of Coverage for newborn children shall be the newborn's date of birth.
4. **Newly Adopted Children**. Coverage will be automatic for a newly adopted child of Subscriber for the first sixty (60) days from the date Subscriber is a party in a suit for adoption or sixty (60) days from the date the adoption is final. Coverage will continue beyond the sixty (60) days only if the child is an eligible Dependent and You submit an enrollment application/change form to HMO within sixty (60) days after the date Subscriber becomes a party in a suit for adoption, the date the adoption becomes final, and You make or agree to make any required Premium payments in accordance with this Certificate. The Effective Date of Coverage for newly adopted children shall be the date You become a party in a suit for adoption or the date the adoption is final.
5. **Court-Ordered Dependents.** Dependent children for whom Subscriber has received a court order requiring Subscriber to provide health coverage will be covered for an initial period of thirty-one (31) days from the date Group receives notification of the court order. Coverage will continue beyond the thirty-one (31) days only if You submit to HMO appropriate enrollment application/change form within thirty-one

(31) days of the date of receipt of the court order by Group and make or agree to make any additional Premium payments in accordance with this Certificate. The Effective Date of Coverage for court-ordered Dependents will be the date the court order is received by Group.

Coverage for a Dependent spouse for whom Subscriber has received a court order requiring You to provide health coverage will be effective on the first day of the month after HMO receives the appropriate enrollment application/change form and applicable Premium payments, if HMO receives such form and payments within thirty-one (31) days after issuance of the court order.

6. **Late Enrollees; Special Enrollment Events**. Eligible Subscribers or Dependents initially or newly eligible for enrollment who do not enroll within thirty-one (31) days after eligibility are late enrollees and may only be enrolled during a subsequent Group Open Enrollment Period. An eligible Subscriber or Dependent is not a late enrollee in the following situations:

    a. **Family Additions.** In the event of marriage, entry into a Domestic Partnership, birth, adoption, becoming a party in a suit for adoption or receipt of a court order to provide coverage for a Subscriber's (or individual eligible as a Subscriber) spouse or child(ren), a Subscriber who did not enroll when initially eligible, may enroll himself and any person becoming eligible to be a Dependent, as set forth below. No proof of insurability is required. If enrollment application/change form and applicable Premium payments are not Timely, these individuals are late enrollees and may only be enrolled in a subsequent Group Open Enrollment Period:

        1. **Marriage or Domestic Partnership**. Subscriber may enroll Subscriber and Subscriber's spouse or Domestic Partner within thirty-one (31) days after the date of marriage or entry into a Domestic Partnership. The Effective Date of Coverage is the first day of the month following the date of the event unless otherwise specified and agreed upon by Group and HMO;

        2. **Birth or Adoption.** Subscriber may enroll Subscriber, Subscriber's spouse or Domestic Partner, and/or Subscriber's newborn or newly adopted child(ren). The Effective Date of Coverage will be the date of birth, adoption, or becoming a party in a suit for adoption;

        3. **Court-Ordered Dependents.** Subscriber may enroll the spouse and/or child(ren) for whom You have received a court order requiring You to provide health coverage;

            i. **Court-ordered child(ren)**: A Subscriber may enroll himself, if not already covered, and such child(ren) subject to the court order. The Effective Date of Coverage is as of the date Group receives notice of the court order if HMO receives enrollment application/change form(s) within thirty-one (31) days after the date Group receives a court order or notice of a court order, and You make or agree to make any additional Premium payments.

            ii. **Court-ordered spouse**: The Effective Date of Coverage is the first day of the month after HMO receives enrollment application/change form, if HMO receives application/change form within thirty-one (31) days after issuance of the court order and You make or agree to make any additional Premium payments.

    b. **Loss of Other Coverage.** Any individual eligible as a Subscriber or Dependent who did not enroll when initially eligible may enroll if each of the following is true, and if HMO receives completed enrollment application/change forms and applicable Premium payments within thirty-one (31) days after the date coverage ends or after a claim is denied due to reaching the lifetime limit under another Health Benefit Plan, self-funded employer Health Benefit Plan, or other health insurance coverage (collectively referred to in this subsection as "Prior Health Benefit Plan"):

        1. You or any eligible Dependent was covered under a Prior Health Benefit Plan at the time You were initially eligible to enroll;

        2. You declined enrollment, in writing, for Yourself and/or Your Dependent(s) at the time of initial eligibility, stating that coverage under a Prior Health Benefit Plan was the reason for declining enrollment; and

3. You or any eligible Dependent lost coverage under a Prior Health Benefit Plan as a result of:
    a. termination of employment;
    b. a reduction in the number of hours of employment;
    c. termination of Your Prior Health Benefit Plan coverage;
    d. You or Your Dependent incurring a claim that would meet or exceed a lifetime limit on all benefits under Prior Health Benefit Plan coverage;
    e. the Prior Health Benefit Plan no longer offering any benefits to the class of similarly situated individuals that include You or Your Dependent(s);
    f. if coverage was through a health maintenance organization, You or Your Dependent(s) no longer residing, living, or working in the Service Area of the health maintenance organization and no other benefit option being available;
    g. termination of contribution toward the Premium made by the former employer;
    h. Dependent status ending (for example, due to death of a spouse, divorce, legal separation or reaching the maximum age to be eligible as a Dependent child under the Prior Health Benefit Plan); or
    i. expiration of the continuation of coverage period of the Prior Health Benefit Plan under Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985
    j. (COBRA), as amended, or under the continuation provisions of the Texas Insurance Code.

The Effective Date of Coverage under this subsection is the day after prior coverage terminated.

c. **Dependent Loss of Governmental Coverage.** An individual who is eligible to enroll and who has lost coverage under Medicaid (Title XIX of the Social Security Act), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s) or under the Texas Children's Health Insurance Program (CHIP), Chapter 62, Health and Safety Code, is not a late enrollee provided appropriate enrollment application/change forms and applicable Premium payments are received by HMO within sixty (60) days after the date on which such individual loses coverage. Coverage will be effective the day after prior coverage terminated.

d. **Health Insurance Premium Payment (HIPP) Reimbursement Program.** An individual who is eligible to enroll and who is a recipient of medical assistance under the state of Texas Medicaid Program or enrolled in CHIP, and who is a participant in the state of Texas HIPP Reimbursement Program may enroll with no enrollment period restrictions. If the individual is not eligible unless a family member is enrolled, both the individual and family member may enroll. The Effective Date of Coverage is on the first day of the month after HMO receives (i) written notice from the Texas Health and Human Services Commission, or (ii) enrollment forms, from You, provided such forms and applicable Premium payments are received by HMO within sixty (60) days after the date the individual becomes eligible for participation in the HIPP Reimbursement Program.

Provider Information

You are entitled to medical care and services from Participating Providers including Medically Necessary medical, surgical, diagnostic, therapeutic and preventive services that are generally and customarily provided in the Service Area. Some services may not be covered. To be covered, a service that is Medically Necessary must also be described in **COVERED SERVICES AND BENEFITS.** Even though a Physician or other Health Care Professional has performed, prescribed or recommended a service does not mean it is Medically Necessary or that it is covered under **COVERED SERVICES AND BENEFITS.**

Only services that are performed, prescribed, directed or authorized in advance by the PCP or HMO are covered benefits under this Certificate except Emergency Care, Participating Urgent Care, Retail Health Clinics, and Virtual Visits.

HMO and Participating Providers do not have any financial responsibility for any services You seek or receive from a non-Participating Provider or facility, except as set forth below, unless both Your PCP and HMO have made prior Referral authorization arrangements.

Utilization Management

Utilization Management may be referred to as Medical Necessity reviews, utilization review (UR), or medical management reviews. A Medical Necessity review for a procedure/service, inpatient admission, and length of stay is based on HMO medical policy and/or level of care review criteria. Medical Necessity reviews may occur prior to services rendered, during the course of care, or after care has been completed.

Refer to the definition of Medically Necessary under the **DEFINITIONS** section of this Certificate for additional information regarding any limitations and/or special conditions pertaining to Your benefits.

Prior Authorization

Prior Authorization establishes in advance the Medical Necessity or Experimental/Investigational nature of certain care and services covered under this Plan. It ensures that the care and services described below for which You have obtained Prior Authorization will not be denied on the basis of Medical Necessity or Experimental/Investigational.

Some Covered Services may also require Prior Authorization which requires the Provider to get approval from HMO before You are admitted to the Hospital or for certain types of Covered Services. Prior Authorization processes will be conducted in accordance with Texas Insurance Code, chapter 843 or in accordance with the laws in the state of Texas. Renewal of an existing Prior Authorization issued by HMO can be requested by a Physician or Health Care Provider up to 60 days prior to the expiration of the existing Prior Authorization.

On receipt of a request from a Participating Physician or Provider for Prior Authorization, HMO shall review and issue a determination:

- not later than the third calendar day after the date the request is received by the HMO for non-hospitalization care;
- within 24 hours of receipt of the request for inpatient and concurrent hospitalization care;
- within the time appropriate to the circumstances relating to the delivery of the services and the condition of the Member but not to exceed one hour from receipt of the request if the proposed services involve post-stabilization treatment or a Life-Threatening Condition.

Some Texas-licensed Providers may qualify for an exemption from Prior Authorization requirements for a particular health care service if the Provider met criteria set forth by applicable law for the particular health care service. If so, where an exemption applies for a particular service, Prior Authorization is not required and will not be denied based on Medical Necessity or medical appropriateness of care. Other Providers providing Your care may not be exempt from such requirements. Exemptions do not apply for services that are materially misrepresented or where the Provider failed to substantially perform the particular service.

For additional information and a current list of medical and health care services that require Prior Authorization, please visit the website at https://www.bcbstx.com/find-care/utilization-management.

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Extension of Length of Stay/Service Review/Concurrent Review

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

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

An extension of length of stay/service review, also known as a concurrent Medical Necessity review, is when You, Your Provider, or other authorized representative may submit a request to HMO for continued services. If You, Your Provider or authorized representative requests to extend care beyond the approved time limit, HMO will make a determination on the request within the timeframes described in the **Review of Claim Determinations** provision of this Benefit Booklet.

Contacting Behavioral Health

You, Your Physician or Provider of services or Your authorized representative may contact BCBSTX for a Prior Authorization by calling the toll-free number shown on the back of Your Identification Card and following the prompts to the Behavioral Health Unit. During regular business hours (8:00 a.m. and 6:00 p.m., Central Time, on business days), the caller will be routed to the appropriate behavioral health clinical team for review. Outpatient requests should be requested during regular business hours. After 6:00 p.m., on weekends, and on holidays, the same behavioral health line is answered by clinicians available for Inpatient acute reviews only. Requests for residential or Partial Hospitalization are reviewed during regular business hours.

Post-Service Medical Necessity Review

A Post-Service Medical Necessity Review or post-service claims request, also known as a retrospective medical necessity review, is the process of determining coverage after treatment has been provided and is based on Medical Necessity guidelines. A Post-Service Medical Necessity Review confirms Your eligibility, availability of benefits at the time of service, and reviews necessary clinical documentation to ensure service was Medically Necessary. A Post-Service Medical Necessity Review may be performed when a Prior Authorization was not obtained prior to services being rendered under certain circumstances.

General Provisions Applicable to All Post-Service Medical Necessity Reviews

1. **No Guarantee of Payment**

   A Post-Service Medical Necessity Review is not a guarantee of payment. Actual availability of benefits is subject to other terms, conditions, limitations, and exclusions of HMO. Post-Service Medical Necessity Review does not guarantee payment of benefits by HMO.

2. **Request for Additional Information**

   The Post-Service Medical Necessity Review process may require additional documentation from Your health care Provider or pharmacist. In addition to the written request for Post-Service Medical Necessity Review, the health care Provider or pharmacist may be required to include pertinent documentation explaining the services rendered, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by the plan to make a determination of coverage pursuant to the terms and conditions of HMO.

Coverage Determinations

Certain services are covered pursuant to HMO medical policies and clinical procedure and coding policies, which are updated throughout the Calendar Year. The medical policies are guides considered by HMO when making coverage determinations and lay out the procedure and criteria to determine whether a procedure, treatment, facility, equipment, drug or device is Medically Necessary and is eligible as a Covered Service or is Experimental /Investigational, cosmetic, or a convenience item. The clinical procedure and coding policies provide information about what services are reimbursable under the Certificate of Coverage. The most up-to-date medical and clinical

procedure and coding policies are available at www.bcbstx.com or call customer service at the toll-free telephone number on the back of Your identification card.

Selecting a PCP

At the time You enroll, You must choose a PCP. If any Member is a minor or otherwise incapable of selecting a PCP, the Subscriber should select a PCP on Member's behalf. If Your Dependents enroll, You and Your Dependents must choose a PCP from HMO's directory of Participating Providers in order to receive Covered Services. For the most current list of Participating Providers visit the website at www.bcbstx.com. You may also refer to Your Provider directory or call customer service at the toll-free telephone number on the back of Your identification card. You may also request a written copy of the Participating Provider directory, which is updated quarterly, by calling customer service. Each directory identifies those Providers who are accepting existing patients only. HMO may assign a PCP if one has not been selected. Until a PCP is selected or assigned, benefits will be limited to coverage for Emergency Care.

In addition to a PCP, members may also select a Participating Obstetrician/Gynecologist (OB/GYN Care) for gynecological and obstetric conditions, including annual well-woman exam and maternity care, without first obtaining a Referral from a PCP or calling HMO.

Members who have been diagnosed with a chronic, disabling or Life-Threatening illness may request approval to choose a Participating Specialist as a PCP using the process described in **Specialist as PCP.**

Your PCP

Your PCP coordinates Your medical care, as appropriate, either by providing treatment or by issuing Referrals to direct You to Participating Providers. Except for Emergency Care/medical emergencies or certain direct-access Specialist benefits described in this Certificate, only those services which are provided by or referred by Your PCP will be covered. It is Your responsibility to consult with the PCP in all matters regarding Your medical care.

If Your PCP performs, suggests, or recommends a course of treatment for You that includes services that are not Covered Services, the entire cost of any such non-Covered Services will be Your responsibility.

Changing Your PCP

You may change Your PCP by calling the customer service toll-free telephone number listed on Your identification card to make the change or to request a change form or assistance in completing that form. The change will become effective on the first day of the month following HMO's receipt and approval of the request.

In the event of termination of a Participating Provider of any kind, HMO will use best efforts to provide reasonable advance notice to Members receiving care from such Participating Provider that termination is imminent. Special circumstances may render You eligible to continue receiving treatment from a Participating Provider after the effective date of termination, which is fully described in **Continuity of Care**.

Continuity of Care

If You are under the care of a Participating Provider who stops participating in HMO's network, (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or for fraud), HMO will continue coverage for that Provider's Covered Services if all the following conditions are met:

- You are undergoing a course of treatment for a serious and complex condition, You are undergoing institutional or inpatient care, You are scheduled to undergo nonelective surgery from the Provider (including receipt of postoperative care from such Provider with respect to such surgery), You are pregnant or undergoing a course of treatment for the pregnancy, or 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 care (for example, 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;
- the Provider submits a request to HMO to continue coverage of Your care that identifies the condition for which You are being treated and, where required, indicates that the Provider reasonably believes that discontinuing treatment could cause You harm; and
- the Provider agrees to continue accepting the same reimbursement that applied when participating in HMO's network, and not to seek payment from You for any amounts for which You would not be responsible if the Provider were still participating in HMO's network.

Continuity coverage shall continue until the treatment is complete but shall not extend for more than ninety (90) days (or more than nine (9) months if You have been diagnosed with a terminal illness) beyond the date the Provider's termination takes effect. If You are past the thirteenth (13^{th}) week of pregnancy when the Provider's termination takes effect, coverage may be extended through delivery, 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 subsection as explained in the **COMPLAINT AND APPEAL PROCEDURES** section of this Certificate.

Specialist as PCP

If You have been diagnosed with a chronic, disabling, or Life-Threatening illness, You may contact customer service at the toll-free telephone number on Your identification card to get information to submit for approval from the HMO Medical Director to choose a Participating Specialist as Your PCP. The Medical Director will require both You and the Participating Specialist interested in serving as Your PCP to sign a certification of medical need, to submit along with all supporting documentation. The Participating Specialist must meet HMO's requirements for PCP participation and be willing to accept the coordination of all Your healthcare needs. If Your request is denied, You may appeal the decision as described in **COMPLAINT AND APPEAL PROCEDURES.** If Your request is approved, the Specialist's designation as Your PCP will not be effective retroactively. As used herein, **"**Life-Threatening**,"** means a disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Availability of Providers

HMO cannot guarantee the availability or continued participation of a particular Provider. Either HMO or any Participating Provider may terminate the Provider contract or limit the number of Members that will be accepted as patients. If the PCP initially selected cannot accept additional patients, You will be given an opportunity to make another PCP selection. You must then cooperate with HMO to select another PCP.

Out-of-Network Services

You may obtain Covered Services from Providers who are not part of HMO's network of Participating Providers when receiving Emergency Care. Also, court-ordered Dependents living outside the Service Area may use non-Participating Providers.

If Inpatient Hospital Services are required after receiving Emergency Care and post stabilization care at a non-Participating Hospital, we request that You notify HMO within forty-eight (48) hours of receiving Emergency Care, or as soon as possible without being medically harmful or injurious to You.

If Covered Services are not available from Participating Providers within the access requirements established by law and regulation, HMO will allow a Referral by Your PCP to a non-Participating Provider, if approved by HMO.

You will not be required to change Your PCP or Participating Specialist Providers to receive Covered Services that are not available from Participating Providers, but the following apply:

- the request must be from a Participating Provider;
- reasonably requested documentation must be received by HMO;
- the Referral will be provided within an appropriate time, not to exceed five business days, based on the circumstances and Your condition;
- when HMO has allowed Referral to a non-Participating Provider, HMO will reimburse the non-Participating Provider at the usual and customary rate or otherwise agreed rate, less the applicable Copayment(s). You are responsible only for the Copayments for such Covered Services; and

- before HMO denies a Referral, a review will be conducted by a Specialist of the same or similar specialty as the type of Provider to whom a Referral is requested.

In some instances where You do not have the ability to choose a network Provider, such as when You receive services from a non-Participating Facility-Based Provider in a Network Facility, or when You receive services from a non-Participating laboratory or diagnostic imaging facility in connection with care provided by Your Participating Provider. In these instances, Your services may be covered and You would not be responsible for any amounts beyond the Copayment. If You receive a bill from an out-of-network Provider in such circumstance, please contact HMO.

If You elect to use out-of-network Providers for non-Emergency Care services and supplies available from Participating Providers, benefits will not be covered.

Balance billing is prohibited for Emergency Care ground ambulance transportation services from non-Participating Providers if the services would be covered with a Participating Provider; state-level protections for ground ambulance services will remain in effect for as long as they are upheld or mandated by Texas Law.

Federal Balance Billing and Other Protections

This section is based upon the No Surprises Act, a federal law enacted in 2020 and effective for plan years beginning on or after January 1, 2022. Unless otherwise required by federal or Texas law, if there is a conflict between the terms of this **Federal Balance Billing and Other Protections** section and the terms in the rest of this Certificate, the terms of this section will apply.

1. **Protections from Unexpected Costs for Medical Services from Non-participating Providers**

   Your plan contains provisions related to protection from surprise balance billing under Texas law. The federal laws provide additional financial protections for You when You receive some types of care from Providers who do not participate in Your network. If You receive the types of care listed below, Your in-network cost-sharing levels will apply to any in-network out-of-pocket maximums. Additionally, for services below that are governed by federal law (instead of state law), Your cost-share amount may be calculated on an amount that generally represents the median payment rate that BCBSTX has negotiated with Participating Providers for similar services in the area.

   - emergency care from facilities or Providers who do not participate in Your network; and
   - care furnished by non-participating Providers during Your visit to a Participating facility; and
   - air ambulance services from non-Participating Providers, if the services would be covered with a Participating Provider.

   Non-participating Providers may not bill You for more than Your Copayment for these types of services. There are limited instances when a non-participating Provider of the care listed above may send You a bill for up to the amount of that Provider's billed charges. You are only responsible for payment of the non-participating Provider's billed charges if, in advance of receiving services, You signed a written notice form that complies with applicable state and/or federal law.

   The requirements of federal law that impact Your costs for care from non-participating Providers may not apply in all cases. Sometimes, Texas law provisions relating to balance billing prohibitions may apply. **You may contact BCBSTX at the number on the back of Your identification card with questions about claims or bills You have received from Providers.**

2. **Primary Care Physician/Practitioner 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).

3. **Obstetrics or Gynecological Care**

You are not required to obtain a Referral or authorization from Your Primary Care Physician/Practitioner (PCP) 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.

To the extent state and federal regulations are adopted or additional guidance is issued by federal regulatory agencies that alter the terms of this section, the regulations and any additional guidance will control over conflicting language in this section.

Inpatient Care by Non-PCP

During an inpatient stay at a Participating Hospital, Skilled Nursing Facility or other Participating facility, it may be appropriate for a Physician other than Your PCP to direct and oversee Your care, if Your PCP does not do so. However, upon discharge, You must return to the care of Your PCP or have Your PCP coordinate care that may be Medically Necessary.

Provider Communication

HMO will not prohibit, attempt to prohibit or discourage any Provider from discussing or communicating to You or Your designee any information or opinions regarding Your health care, any provisions of the Health Benefit Plan as it relates to Your medical needs or the fact that the Provider's contract with HMO has terminated or that the Provider will no longer be providing services under HMO.

Your Responsibilities

- You shall complete and submit an application or other forms or statements that may be reasonably requested. You agree that all information contained in the applications, forms and statements submitted to HMO due to enrollment under this Certificate or the administration herein shall be true, correct, and complete to the best of Your knowledge and belief.
- You shall notify HMO immediately of any change of address for You or any of Your covered Dependents.
- You understand that HMO is acting in reliance upon all information You provided at time of enrollment and afterwards and represents that information so provided is true and accurate.
- by electing coverage pursuant to this Certificate, or accepting benefits hereunder, all Members who are legally capable of contracting, and the legal representatives of all Members who are incapable of contracting, at time of enrollment and afterwards, represent that all information so provided is true and accurate and agree to all terms, conditions and provisions hereof.
- You are subject to and shall abide by the rules and regulations of each Provider from which benefits are provided.

Refusal to Accept Treatment

You may, for personal reasons, refuse to accept procedures or treatment by a Participating Provider. Participating Providers may regard such refusal to accept their recommendations as incompatible with continuance of the Provider-patient relationship and as obstructing the provision of proper medical care. Participating Providers shall use their best efforts to render all necessary and appropriate Professional Services in a manner compatible with Your wishes, insofar as this can be done consistent with the Participating Provider's judgment as to the requirements of proper medical practice. If You refuse to follow a recommended treatment or procedure, and the Participating Provider informed You of their belief that no professionally acceptable alternative exists, neither HMO nor any Participating Provider shall have any further responsibility to provide care for the condition under treatment.

Premium Payment

On or before the Premium due date, Group or its designated agent shall remit payment to HMO on behalf of each Subscriber and Dependents the amount specified by HMO.

Failure to Render Payments

Only if HMO receives Your stipulated payment, shall You be entitled to health services covered hereunder and then only for the Contract Month for which such payment is received. If any required payment is not received by the Premium due date of the Contract Month, then You will be terminated at the end of the Grace Period of the Contract Month. You will be responsible for the cost of services rendered to You during the Grace Period of the Contract Month in the event that Premium payments are not made by Group.

Change in Premium Rates

HMO reserves the right to establish a revised schedule of Premium payments on each anniversary date of this Certificate upon sixty (60) days written notice to Group.

A Tobacco User may be subject to a Premium increase of up to 1.5 times the rate applicable to those who are not Tobacco Users, to the extent permitted by applicable law, provided that HMO will provide an opportunity to offset such Premium variation through participation in a wellness program to prevent or reduce Tobacco Use, if required by applicable law.

Member Complaint Procedure

Any problem or claim between You and HMO or between You and a Participating Provider must be dealt with using the process described in **COMPLAINT AND APPEAL PROCEDURES**. Complaints may concern non-medical or medical aspects of care as well as this Certificate, including its breach or termination.

Identification Card

Cards issued to Members under this Certificate are for identification only. The identification card confers no right to services or other benefits under this Certificate. To be entitled to any services or benefits, the holder of the identification card must be a Member on whose behalf all applicable Premiums under this Certificate have actually been paid.

The card offers a convenient way of providing important information specific to Your coverage including, but not limited to, the following:

- **Your Member identification number**. This unique identification number is preceded by a three-character alpha prefix that identifies Blue Cross and Blue Shield of Texas as Your insurer;
- any Copayment that may apply to Your coverage;
- important telephone numbers.

Always remember to carry Your identification card with You and present it to Your Providers or Pharmacies when receiving health care services or supplies.

Please remember that any time a change in Your family takes place it may be necessary for a new identification card to be issued to You and/or each covered Dependent (refer to the **WHO GETS BENEFITS** section for instructions when changes are made). Upon receipt of the change in information, HMO will provide a new identification card.

Unauthorized, Fraudulent, Improper, or Abusive Use of Identification Cards

1. The unauthorized, fraudulent, improper, or abusive use of identification cards issued to You and Your covered Dependents will include, but not be limited to, the following actions, when intentional:
    a. use of the identification card prior to Your Effective Date of Coverage;
    b. use of the identification card after Your date of termination of coverage under the Certificate;
    c. obtaining prescription drugs or other benefits for persons not covered under the Certificate;
    d. obtaining prescription drugs or other benefits that are not covered under the Certificate;
    e. obtaining Covered Drugs for resale or for use by any person other than the person for whom the Prescription Order is written, even though the person is otherwise covered under the Certificate;
    f. obtaining Covered Drugs without a Prescription Order or through the use of a forged or altered Prescription Order;
    g. obtaining quantities of prescription drugs in excess of Medically Necessary or prudent standards of use or in circumvention of the quantity limitations of the Certificate;

h. obtaining prescription drugs using Prescription Orders for the same drugs from multiple Providers;
i. obtaining prescription drugs from multiple Pharmacies through use of the same Prescription Order.

2. The fraudulent or intentionally unauthorized, abusive, or other improper use of identification cards by any Member can result in, but is not limited to, the following sanctions being applied to all Members covered under Your coverage:

   a. denial of benefits;
   b. cancellation of coverage under the Certificate for all Members under Your coverage;
   c. recoupment from You or any of Your covered Dependents of any benefit payments made;
   d. pre-approval of drug purchases and medical services for all Members receiving benefits under Your coverage;
   e. notice to proper authorities of potential violations of law or professional ethics.

Member Claims Refund

You are not expected to make payments, other than required Copayments, for any benefits provided hereunder. However, if You make such payments, You may send HMO a claim for reimbursement, and when a refund is in order, the Provider shall make such refund to You. Your claim will be allowed only if You notify HMO within ninety (90) days from the date on which covered expenses were first incurred, unless it can be shown that it was not reasonably possible to give notice within the time limit, and that notice was given as soon as reasonably possible. However, benefits will not be allowed if notice of claim is made beyond one (1) year from the date covered expenses were incurred, except for Prescription Drug claims which must be filed within ninety (90) days of the date of purchase to qualify for reimbursement under pharmacy benefits. You must provide written proof of such payment to HMO within one (1) year of occurrence. Within fifteen (15) days of receipt of written notice of a claim, HMO shall acknowledge receipt of claim and begin any necessary investigation.

It may be necessary for HMO to request additional information from You. Claims shall be acted upon within fifteen (15) business days of receipt of a completed claim unless You are notified that additional time is needed and why. HMO will act on a completed claim no later than forty-five (45) days after the additional time notification is given to You. If HMO notifies You that HMO will pay a claim or part of a claim, HMO will pay an approved claim not later than five (5) business days after the date notice is made. Visit the website at www.bcbstx.com or call customer service at the toll-free number on the back of Your identification card to obtain a medical claim form or a prescription reimbursement claim form.

Claim or Benefit Reconsideration

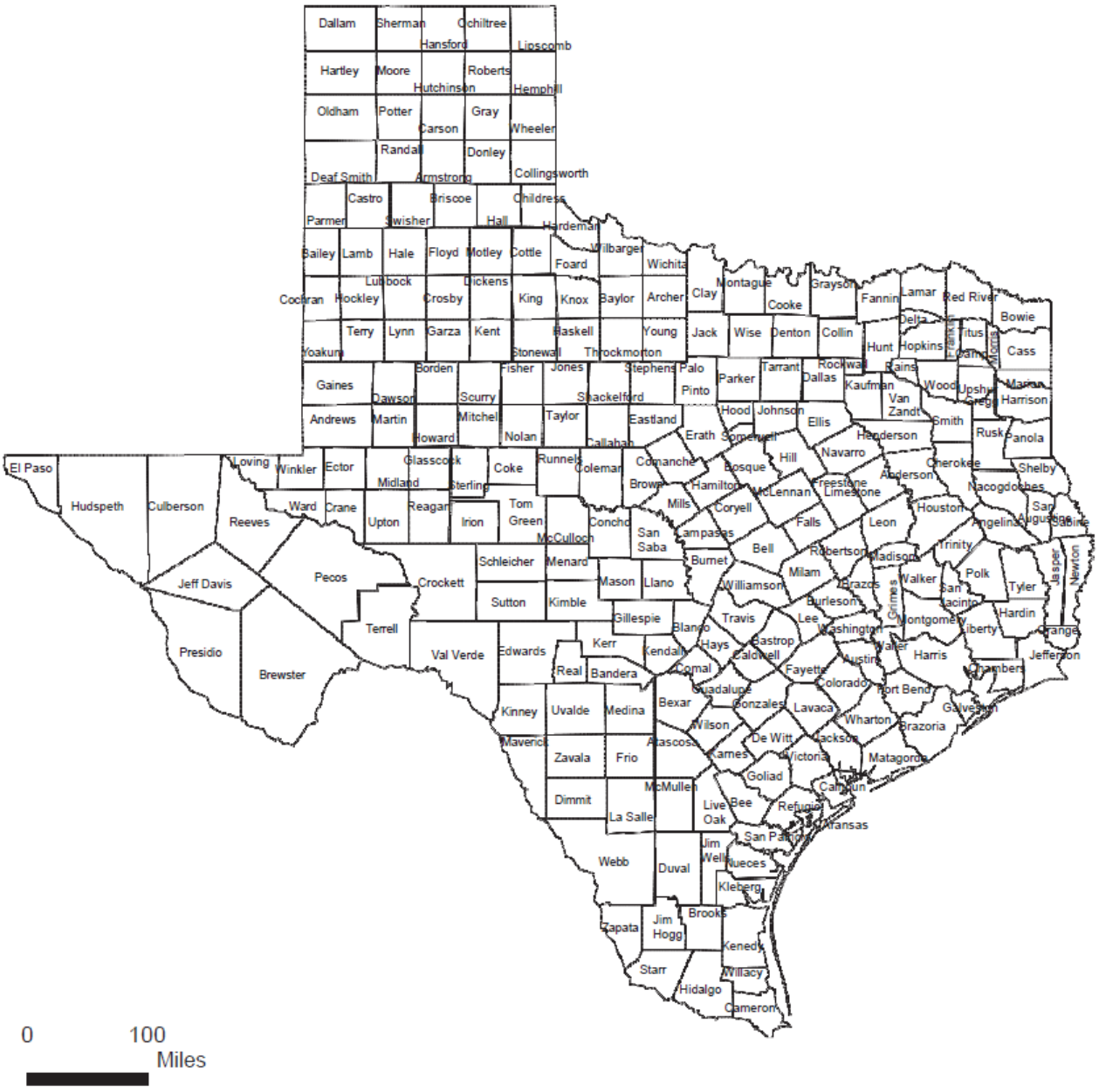
If a claim or a request for benefits is partly or completely denied by HMO, You will receive a written explanation of the reason for the denial and be entitled to a full review. If You wish to request a review or have questions regarding the explanation of benefits, call or write customer service at the phone number or address on the back of Your identification card. If You are not satisfied with the information received either on the call or in written correspondence, You may request an appeal of the decision or file a Complaint. You may obtain a review of the denial by following the process set out in **COMPLAINT AND APPEAL PROCEDURES**.

Service Area

See Service Area map and description on the following page(s).

Service Area

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



SERVICE AREA

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

Customer Inquiries

You or a designated representative may direct inquiries to an HMO customer service representative by mail or by calling the toll-free telephone number on the back of Your identification card. Inquiries resolved to Your satisfaction will be tracked by the HMO. If an inquiry is not resolved promptly to Your satisfaction, it will be handled according to the Complaint procedure described below.

How to File a Complaint with the HMO

A "Complainant" means You or another person, including a Physician or Provider, designated to act on Your behalf, who files a Complaint.

A "Complaint" means any dissatisfaction expressed by a Complainant orally or in writing to HMO about any aspect of HMO's operation, including, but not limited to:

- information relied upon in making the benefit determination;
- HMO administration;
- procedures related to review or appeal of an Adverse Determination;
- the denial, reduction or termination of a service for reasons not related to medical necessity, including an Out-of-Network denial because services rendered do not meet the definition of Emergency Care as shown in the **DEFINITIONS** section;
- the way a service is provided; or
- disenrollment decisions.

It does not mean a misunderstanding or problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to Your satisfaction. A Complaint also does not include a Provider's or Member's oral or written expression of dissatisfaction or disagreement with an Adverse Determination, which is defined under **How to Appeal an Adverse Determination.**

Within five (5) business days of receiving a Complaint, the HMO will send Complainant a letter acknowledging the date of receipt, along with a description of the HMO's Complaint process and timeframes. If the Complaint was oral, HMO will also enclose a one-page Complaint form clearly stating that the form must be filled out and returned to HMO for prompt resolution of the Complaint.

Within thirty (30) calendar days after HMO receives the written Complaint or Complaint form, HMO will investigate and resolve the Complaint and send Complainant a letter explaining HMO's resolution. The letter will include: 1) the specific medical and contractual reasons for the decision, including any applicable benefit exclusion, limitation or medical circumstance; 2) additional information required to adjudicate a claim, if needed; 3) the specialization of any Provider consulted; and 4) a full description of the Complaint appeal process, including deadlines for the appeal process and for the final decision on the appeal.

If You dispute the resolution of the Complaint, You may follow the HMO's Complaint appeals process described under **How to Appeal an HMO Complaint Decision**. If Your health plan is governed by the Employee Retirement Income Security Act (ERISA), You have the right to bring civil action under 502(a) of ERISA.

Complaints concerning emergencies or denial of continued Hospital stays will be investigated and resolved in accordance with the medical or dental immediacy of the case, but no later than one business day from HMO's receipt of the Complaint.

HMO will not engage in any retaliatory action against You or the Group, including termination or refusal to renew this Certificate of Coverage, because You or the Group has reasonably filed a Complaint against the HMO or appealed a decision of HMO. HMO also shall not retaliate against a Physician or Provider, including termination or refusal to renew their contract, because the Physician or Provider has, on behalf of a Member, reasonably filed a Complaint against the HMO or appealed a decision of HMO.

How to Appeal an HMO Complaint Decision

If the Complaint is not resolved to Your satisfaction, the HMO Complaint appeal process gives You the right to appear in person, by telephone or other technological methods before a Complaint appeal panel in the Service Area where You normally receive health care services, unless Complainant agrees to another site. The Complaint appeal panel can also consider a written appeal.

HMO will send Complainant an acknowledgment letter no later than five (5) business days after the date HMO receives the written request for appeal and will complete the appeals process no later than thirty (30) calendar days after receiving the written request for appeal.

To advise HMO on resolution of the dispute, HMO will appoint persons to a Complaint appeal panel composed of an equal number of HMO staff, Physicians or other Providers, and Members of the HMO. Complaint appeal panel representatives will not have been previously involved in the disputed decision. Physicians or other Providers must have experience in the area of care that is in dispute and must be independent of any Physician or Provider who made any prior determination. If specialty care is in dispute, the Complaint appeal panel must include a person who is a Specialist in that field. Members of the HMO on the Complaint appeal panel will not be employees of the HMO.

No later than the fifth business day before the scheduled meeting of the Complaint appeal panel, unless Complainant agrees otherwise, HMO will provide to Complainant or Complainant's designated representative:

- documentation to be presented to the Complaint appeal panel by HMO staff;
- the specialization of any Physicians or Providers consulted during the investigation;
- the name and affiliation of each HMO representative on the Complaint appeal panel; and
- the date and location of the hearing.

Complainant or a designated representative, if Member is a minor or disabled, is entitled to appear before the Complaint appeal panel in person or by conference call or other appropriate technology, and to:

- present written or oral information;
- present alternative expert testimony;
- request the presence of and question those responsible for making the prior determination that resulted in the appeal; and
- bring any person Complainant wishes, but only Complainant may directly question meeting participants.

Complainant or designee will receive a written decision of the Complaint appeal, including the specific medical determination, clinical basis and contractual criteria used to reach the final decision, and the toll-free telephone number and address of the Texas Department of Insurance (TDI). Additionally, in the case of a denied Complaint appeal due to services not meeting the definition of Emergency Care as shown in the **DEFINITIONS** section, the written decision will also include notice of Your right to have an Independent Review Organization (IRO) review the denial and the procedures to obtain a review as shown below in How to Appeal to an Independent Review Organization (IRO).

Complaint appeals relating to an ongoing emergency or denial of continued hospitalization shall be investigated and resolved in accordance with the medical or dental immediacy of the case, but no later than one business day from HMO's receipt of the Complainant's request for an appeal. At the request of Complainant, HMO shall provide (instead of a Complaint appeal panel) a review by a Physician or Provider who has not previously reviewed the case and is of the same or similar specialty that typically manages the medical or dental condition, procedure or treatment under consideration in the appeal. The Physician or Provider reviewing the appeal may interview the patient or patient's designated representative and will decide the appeal. The Physician or Provider may deliver initial notice of the appeal decision orally if they then provide written notice no later than the third day after the date of the decision.

Upon request and free of charge, Complainant or designee may have reasonable access to, and copies of, all documents, records and other information relevant to the claim or appeal, including:

- information relied upon to make the decision;
- information submitted, considered or generated in the course of making the decision, whether or not it was relied upon to make the decision;
- descriptions of the administrative process and safeguards used to make the decision;
- records of any independent reviews conducted by HMO;
- medical judgments, including whether a particular service is Experimental, Investigational or not Medically Necessary or appropriate; and
- expert advice and consultation obtained by HMO in connection with the denied claim, whether or not the advice was relied upon to make the decision.

How to Appeal to the Texas Department of Insurance

Anyone, including persons who attempted to resolve Complaints through HMO's Complaint process and are dissatisfied with the resolution, may report an alleged violation to TDI, Consumer Protection, MC:CP-Texas Department of Insurance, PO Box 12030, Austin, TX, 78711-2030

You may file a TDI Complaint:

- by mailing to the address listed above; or
- online at www.tdi.texas.gov.

For general information or information about how to resolve insurance-related Complaints call TDI Consumer Help line between 8 a.m. and 5 p.m., Central Time, Monday through Friday at (800) 252-3439. To request a TDI Complaint form call (800) 599-SHOP, or in Austin call (800) 252-3439.

The Commissioner will investigate a Complaint against HMO within sixty (60) days after TDI receives the Complaint and all information necessary to determine if a violation occurred. The Commissioner may extend the time to complete an investigation if:

- additional information is needed;
- an on-site review is necessary;
- HMO, the Physician or Provider, or Complainant does not provide all documentation necessary to complete the investigation; or
- other circumstances beyond TDI's control occur.

How to Request a Drug List Exception

Please refer to the **PHARMACY BENEFITS** section for information on Drug List Exception Requests.

How to Appeal an Adverse Determination

An "Adverse Determination" means a determination by HMO or a utilization review agent that the health care services provided or proposed to be provided to You are not Medically Necessary or are Experimental/Investigational. Adverse Determination does not mean a denial of health care services due to the failure to request prospective or concurrent utilization review.

HMO or a utilization review agent must notify You of an Adverse Determination:

- within one (1) working day if You are hospitalized at the time of the Adverse Determination;
- within three (3) working days if You are not hospitalized at the time of the Adverse Determination;
- within the time appropriate to the circumstance, but in no case to exceed one hour after the time of the request if You require post-stabilization care after an Emergency.

In Life-Threatening or Urgent Care circumstances, if HMO has discontinued coverage of prescription drugs or intravenous infusions for which You were receiving health benefits under the Certificate, or if You do not receive a timely decision, You are entitled to an immediate appeal to an Independent Review Organization ("IRO") and are not required to comply with HMO's appeal of an Adverse Determination process. An IRO is an organization independent of the HMO which may perform a final administrative review of an Adverse Determination made by HMO.

The HMO maintains an internal appeal system that provides reasonable procedures for notification, review, and resolution of an oral or written appeal concerning dissatisfaction or disagreement with an Adverse Determination. You, a person acting on Your behalf, or Your Provider of record must initiate an appeal of an Adverse Determination (which is not part of the Complaint process).

When You, a person acting on Your behalf, or Your Provider of record expresses orally or in writing any dissatisfaction or disagreement with an Adverse Determination, HMO or a utilization review agent will treat that expression as an appeal of an Adverse Determination.

Within five (5) business days after HMO receives an appeal of Adverse Determination, HMO will send to the appealing party a letter acknowledging the date HMO received the appeal and a list of documents the appealing party must submit. If the appeal was oral, HMO will enclose a one-page appeal form clearly stating that the form must be returned to HMO for prompt resolution. HMO has thirty (30) calendar days from receipt of a written appeal

of Adverse Determination or the appeal form to complete the appeal process and provide written notice of the appeal decision to the appealing party. The appeal will be reviewed by a health care Provider not involved in the initial decision, who is in the same or similar specialty that typically manages the medical or dental condition, procedure or treatment under review.

Notice of HMO's final decision on the appeal will include the dental, medical and contractual reasons for the resolution; clinical basis for the decision and the specialization of Provider consulted. A denial will also include notice of Your right to have an IRO review the denial and the procedures to obtain a review.

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

Expedited Appeal of Adverse Determination
(Emergencies or Continued Hospitalization Situations)

Appeals relating to ongoing emergencies, denials of continued Hospital stays, or the discontinuance by HMO of prescription drugs or intravenous infusions for which You were receiving health benefits under the Certificate are referred directly to an expedited appeal process for investigation and resolution. They will be concluded in accordance with the medical or dental immediacy of the case but in no event will exceed one (1) working day from the date all information necessary to complete the appeal is received. Initial notice of the decision may be delivered orally if followed by written notice of the decision within three (3) days.

The appeal will be reviewed by a health care Provider not involved in the initial decision, who is in the same or similar specialty that typically manages the medical or dental condition, procedure or treatment under review. The Physician or Provider reviewing the appeal may interview the patient or patient's designated representative.

How to Appeal to an Independent Review Organization (IRO)

This procedure (not part of the Complaint process) pertains only to appeals of Adverse Determinations and Complaint appeals concerning denials because services do not meet the definition of Emergency Care as shown in the **DEFINITIONS** section. In Life-Threatening or Urgent Care circumstances, if HMO has discontinued coverage of prescription drugs or intravenous infusions for which You were receiving health benefits under the Certificate, or if You do not receive a timely decision, You are entitled to an immediate appeal to an IRO and are not required to comply with HMO's appeal of an Adverse Determination process.

Any party whose appeal of an Adverse Determination is denied by HMO may seek review of the decision by an IRO assigned to the appeal. At the time the appeal is denied, HMO will provide You, Your designated representative or Your Provider of record, information on how to appeal the denial, including the approved form, which You, Your designated representative, or Your Provider of record must complete and return to HMO to begin the independent review process. A request for review by an IRO must be submitted within four (4) months after Your receipt of the Adverse Determination:

- in Life-Threatening, Urgent Care situations, or if HMO has discontinued coverage of prescription drugs or intravenous infusions for which You were receiving health benefits under the Certificate, You, Your designated representative, or Your Provider of record may contact HMO by telephone to request the review and provide the required information;
- HMO will submit medical records, names of Providers and any documentation pertinent to the decision of the IRO;
- HMO will comply with the decision by the IRO;
- HMO will pay for the independent review.

Upon request and free of charge, Member or designee may have reasonable access to, and copies of, all documents, records and other information relevant to the claim or appeal, including:

- information relied upon to make the decision;
- information submitted, considered or generated in the course of making the decision, whether or not it was relied upon to make the decision;
- descriptions of the administrative process and safeguards used to make the decision;
- records of any independent reviews conducted by HMO;

- medical judgements, including whether a particular service is Experimental, Investigational or not Medically Necessary or appropriate; and
- expert advice and consultation obtained by HMO in connection with the denied claim, whether or not the advice was relied upon to make the decision.

The appeal process does not prohibit You from pursuing other appropriate remedies, including injunctive relief; a declaratory judgment or other relief available under law, if the requirement to exhaust the process for appeal and review places Your health in serious jeopardy. If Your health plan is governed by the Employee Retirement Income Security Act (ERISA), You have the right to bring civil action under 502(a) of ERISA.

This section lists the Covered Services under Your Certificate.

Please note that services must be determined to be Medically Necessary by the Plan in order to be covered under this Certificate.

Coverage of items and services provided to You is subject to BCBSTX policies and guidelines, including, but not limited to, medical, medical management, utilization or clinical review, utilization management, and clinical payment and coding policies, which are updated throughout the plan year. These policies are resources utilized by BCBSTX when making coverage determinations and lay out the procedure and/or criteria to determine whether a procedure, treatment, facility, equipment, drug or device is Medically Necessary and is eligible as a Covered Service or is Experimental/Investigational, cosmetic, or a convenience item.

The clinical payment and coding policies are intended to ensure accurate documentation for services performed and require all Providers to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act ("HIPAA") approved code sets. Under the clinical payment and coding policies, claims are required to be coded correctly according to industry standard coding guidelines including, but not limited to:

- Uniform Billing ("UB") Editor;
- American Medical Association ("AMA");
- Current Procedural Terminology ("CPT®");
- CPT® Assistant;
- Healthcare Common Procedure Coding System ("HCPCS");
- ICD-10 CM and PCS;
- National Drug Codes ("NDC");
- Diagnosis Related Group ("DRG") guidelines;
- Centers for Medicare and Medicaid Services ("CMS");
- National Correct Coding Initiative ("NCCI") Policy Manual;
- CCI table edits; and
- other CMS guidelines.

Coverage for Covered Services is subject to the code edit protocols for services/procedures billed and claim submissions are subject to applicable claim review which may include, but is not limited to, review of any terms of benefit coverage, Provider contract language, medical and medical management policies, utilization or clinical review or utilization management policies, clinical payment and coding policies as well as coding software logic, including but not limited to lab management or other coding logic or edits.

Any line on the claim that is not correctly coded and is not supported with accurate documentation (where applicable) may not be included in the covered charge and will not be eligible for payment by the Plan. The clinical payment and coding policies apply for purposes of coverage regardless of whether the Provider rendering the item or service or submitting the claim is an In-Network or Out-of-Network Provider. The most up-to-date medical policies and clinical procedure and coding policies are available at www.bcbstx.com or by contacting customer service at the toll-free number on the back of Your identification card.

Copayments

You are liable for certain Copayments to Participating Providers, which are due at the time of service. The Copayment due for specific Covered Services, benefit limitations and out-of-pocket maximums can be found in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**. The Copayment amount shall not exceed 50% of the total cost of the services provided.

Out-of-Pocket Maximums

Copayments paid by You or on Your behalf in a Calendar Year shall not exceed 200% of the total annual Premium. HMO will determine when maximums have been reached for Covered Services and for Covered Drugs based on information provided to HMO by You and Participating Providers to whom You have made payments for Covered Services and for Covered Drugs. Out-of-pocket maximums will include Copayments for Covered Services and any eligible dental expenses payment obligations from the indemnity dental Rider. Once You reach the out-of-pocket maximum, You are not required to make additional payments for Covered Services or Covered Drugs for the remainder of the Calendar Year.

If You have several covered Dependents, all charges used to apply toward an individual out-of-pocket maximum will be applied towards the family out-of-pocket maximum amount shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS.** When the family out-of-pocket maximum amount is reached, You are not required to make additional payments for Covered Services or Covered Drugs for the remainder of the Calendar Year.

Requirements

All Covered Services, unless otherwise specifically described:

- must be Medically Necessary;
- must be performed, prescribed, directed or authorized in advance by the PCP and/or the HMO;
- must be rendered by a Participating Provider;
- are subject to the Copayment shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**;
- may have limitations, restrictions or exclusions described in **LIMITATIONS AND EXCLUSIONS;** and
- may require Prior Authorization.

Professional Services

Services must be provided or arranged by the PCP (except for Virtual Visits) and rendered by a licensed Physician. HMO may allow other health Providers to provide Covered Services that may be provided under applicable state law by such Providers. Certain services may be restricted in **LIMITATIONS AND EXCLUSIONS.**

- **PCP or Specialist Office Visits.** Services provided in the medical office of the PCP or authorized Specialist for the diagnosis and treatment of illness or injury;
- **PCP or Specialist Home Visits.** Medically Necessary home visits provided by Participating Physicians when, in the judgment of the PCP or authorized Specialist, the nature of the illness or injury so indicates;
- **Virtual Visits.** Services provided for the treatment of conditions as described below in **Virtual Visits**. Virtual Visits do not require a Referral by the PCP and/or HMO.

Services of Participating Physicians for diagnosis, treatment and consultation are provided while You are an inpatient or outpatient in a facility for authorized Medically Necessary Covered Services or Emergency Care as defined herein. Inpatient care may be directed by a Participating Physician other than Your PCP.

Inpatient Hospital Services

Services, except Emergency Care and treatment of breast cancer, must be arranged by Your PCP and approved through Prior Authorization by HMO. Covered Services include:

1. semi-private room and board, with no limit to number of days unless otherwise indicated;
2. private rooms when Medically Necessary and authorized by the PCP;
3. special diets and meals when Medically Necessary and authorized by the PCP;
4. use of intensive care or cardiac care units and related services when Medically Necessary and authorized by the PCP;
5. use of operating and delivery rooms and related facilities;
6. anesthesia and oxygen services;
7. laboratory, x-ray and other diagnostic services;
8. drugs, medications, biologicals and their administration;
9. general nursing care;
10. special duty and private duty nursing when Medically Necessary and authorized by the PCP;
11. radiation therapy, inhalation therapy and chemotherapy;
12. whole blood, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for You;
13. administration of whole blood and blood plasma;
14. short-term Rehabilitation therapy services in an acute Hospital setting;
15. treatment of breast cancer, for a minimum of forty-eight (48) hours following a mastectomy and twenty-four (24) hours following a lymph node dissection (with no Prior Authorization required); provided, however, that such minimum hours of coverage are not required if You and Your attending Physician determine that a shorter period of inpatient care is appropriate. Upon request, the length-of-stay may be extended if HMO determines that an extension is Medically Necessary; and

16. organ and tissue transplants. Prior Authorization is required for any organ or tissue transplant, even if the patient is already in a Hospital under another Prior Authorization. At the time of Prior Authorization, HMO will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if HMO determines that an extension is Medically Necessary.

    a. Services, including donor expenses, for organ and tissue transplants are covered, but only if all the following conditions are met:

        1. the transplant procedure is not Experimental/Investigational in nature;
        2. donated human organs or tissue or a United States Food and Drug Administration approved artificial device are used;
        3. the recipient is a Member;
        4. the Member meets all of the criteria established by HMO in pertinent written medical policies; and
        5. the Member meets all of the protocols established by the Hospital in which the transplant is performed.

    Covered Services and supplies related to an organ or tissue transplant include, but are not limited to x-rays, laboratory testing, chemotherapy, radiation therapy, prescription drugs, procurement of organs or tissues from a living or deceased donor, and complications arising from such transplant.

    b. Benefits will be determined on the same basis as any other sickness when the transplant procedure is considered Medically Necessary and meets all of the conditions cited above. Benefits will be available for:

        1. a recipient who is a Member covered under the HMO;
        2. a donor who is a Member covered under the HMO; or
        3. a donor who is not a Member covered under the HMO.

    c. Covered Services and supplies include those provided for the:

        1. donor search and acceptability testing of potential live donors;
        2. evaluation of organs or tissues including, but not limited to, the determination of tissue matches;
        3. removal of organs or tissues from living or deceased donors; and
        4. transportation and short-term storage of donated organs or tissues.

    d. No benefits are available for a Member for the following services and supplies:

        1. living and/or travel expenses of the recipient or a live donor;
        2. expenses related to maintenance of life of a donor for purposes of organ or tissue donation;
        3. purchase of the organ or tissue other than payment for Covered Services and supplies identified above; and
        4. organ or tissue (xenograft) obtained from another species.
        5. if the transplant operation or post-transplant care is performed in China or another country known to have participated in forced organ harvesting, or
        6. 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.

Outpatient Facility Services

Services provided through a Participating Hospital outpatient department or a free-standing facility must be prescribed by the PCP. Prior Authorization may be required for the following services:

1. Infusion Therapy (including chemotherapy);
2. outpatient surgery;
3. radiation therapy; and
4. dialysis.

Outpatient Infusion Therapy Services

Services must be arranged by a PCP and approved through Prior Authorization by HMO. Some outpatient Infusion Therapy services for routine maintenance drugs have been identified as capable of being safely administered, outside of a Hospital. Your out-of-pocket expenses may be lower when these Covered Services are provided in an Infusion Suite, a home or an office instead of an Outpatient Hospital setting. Non-maintenance outpatient Infusion Therapy services will be covered the same as any other illness. The SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS describes payment for Infusion Therapy services.

Outpatient Laboratory and X-Ray Services

Laboratory and radiographic procedures, services and materials, including (but not limited to) diagnostic x-rays, x-ray therapy, chemotherapy, fluoroscopy, electrocardiograms, laboratory tests and therapeutic radiology services must be ordered, authorized or arranged by the PCP and provided through a Participating facility. Prior Authorization may be required.

Clinician-Administered Drugs

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

Rehabilitation Services and Habilitation Services

Rehabilitation Services and physical, speech and occupational therapies that in the opinion of a Physician are Medically Necessary and meet or exceed Your treatment goals are provided when Prior Authorization is obtained or prescribed by Your PCP or Specialist. For a physically disabled person, treatment goals may include maintenance of functioning or prevention or slowing of further deterioration. Rehabilitation Services and Habilitation Services may be provided in the Provider's office, in a Hospital as an inpatient, in an outpatient facility, or as home health care visits. Rehabilitation Services and Habilitation Services, including coverage for chiropractic services, are available from a Participating Provider when Prior Authorization is obtained or prescribed by Your PCP.

Benefits are provided for Habilitation Services provided for a Member with a disabling condition when both of the following conditions are met:

- the treatment is administered by one of the following Participating Providers: a licensed speech language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.
- the initial or continued treatment must be proven and not Experimental/Investigational.

Benefits for Habilitation Services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not Habilitation Services. A service that does not help the Member to meet functional goals in a treatment plan within a prescribed time frame is not a Habilitation Service.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of Habilitation Services are described under **Durable Medical Equipment** and **Prosthetic Appliances and Orthotic Devices**.

Treatment of Acquired Brain Injury will be covered the same as any other physical condition. Cognitive Rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and Rehabilitation; neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing or treatment; neurofeedback therapy, remediation, post-acute transition services and community reintegration services, including outpatient day treatment services, or any other post-acute treatment services are covered, if such services are necessary as a result of and related to an Acquired Brain Injury. To ensure that appropriate post-acute care treatment is provided, HMO includes coverage for periodic reevaluation for a Member who: (1) has incurred an Acquired Brain Injury; (2) has been unresponsive to treatment; and (3) becomes responsive to treatment at a later date. Services 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 Autism Spectrum Disorder will not apply towards and are not subject to any Rehabilitation services and Habilitation services visits maximum indicated on Your **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**.

Maternity Care and Family Planning Services

Maternity Care. HMO provides coverage for inpatient care for the mother/birthing parent and the newborn in a Hospital for a minimum of forty-eight (48) hours following an uncomplicated vaginal delivery, or ninety-six (96) hours following an uncomplicated delivery by cesarean section. Prior Authorization is not required. Upon request, the length-of-stay may be extended if HMO determines that an extension is Medically Necessary.

Covered Services, which may require Prior Authorization, include:

1. prenatal visits;
2. use of Hospital delivery rooms and related facilities. A separate Hospital admission Copayment is required for a newborn child at time of delivery. If a newborn child is discharged and readmitted to a Hospital more than five (5) days after the date of birth, a separate Hospital admission Copayment for such readmission will be required;
3. administration of a newborn screening test, including the test kit, required by the state of Texas;
4. use of newborn nursery and related facilities;
5. special procedures as may be Medically Necessary and authorized by the PCP or designated Obstetrician/Gynecologist; and
6. postnatal visits. If the mother/birthing parent or newborn is discharged before the minimum hours of inpatient coverage have passed, the HMO provides coverage for Post-Delivery Care for the mother/birthing parent and newborn. Post-Delivery Care may be provided at the mother/birthing parent's home or a Participating Provider's office or facility. A newborn child will not be required to receive health care services only from Participating Providers if born outside the Service Area due to an emergency or born in a non-network facility to a mother/birthing parent who is not a Member. HMO may require the newborn to be transferred to a Participating facility, at HMO's expense, when determined to be medically appropriate by the newborn's treating Physician.

Complications of Pregnancy. Covered Services for Complications of Pregnancy will be the same as for treatment of any other physical illness and may require Prior Authorization.

Family Planning. Covered Services, which may require Prior Authorization, include:

1. diagnostic counseling, consultations and planning services for family planning;
2. insertion or removal of an intrauterine device (IUD), including the cost of the device;
3. diaphragm or cervical cap fitting, including the cost of the device;
4. insertion or removal of birth control device implanted under the skin, including the cost of the device;
5. injectable contraceptive drugs, including the cost of the drug; and
6. voluntary sterilizations, including but not limited to vasectomy and tubal ligation.

Note: some benefits for family planning are available under **Health Maintenance and Preventive Services.**

Fertility Preservation Services. Benefits for Fertility Preservation Services for Members who will receive Medically Necessary treatment which may directly or indirectly cause Iatrogenic Infertility.

The Fertility Preservation Services must be standard procedures to preserve fertility consistent with established medical practices or professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

Infertility Services. Covered Services, which may require Prior Authorization, include diagnostic counseling, consultations, planning services and treatment for problems of fertility and Infertility, subject to the exclusions in **LIMITATIONS AND EXCLUSIONS**. Once the Infertility workup and testing have been completed, subsequent workups and testing will require approval of the HMO Medical Director.

Behavioral Health Services

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

Outpatient Mental Health Care. Covered Services include diagnostic evaluation and treatment or crisis intervention when authorized by HMO or its designated behavioral health administrator.

Inpatient Mental Health Care. Covered Services include inpatient Mental Health Care when authorized by HMO or its designated behavioral health administrator. Covered Services must be rendered based on an individual treatment plan with specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.

Services in a Residential Treatment Center for Children and Adolescents, a Residential Treatment Center or a Crisis Stabilization Unit are available only when the Member has an acute condition that substantially impairs thought, perception of reality, emotional process or judgment, or grossly impairs behavior as manifested by recent disturbed behavior, which would otherwise necessitate confinement in a Participating Mental Health Treatment Facility.

Serious Mental Illness. Covered Services include treatment of Serious Mental Illness when authorized by HMO or its designated behavioral health administrator and rendered by a Participating Provider which includes a Psychiatric Day Treatment Facility. Services are subject to the same terms and conditions as medical and surgical benefits for any other physical illness.

Chemical Dependency Services. Coverage for treatment of Chemical Dependency is the same as coverage for treatment of any other physical illness but is restricted as described in **LIMITATIONS AND EXCLUSIONS.** Inpatient treatment of Chemical Dependency must be provided in a Chemical Dependency Treatment Center**.** Some services may require Prior Authorization by HMO or its designated behavioral health administrator.

Emergency Services

PCPs provide coverage for Members 24 hours a day, 365 days a year. You must notify Your PCP within forty-eight (48) hours of receiving Emergency Care, or as soon as possible without being medically harmful or injurious to You. HMO will pay for a medical screening examination or other evaluation required by Texas or federal law and provided in the emergency department of a Hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility that is necessary to determine whether an emergency medical condition exists.

Emergency Care. You may obtain Emergency Care, including the treatment and stabilization of an emergency medical condition that originated in a Hospital emergency facility or in a comparable facility, from a Participating or non-Participating Providers and the Emergency Care will be covered, based upon the signs and symptoms presented at the time of treatment as documented by the attending health care personnel, whether the Emergency Care services were received within the Service Area or Out-of-Area. Emergency Care services are subject to the Copayment, unless You are admitted as an inpatient directly from the emergency room, in which case You pay the inpatient Hospital Copayment. You are not responsible for any amounts beyond the Copayment as indicated on the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**.

You may be entitled to protection from balance billing if You receive out-of-network Emergency Care. If You received services because You believed that failing to get care placed Your health or the health of a spouse, child or unborn child in danger, but You have questions about whether Your claim was processed as Emergency Care or questions about a balance bill, please call the number on the back of Your Member identification card.

If post stabilization care is required after an Emergency Care condition that originated in a Participating Hospital emergency facility or in a Participating comparable facility (as defined in this paragraph), has been treated and stabilized, the treating Physician or Provider will contact HMO or its designee, who must approve or deny coverage of the post stabilization care requested within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case may approval or denial exceed one hour of receiving the call. If post stabilization care is required in a non-Participating Hospital after an Emergency Care condition that originated in a Hospital emergency facility or in a Participating comparable facility (as defined in this paragraph), has been treated and stabilized, the treating Physician or Provider may contact HMO or its designee, but Prior Authorization is not required for post-stabilization care in a non-Participating Hospital. For purposes of this paragraph, “comparable facility” includes the following:

1. any stationary or mobile facility, including, but not limited to, Level V Trauma Facilities and Rural Health Clinics that have licensed or certified or both licensed and certified personnel and equipment to provide Advanced Cardiac Life Support consistent with American Heart Association and American Trauma Society

standards of care and a free-standing emergency medical care facility as that term is defined in Insurance Code §843.002 (concerning Definitions);

2. for purposes of Emergency Care related to mental illness, a mental health facility that can provide 24-hour residential and psychiatric services and that is:
    a. a facility operated by the Texas Department of State Health Services;
    b. a private mental Hospital licensed by the Texas Department of State Health Services;
    c. a community center as defined by Texas Health and Safety Code §534.001 (concerning Establishment);
    d. a facility operated by a community center or other entity the Texas Department of State Health Services designates to provide mental health services;
    e. an identifiable part of a general Hospital in which diagnosis, treatment, and care for persons with mental illness is provided and that is licensed by the Texas Department of State Health Services; or
    f. a Hospital operated by a federal agency.

Regardless of other provisions in this Certificate to the contrary, for Emergency Care rendered by Providers who are not part of HMO's network of Participating Providers (non-Participating Provider) or otherwise contracted with HMO, HMO shall fully reimburse such Providers at its usual and customary rate or an agreed upon rate not to exceed billed charges.

This amount is calculated excluding any in-network Copayment imposed with respect to the Member.

Out-of-Area Services. Only Emergency Care services as described above are covered. Continuing or follow-up treatment for accidental injury or Emergency Care is limited to care required before You can return to the Service Area without medically harmful or injurious consequences. Emergency Care services for Out-of-Area Services are subject to the Copayment, as indicated on Your **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**.

Urgent Care Services

Urgent Care services are covered when rendered by an Urgent Care Provider for the immediate treatment of a medical condition that requires prompt medical attention but where a brief time lapse before receiving services will not endanger life or permanent health and does not require Emergency Care services. A PCP Referral is not required. Additional charges described in **Outpatient Laboratory and X-ray Services** or **Outpatient Facility Services** may also apply.

Unless designated and recognized by HMO as an Urgent Care center, neither a Hospital nor an emergency room will be considered an Urgent Care center.

Retail Health Clinics

Retail Health Clinics provide diagnosis and treatment of uncomplicated minor conditions in situations that can be handled without a traditional PCP office visit, Urgent Care visit or Emergency Care visit. A PCP Referral is not required to obtain Covered Services.

Virtual Visits

Virtual Visits provide You with access to Virtual Network Providers that can provide diagnosis and treatment of non-emergency medical and behavioral health conditions in situations that can be handled without a traditional PCP office visit, behavioral health office visit, Urgent Care visit or Emergency Care visit. Covered Services may be provided via a consultation with a licensed medical professional through interactive audio via telephone or interactive audio-video via online portal or mobile application. For information on accessing this service, You may access the website at www.bcbstx.com or contact customer service at the toll-free number on the back of Your identification card. A PCP Referral is not required to obtain Covered Services.

Note: Not all medical or behavioral health conditions can be appropriately treated through Virtual Visits. The Virtual Network Provider will identify any condition for which treatment by an in-person Provider is necessary.

Ambulance Services

For Emergency Care, as defined in this Certificate, professional local ground ambulance services or air ambulance services to the nearest Hospital appropriately equipped and staffed for treatment of the Member's condition is covered. For non-Emergency Care, professional local ground ambulance services or air ambulance services is covered, when Medically Necessary and authorized by the PCP, to or from a facility appropriately equipped and staffed for treatment of the Member's condition. This includes but is not limited to transportation from one Hospital to another Hospital and from a Hospital to a Rehabilitation facility or Skilled Nursing Facility. The Member's condition must be such that any other form of transportation would be medically contraindicated.

For non-Emergency Care, air ambulance services are only covered when authorized by the PCP or HMO and 1) Ambulance transportation is Medically Necessary, 2) terrain, distance, Your physical condition, or other circumstances require the use of air ambulance services rather than ground ambulance services, and 3) transfer is to the nearest facility with the capabilities to perform medically necessary services not available to the originating facility.

Extended Care Services

Covered Services include the following when prescribed by the PCP and authorized by the HMO. Services may have additional limitations, as indicated on the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** and restrictions or exclusions described in **LIMITATIONS AND EXCLUSIONS**.

Skilled Nursing Facility Services. Services must be temporary and lead to rehabilitation and an increased ability to function. Custodial Care is not covered. If You remain in a Skilled Nursing Facility after the PCP discharges You or after You reach the maximum benefit period or period authorized by HMO, You will be liable for all subsequent costs incurred.

Hospice Care. Care that is provided by a Hospital, Skilled Nursing Facility, Hospice, or a duly licensed Hospice Care agency, is approved by HMO, and is focused on a palliative rather than curative treatment. Services include bereavement counseling. For care provided in a Hospital, charges described in **Inpatient Hospital Services** will apply.

Home Health Care. Care in the home by Health Care Professionals who are Participating Providers, including but not limited to registered nurses, licensed practical nurses, physical therapists, inhalation therapists, speech or hearing therapists or home health aides. Services must be provided or arranged by the PCP.

Health Maintenance and Preventive Services

Covered Services, which may require Prior Authorization and will not be subject to any Copayment or dollar maximums, include evidence-based items or services that 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.

The services listed below may include requirements pursuant to state regulatory mandates and are to be covered at no cost to the Member:

1. well-child care for Members through age twenty-one (21) which includes evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents;
2. periodic health assessments for Members twenty-one (21) and older, based on age, sex and medical history;
3. routine immunizations recommended by the American Academy of Pediatrics, U.S. Public Health Service for people in the United States and required by law and immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved. Examples of covered immunizations include diphtheria, haemophilus influenza type b, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, rotavirus, COVID-19 and any other immunization that is required by the law for a child. (Allergy injections are not considered immunizations under this benefit provision.);
4. bone mass measurement for the detection of low bone mass and to determine risk of osteoporosis and fractures associated with osteoporosis, for qualified individuals including postmenopausal women who are not receiving estrogen replacement therapy; individuals with vertebral abnormalities, primary

hyperparathyroidism or a history of bone fractures; or individuals receiving long-term glucocorticoid therapy or being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy;

5. preventive care and screenings provided with respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the HRSA such as a well-woman gynecological exam (once every twelve months) for female Members, and an exam for the early detection of cervical cancer for female Members age eighteen (18) and older. Your PCP or any Obstetrician/Gynecologist in Your PCP's network of Participating Providers may perform the well-woman exam. The exam may include, but is not limited to, a conventional Pap smear screening; a screening using liquid-based cytology methods alone or in combination with a test approved by the United States Food and Drug Administration for the detection of human papillomavirus. You must first obtain a Referral from Your PCP for follow-up services related to treatment of a disease or condition that is not within the scope of an Obstetrician/Gynecologist. For help in selecting an Obstetrician/Gynecologist, refer to the HMO Provider directory, contact Your PCP or call customer service;

6. a screening (non-diagnostic) low-dose mammogram to detect the presence of occult breast cancer for female Members age thirty-five (35) and over (once every twelve months), and for female Members with other risk factors. Mammograms may be obtained whether or not a well-woman exam is performed at the same time. Low-dose mammograms include digital mammography or breast tomosynthesis;

7. preventive care and screenings provided with respect to women's services will be provided for the following Covered Services and will not be subject to a Copayment:

   Contraceptive Services and Supplies. Benefits are available for female sterilization procedures and Outpatient Contraceptive Services for women of reproductive capacity. Outpatient Contraceptive Services means a consultation, examination, procedure, or medical service that is related to the use of a drug or device intended to prevent pregnancy.

   Benefits will be provided to women with reproductive capacity for specified drugs and devices in each of the following categories of FDA approved contraceptive drugs and devices, including certain: progestin-only contraceptives; combination contraceptives; emergency contraceptives; extended-cycle/continuous oral contraceptives; cervical caps; diaphragms; implantable contraceptives; intra-uterine devices; injectables; transdermal contraceptives, condoms and vaginal contraceptive devices. This list may change as FDA guidelines, medical management and medical policies are modified. NOTE: Prescription contraceptive medications are covered under **PHARMACY BENEFITS**.

   To determine if a specific drug or device is available under this Preventive Services benefit contact customer service at the toll-free number on the back of Your identification card. This list may change as FDA guidelines, medical management and medical policies are modified.

   Benefits will also be provided to women with reproductive capacity for FDA approved over-the-counter contraceptives for women such as spermicide and condoms with 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 HMO with itemized receipts. Visit the website at www.bcbstx.com to obtain a claim form.

   Contraceptive drugs and devices not available under this Preventive Services benefit may be covered under other sections of this Certificate and may be subject to any applicable Copayments.

   Breastfeeding Support, Counseling and Supplies. Covered Services include support and counseling services obtained from a Participating Provider during pregnancy and/or in the post-partum period. Benefits will also be provided for the rental of Hospital grade breast pumps (not to exceed the total cost) or purchase of a manual or electric breast pump, breast pump supplies and breast milk storage supplies, with a written prescription from a Provider, and are not subject to Copayment or benefit maximums when received from a Participating Provider. Benefits for the purchase of an electric breast pump is limited to one per benefit period. You may be required to pay the full amount and submit a reimbursement claim form along with the written prescription to HMO with itemized receipts for the manual, electric or Hospital grade breast pump and supplies. Visit the website at www.bcbstx.com to obtain a claim form.

   Benefits are limited as indicated on the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS.**

8. a screening test for hearing loss for Members from birth through age thirty (30) days, and necessary diagnostic follow-up care related to the screening test from birth through age twenty-four (24) months; and

9. a medically recognized rectal screening exam for the detection of colorectal cancer for Members age forty-five (45) or older.

    - all colorectal cancer examinations, preventive services, and laboratory tests assigned a grade of "A" or "B" by the United States Preventive Services Task Force for average-risk individuals, including the services that may be assigned a grade of "A" or "B" in the future; and
    - an initial colonoscopy or other medical test or procedure for colorectal cancer screening and a follow-up colonoscopy, if the results of the initial colonoscopy, test, or procedure are abnormal.

Examples of other covered preventive services that are not subject to Copayment or dollar maximums include smoking cessation counseling services (including FDA-approved tobacco cessation medications), healthy diet counseling and obesity screening/counseling. NOTE: smoking cessation medications are covered under **PHARMACY BENEFITS** with a Prescription Order from Your Health Care Practitioner.

Preventive drugs (including both prescription and over-the-counter products) that meet the preventive recommendations outlined above and that are listed on the No-Cost Preventive Drug List (to be implemented in the quantities and within the time period allowed under applicable law) will be covered and will not be subject to any Copayment or dollar maximum when obtained from a Participating Pharmacy.

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.

The covered preventive services described above may change as the USPSTF, CDC, HRSA guidelines and state laws are modified. If a recommendation or guideline for a particular preventive service does not specify the frequency, method, treatment or setting in which it must be provided, HMO may use reasonable medical management techniques to determine benefits. For more information, contact customer service at the toll-free number on Your identification card.

If a covered preventive service is provided during an office visit and is billed separately from the office visit, You may be responsible for any Copayment for the office visit only. If an office visit and the preventive health service are not billed separately and the primary purpose of the visit was not the preventive health service, You may be responsible for the Copayment for the office visit including the preventive health service.

Additional preventive screening services, which may require Prior Authorization and may be subject to Copayment or dollar maximums, include:

1. eye and ear screenings (once every twelve months) performed or authorized by the PCP for Members through age seventeen (17) to identify vision and hearing problems. Eye screenings may be performed in the PCP office and do not include refractions;
2. eye and ear screenings (once every two years) performed or authorized by the PCP for Members eighteen (18) and older to identify vision and hearing problems. Eye screenings may be performed in the PCP office and do not include refractions;

    Note: Covered children to age 19 do have additional benefits as described in **PEDIATRIC VISION CARE BENEFITS.**
3. early detection test for cardiovascular disease. Benefits are available for 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:

    (1) computed tomography (CT) scanning measuring coronary artery calcifications; or
    (2) ultrasonography measuring carotid intima-media thickness and plaque.

    Tests are available to each covered Member who is: (1) a male older than 45 years of age and younger than 76 years of age, or (2) a female older than 55 years of age and younger than 76 years of age. The Member must be a diabetic or have a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher;

    Benefits are limited as indicated on the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**.
4. early detection test for ovarian cancer. Benefits are available for a CA 125 blood test once every twelve months and any other test or screenings approved by the United States Food and Drug Administration for

the detection of ovarian cancer for female Members age eighteen (18) and older. Your PCP or any Obstetrician/Gynecologist in Your PCP's network of Participating Providers may administer the test.

Limitations: To the extent that providing coverage for ovarian cancer screening under Chapter 1370 of the Texas Insurance Code would otherwise require the State of Texas to make a payment under 42 U.S.C. Section 18031(d)(3)(B)(ii), a qualified health plan, as defined by 45 C.F.R. Section 155.20, is not required to provide a benefit for the ovarian cancer screening under Chapter 1370 of the Texas Insurance Code that exceeds the specified essential health benefits required under 42 U.S.C. Section 18022(b).

5. a physical exam and an annual prostate-specific antigen (PSA) test (once every twelve months) for the detection of prostate cancer for male Members who are at least fifty (50) years of age and asymptomatic; or at least forty (40) years of age with a family history of prostate cancer or another prostate cancer risk factor.

Dental Surgical Procedures

General dental services are not covered, but limited oral surgical procedures are covered when prescribed by Your PCP and performed in a Participating Provider's office or in the inpatient or outpatient setting. The following Covered Services may require Prior Authorization by HMO:

1. treatment for accidental injury and such injury resulting from domestic violence or a medical condition, to Sound Natural Adult Teeth, the jaw bones or surrounding tissues, not caused by biting or chewing. "Sound Natural Adult Teeth" means teeth that are free of active or chronic clinical decay, have at least 50% bony support, are functional in the arch, and have not been excessively weakened by multiple dental procedures;
2. treatment or correction of a non-dental physiological condition which has resulted in severe functional impairment;
3. treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
4. diagnostic and surgical treatment of conditions affecting the temporomandibular joint (including the jaw or craniomandibular joint) as a result of an accident, a trauma, a developmental defect, or a pathology;
5. services provided which are necessary for treatment or correction of a congenital defect; and
6. removal of complete bony impacted teeth.

This plan provides coverage for Medically Necessary general anesthesia in connection with dental services.

Cosmetic, Reconstructive or Plastic Surgery

Coverage will be the same as for treatment of any other physical illness generally, only when prescribed or arranged by Your PCP, and may require Prior Authorization by HMO. Covered Services are limited to the following:

1. surgery to correct a defect resulting from accidental injury;
2. Reconstructive Surgery following cancer surgery;
3. surgery to correct a functional defect which results from a congenital and/or acquired disease or anomaly;
4. surgical reconstruction of the breast following a mastectomy, and surgical reconstruction of the other breast to achieve a symmetrical appearance; and
5. Reconstructive Surgery for Craniofacial Abnormalities.

Allergy Care

Covered Services for testing and treatment must be provided or arranged by the PCP.

Diabetes Care

Diabetes Self-Management Training. Covered Services, which may require Prior Authorization, include instructions enabling a person with diabetes and/or their caretaker to understand the care and management of diabetes; development of an individualized management plan; nutritional counseling and proper use of diabetes equipment and supplies. Diabetes self-management training is provided upon the following occasions:

1. the initial diagnosis of diabetes;
2. a significant change in symptoms or condition that requires changes in Your self-management regime, as diagnosed by a Participating Physician or practitioner;
3. the prescription of periodic or episodic continuing education warranted by the development of new techniques and treatments for diabetes; or
4. the need for a caretaker or a change in caretakers for the person with diabetes necessitates diabetes management training for the caretaker.

Diabetes Equipment and Supplies. Diabetes equipment and supplies are covered for Members diagnosed with insulin dependent or non-insulin dependent diabetes; elevated blood glucose levels induced by pregnancy; or another medical condition associated with elevated blood glucose levels.

When the following diabetes equipment and supplies are obtained, You may be required to pay the full amount of their bill and submit a reimbursement claim form to HMO with itemized receipts. Visit the website at www.bcbstx.com to obtain a medical claim form. If You choose to purchase diabetes supplies utilizing pharmacy benefits, You must pay the applicable **PHARMACY BENEFITS** Copayment in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** and any applicable pricing differences. No claim forms are required.

Diabetes equipment and supplies include, but are not limited to:

- blood glucose monitors;
- noninvasive glucose monitors and monitors for the blind;
- insulin pumps and necessary accessories;
- insulin infusion devices;
- biohazard disposable containers;
- podiatric appliances (including up to two pairs of therapeutic footwear per Calendar Year).

Also included are 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.

The diabetes equipment and supplies in the list below are only available utilizing pharmacy benefits. When You purchase these items utilizing pharmacy benefits, You must pay the applicable **PHARMACY BENEFITS** Copayment in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** and any applicable pricing differences. No claim forms are required.

- glucose meter solution;
- test strips specified for use with a corresponding blood glucose monitor;
- visual reading and urine test strips and tablets that test for glucose, ketones and protein;
- lancets and lancet devices;
- injection aids, including devices used to assist with insulin injection and needleless systems;
- glucagon emergency kits;
- prescription orders for insulin and insulin analog preparations;
- insulin syringes;
- prescriptive and nonprescriptive oral agents for controlling blood sugar levels.

As new or improved treatment and monitoring equipment or supplies become available and are approved by the U.S. Food and Drug Administration (FDA), such equipment or supplies may be covered if determined to be Medically Necessary and appropriate by the treating Physician or Provider who issues the written order for the supplies or the equipment.

Prosthetic Appliances and Orthotic Devices

The following covered appliances and devices must be provided or arranged by the PCP and may require Prior Authorization by HMO:

1. initial Prosthetic Appliances, including professional fitting services related to the fitting and use of these devices, are covered subject to restrictions in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** and **LIMITATIONS AND EXCLUSIONS;**
2. repair and replacement of Prosthetic Appliances and orthotic devices are covered unless the repair or replacement is a result of misuse or loss by You;
3. orthopedic braces, such as orthopedic appliances used to support, align, or hold bodily parts in a correct position; crutches, including rigid back, leg or neck braces; casts for treatment of any part of the legs, arms, shoulders, hips or back; special surgical and back corsets; and Physician-prescribed, directed or applied dressings, bandages, trusses and splints that are custom designed for the purpose of assisting the function of a joint;
4. breast prostheses and surgical brassieres after mastectomy;
5. Medically Necessary foot orthotics that are consistent with the Medicare Benefit Policy Manual are covered. There is no Calendar Year maximum. This is in addition to, and does not affect, the coverage for podiatric appliances shown in **Diabetes Care**;
6. one cochlear implant, which includes an external speech processor and controller, per impaired ear is covered. Coverage also includes related treatments such as Habilitation and Rehabilitation Services, fitting and dispensing services and the provision of ear molds as necessary to maintain optimal fit of hearing aids. Implant components may be replaced as Medically Necessary or audiologically necessary.

Durable Medical Equipment

You must obtain services and devices through a Participating DME Provider, which must be consistent with the Medicare DME Manual, and may require Prior Authorization by HMO. HMO will determine whether DME is rented or purchased and retains the option to recover the DME upon cancellation or termination of Your coverage.

Examples of DME are: standard wheelchairs, crutches, walkers, orthopedic tractions, Hospital beds, oxygen, bedside commodes, suction machines, etc. Excluded items are listed in **LIMITATIONS AND EXCLUSIONS**.

Ostomy Supplies

Benefits for supplies related to ostomy may include, but are not limited to:

1. pouches, face plates and belts;
2. irrigation sleeves, bags and ostomy irrigation catheters;
3. skin barriers; and
4. deodorants, filters, lubricants, tape, appliance cleaners, adhesive and adhesive remover.

Medical Supplies

Medical or disposable supplies prescribed by a Physician include, but are not limited to:

1. urinary catheters;
2. wound care or dressing supplies given by a Provider during treatment for covered health services; and
3. medical-grade compression stockings when considered Medically Necessary. The stockings must be prescribed by a Physician, individually measured and fitted to the patient.

Coverage also includes disposable supplies necessary for the effective use of Durable Medical Equipment and diabetic supplies for which benefits are provided as described under **Durable Medical Equipment** and **Diabetes Services**.

Hearing Aids

Covered Services and equipment, which may require Prior Authorization, include one audiometric examination to determine type and extent of hearing loss once every thirty-six (36) months and the fitting and purchase of hearing

aid device(s). Coverage also includes fitting and dispensing services, the provision of ear molds as necessary to maintain optimal fit of hearing aids and Habilitation and Rehabilitation Services. Exclusions are listed in **LIMITATIONS AND EXCLUSIONS**.

Speech and Hearing Services

Covered Services, which may require Prior Authorization, include inpatient and outpatient care and treatment for loss or impairment of speech or hearing that is not less favorable than for physical illness generally.

Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any speech and hearing services visits maximum indicated on Your **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**.

Therapies for Children with Developmental Delays

Covered Services include treatment for "Developmental Delays", which means a significant variation in normal development as measured by appropriate diagnostic instruments and procedures in one or more of the following areas:

- cognitive;
- physical;
- communication;
- social or emotional; or
- adaptive.

Treatment includes the necessary rehabilitative and habilitative therapies in accordance with an "Individualized Family Service Plan", which is the initial and ongoing treatment plan developed and issued by the Interagency Council on Early Childhood Intervention under Chapter 73 of the Human Resources Code for a dependent child with Developmental Delays, including:

- occupational therapy evaluations and services;
- physical therapy evaluations and services;
- speech therapy evaluations and services; and
- dietary or nutritional evaluations.

You must submit an Individualized Family Service Plan to HMO before You receive any services, and again if the Individualized Family Service Plan is changed. After a child is three (3) years of age and services under the Individualized Family Service Plan are completed, the standard contractual provisions in this Certificate of Coverage and any benefit exclusions or limitations will apply.

Autism Spectrum Disorder

Generally recognized services prescribed in relation to Autism Spectrum Disorder by Your PCP in a treatment plan recommended by that Physician are covered. No benefit maximums will apply.

Individuals providing treatment prescribed under that plan must be:

1. a health care practitioner:
    - who is licensed, certified, or registered by an appropriate agency of the state of Texas;
    - whose professional credential is recognized and accepted by an appropriate agency of the United States; or
    - who is certified as a Provider under the TRICARE military health system.
2. an individual acting under the supervision of a health care practitioner described in item 1.

Treatment may include services such as:

- evaluation and assessment services;
- screening at 18 and 24 months;
- applied behavior analysis;
- behavior training and behavior management;
- speech therapy;
- occupational therapy;
- physical therapy; or

- medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder.

All standard contractual provisions of this Certificate will apply, including but not limited to, defined terms, limitations and exclusions.

Benefits for Autism Spectrum Disorder will not apply towards any visit maximum indicated on Your **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**. Please review the Rehabilitation and Habilitation Services provision and the Speech and Hearing Services provision in this section of the Certificate.

Routine Patient Costs for Participants in Certain Clinical Trials

Covered Services for Routine Patient Care Costs, as defined in **DEFINITIONS** are provided in connection with a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and is recognized under state and/or federal law.

Services are not available under this section for services that are a part of the subject matter of the clinical trial and that are customarily paid for by the Research Institution conducting the clinical trial. Services must be provided or arranged by the PCP.

Teledentistry, Telehealth and Telemedicine Medical Services

Teledentistry, Telehealth and Telemedicine Medical Services are covered, as defined in **DEFINITIONS** and may require Prior Authorization.

Diagnostic Mammography and Other Breast Imaging

Diagnostic Imaging is covered to the same extent as screening mammograms as described in **COVERED SERVICES AND BENEFITS; Health Maintenance and Preventive Services.**

In addition to the applicable terms provided in the **DEFINITIONS** section of the Certificate, the following term will apply specifically to this provision.

Diagnostic Imaging means an imaging examination using mammography, ultrasound imaging, or magnetic resonance imaging that is designed to evaluate:

1. a subjective or objective abnormality detected by a Physician or patient in a breast;
2. an abnormality seen by a Physician on a screening mammogram;
3. an abnormality previously identified by a Physician as probably benign in a breast for which follow-up imaging is recommended by a Physician; or
4. an individual with a personal history of breast cancer or dense breast tissue.

The Copayment amounts indicated in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS; Health Maintenance and Preventive Services** for screening mammograms will apply but without Member age restrictions.

Biomarker Testing

Covered Services for Medically Necessary Biomarker Testing for the purpose of diagnosis, treatment, appropriate management, or 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 Testing will be covered only when use of Biomarker Testing provides clinical utility because use of the test for the condition is evidence-based, is scientifically valid based on the medical and scientific evidence, informs the members outcome and a provider's clinical decision, and predominantly addresses the acute or chronic issue for

which the test is ordered. This coverage will be provided in a manner that limits disruptions in care, including limiting the number of biopsies and biospecimen samples.

Benefits for Chimeric Antigen Receptor (CAR) T-Cell Therapy

If your Plan has coverage for Chimeric Antigen Receptor (CAR) T-Cell Therapy services, benefits will be provided for these services when the therapy is Necessary and administered by a Network Provider that is qualified as a certified health care facility in accordance with the U.S. Food and Drug Administration-approved product license.

Routine Foot Care

Medically Necessary routine foot care is covered, when obtained from a licensed Provider.

Medical Drug Benefit Program

Certain prescription drugs administered by a health care professional may be covered under this Benefit section. Coverage is based on recommendations of a committee, which is made up of physicians and pharmacists from across the country, some of whom are affiliated with BCBSTX. The committee considers existing FDA-approved drugs, as well as newly FDA-approved drugs, using factors including but not limited to, safety, effectiveness, cost, and how they compare with other Covered prescription drugs.

Medical Drug Benefit Review and Limitations

The following rules apply to prescription drugs which may be covered under this Benefit section:

- **Accelerated FDA-approved drugs:** Prescription drugs which may be administered by a health care professional and have been approved by the FDA through the accelerated approval program are subject to review by the Plan and may not be covered.
- **New FDA-approved drugs:** Prescription drugs which may be administered by a health care professional and have recently received FDA approval are subject to review by the Plan and may not be covered.
- **Self-administered formulations**: Select medications may be excluded from coverage under this Benefit section when a self-administered formulation of the drug is available.
- **Therapeutic equivalents or 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. Depending on your benefit plan, therapeutic equivalents or therapeutic alternatives may be covered through your prescription drug benefit.

Note: To learn more about prescription drugs that may be covered under this Benefit section or about how to request an exception, you, your Provider, or your authorized representative may contact Customer Service at the toll-free telephone number on the back of your Identification Care, or visit www.BCBSTX.com/find-care/medical-rx .

For prescription drugs that are not otherwise covered under this Benefit section, your Provider may request an exception by submitting a completed Medical Drug Benefit Program Coverage Exception Request form available at www.BCBSTX.com/docs/provider/TX/education/forms/TX-mbta-exception-request.pdf. Notice of coverage determinations will be provided to you and your Provider.

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

LIMITATIONS AND EXCLUSIONS

The following benefits are not covered unless specifically provided for in **COERED SERVICES AND BENEFITS, PHARMACY BENEFITS** or a **RIDER**.

1. Services or supplies of non-Participating Providers or self-referral to a Participating Provider, except:
    a. Emergency Care;
    b. when authorized by HMO or Your PCP; and
    c. Members may directly access an Obstetrician/Gynecologist for: (1) well-woman exams; (2) obstetrical care; (3) care for all active gynecological conditions; and (4) diagnosis, treatment and Referral for any disease or condition within the scope of the professional practice of the Obstetrician/Gynecologist.
2. Services or supplies which in the judgment of the PCP or HMO are not Medically Necessary and essential to the diagnosis or direct care and treatment of a sickness, injury, condition, disease or bodily malfunction as defined herein.
3. If a service is not covered, HMO will not cover any services related to it except for routine patient care for participants in an Approved Clinical Trial. Related services are:
    a. services in preparation for the non-covered service;
    b. services in connection with providing the non-covered service;
    c. hospitalization required to perform the non-covered service; or
    d. services that are usually provided following the non-covered service, such as follow-up care or therapy after surgery.
4. Experimental/Investigational services and supplies. Denials based on Experimental/Investigational services and supplies are Adverse Determinations and are subject to the utilization review process, including reviews by an Independent Review Organization (IRO) as described in the **COMPLAINT AND APPEAL PROCEDURES** section. 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.
5. 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.
6. Any charges resulting from the failure to keep a scheduled visit with a Participating Provider or for acquisition of medical records.
7. Special medical reports not directly related to treatment.
8. Examinations, testing, vaccinations or other services required by employers, insurers, schools, camps, courts, licensing authorities, other third parties or for personal travel.
9. Services or supplies provided by a person who is related to a Member by blood or marriage and self-administered services.
10. Services or supplies for injuries sustained as a result of war, declared or undeclared, or any act of war or while on active or reserve duty in the armed forces of any country or international authority.
11. Benefits You are receiving through Medicare or for which You are eligible through entitlement programs of the federal, state, or local government, including but not limited to Medicaid and its successors.
12. Care for conditions that federal, state or local law requires to be treated in a public facility.
13. Appearances at court hearings and other legal proceedings, and any services relating to judicial or administrative proceedings or conducted as part of medical research.
14. 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.
15. Any services, supplies or drugs received by a Member outside of the United States, except for Emergency Care.

16. Transportation services except as described in **Ambulance Services**, or when approved by HMO.
17. Personal or comfort items, including but not limited to televisions, telephones, guest beds, admission kits, maternity kits and newborn kits provided by a Hospital or other inpatient facility.
18. Private rooms unless Medically Necessary and authorized by the HMO. If a semi-private room is not available, HMO covers a private room until a semi-private room is available.
19. Any and all transplants of organs, cells, and other tissues, except as described in **Inpatient Hospital Services**. Services or supplies related to organ and tissue transplant or other procedures when You are the donor and the recipient is not a Member are not covered.
20. Services or supplies for Long Term or Custodial Care.
21. Services or supplies furnished by an institution that is primarily a place of rest, a place for the aged or any similar institution.
22. Private duty nursing, except when determined to be Medically Necessary and ordered or authorized by the PCP.
23. Services or supplies for Dietary and Nutritional Services, including home testing kits, vitamins, dietary supplements and replacements, and special food items, except:
    a. an inpatient nutritional assessment program provided in and by a Hospital and approved by HMO;
    b. dietary formulas necessary for the treatment of phenylketonuria or other heritable diseases;
    c. as described in **Diabetes Care**;
    d. as described in **Autism Spectrum Disorder**; or
    e. as described in **Therapies for Children with Developmental Delays**.
24. Services or supplies for Cosmetic, Reconstructive or Plastic Surgery, including breast augmentation (enlargement) surgery, even when Medically Necessary, except as described in **Cosmetic, Reconstructive or Plastic Surgery**.
25. Services or supplies provided primarily for:
    a. Environmental Sensitivity; or
    b. Management and treatment of Idiopathic Environmental Intolerance (IEI), including laboratory or other diagnostic tests to affirm the diagnosis of IEI
    c. Clinical Ecology or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists; or
    d. inpatient allergy testing or treatment; or
    e. allergen specific IgG measurement.
26. Services or supplies provided for, in preparation for, or in conjunction with the following, except as described in **Maternity Care and Family Planning Services**:
    a. sterilization reversal;
    b. treatment of sexual dysfunction including medications, penile prostheses and other surgery, and vascular or plethysmographic studies that are used only for diagnosing impotence;
    c. promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination super ovulation uterine capacitation enhancement, direct-intraperitoneal insemination, trans-uterine tubal insemination, gamete intrafallopian transfer, pronuclear oocyte stage transfer, zygote intrafallopian transfer and tubal embryo transfer;
    d. any services or supplies related to in vitro fertilization or other procedures when You are the donor and the recipient is not a Member;
    e. in vitro fertilization and fertility drugs, unless covered by a Rider.
27. Treatment of decreased blood flow to the legs with pneumatic compression device high pressure rapid inflation-deflation cycle.
28. Treatment of tissue damage in any location with platelet rich plasma.
29. Services or supplies in connection with foot care for flat feet, fallen arches, or chronic foot strain.

30. Services or supplies for reduction of obesity or weight, including prescription drugs, even if the Member has other health conditions which might be helped by a reduction of obesity or weight, except for healthy diet counseling and obesity screening/counseling as may be provided under **Preventive Services**.
31. Services or supplies for, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.
32. Services or supplies for dental care, except as described in **Dental Surgical Procedures**.
33. Non-surgical or non-diagnostic services or supplies for treatment or related services to the temporomandibular (jaw) joint or jaw-related neuromuscular conditions with oral appliances, oral splints, oral orthotics, devices, prosthetics, dental restorations, orthodontics, physical therapy, or alteration of the occlusal relationships of the teeth or jaws to eliminate pain or dysfunction of the temporomandibular joint and all adjacent or related muscles and nerves. Medically Necessary diagnostic and/or surgical treatment is covered for conditions affecting the temporomandibular joint (including the jaw or craniomandibular joint) as a result of an accident, trauma, congenital defect, developmental defect or pathology, as described in **Dental Surgical Procedures**.
34. Alternative treatments such as acupuncture, dry needling, trigger-point acupuncture, acupressure, hypnotism, massage therapy and aroma therapy.
35. Services or supplies for:
    a. intersegmental traction;
    b. all types of home traction devices and equipment;
    c. vertebral axial decompression sessions;
    d. surface EMGs;
    e. spinal manipulation under anesthesia;
    f. muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron; or
    g. balance testing through computerized dynamic posturography sensory organization test.
36. Galvanic stimulators or TENS units.
37. Scanning the visible front portion of the eye with computerized ophthalmic diagnostic imaging, or measuring the firmness of the front of the eye with corneal hysteresis by air impulse stimulation.
38. Disposable or consumable outpatient supplies, such as syringes, needles, blood or urine testing supplies (except as used in the treatment of diabetes); sheaths, bags, elastic garments, stockings and bandages, garter belts.
39. Excluded supplies include, but are not limited to, compression stockings, ace bandages, wound care or dressing supplies, prescribed or non-prescribed medical and disposable supplies that can be purchased over the counter.

    This exclusion does not apply to:

    a. ostomy bags and related supplies for which benefits are provided as described under **Ostomy Supplies** section;
    b. disposable supplies necessary for the effective use of Durable Medical Equipment for which benefits are provided as described under **Durable Medical Equipment** section;
    c. urinary catheters, wound care or dressing supplies given by a Provider during treatment for **Covered Services**;
    d. medical grade compression stockings when considered Medically Necessary. The stockings must be prescribed by a Physician, individually measured and fitted to the patient;
    e. diabetic supplies for which benefits are provided as described under **Diabetes Services** section;
    f. batteries, tubing, nasal cannulas, connectors and masks except when used with Durable Medical Equipment.

40. Prosthetic Appliances or orthotic devices not described in **Diabetes Care** or **Prosthetic Appliances and Orthotic Devices** including, but not limited to:
    a. orthodontic or other dental appliances or dentures;
    b. splints or bandages provided by a Physician in a non-Hospital setting or purchased over the counter for the support of strains and sprains;
    c. corrective orthopedic shoes, including those which are a separable part of a covered brace; specially-ordered, custom-made or built-up shoes and cast shoes; shoe inserts designed to support the arch or affect changes in the foot or foot alignment; arch supports; braces; splints or other foot care items.
41. Testing of:
    a. blood for measurement of levels of: Lipoprotein a; small dense low density lipoprotein; lipoprotein subclass high resolution; lipoprotein subclass particle numbers; lipoprotein associated phospholipase A2, which are fat/protein substances in the blood that might be ordered in people with suspected deposits in the walls of blood vessels;
    b. urine for measurement of collagen cross links, which is a substance that might be ordered in people with suspected high bone turnover;
    c. cervicovaginal fluid for amniotic fluid protein during pregnancy, which might be ordered in people suspected to have fluid leaking from around the baby (premature ruptured membranes).
42. The following psychological/neuropsychological testing and psychotherapy services:
    a. educational testing;
    b. employer/government mandated testing;
    c. testing to determine eligibility for disability benefits;
    d. testing for legal purposes (e.g., custody/placement evaluations, forensic evaluations, and court mandated testing);
    e. testing for vocational purposes (e.g., interest inventories, work related inventories, and career development);
    f. services directed at enhancing one's personality or lifestyle;
    g. vocational or religious counseling;
    h. activities primarily of an educational nature;
    i. music or dance therapy; or
    j. bioenergetic therapy.
43. Biofeedback (except for an Acquired Brain Injury diagnosis) or other behavior modification services.
44. Mental health services except as described in **Behavioral Health Services** or as may be provided under **Autism Spectrum Disorder.**
45. Residential Treatment Centers for Chemical Dependency that are not:
    a. affiliated with a Hospital under a contractual agreement with an established system for patient Referral;
    b. accredited as such a facility by the Joint Commission on Accreditation of Hospitals;
    c. licensed as a Chemical Dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or
    d. licensed, certified or approved as a Chemical Dependency treatment program or center by any other state agency having legal authority to so license, certify or approve.
46. Trauma or wilderness programs for behavioral health or Chemical Dependency treatment.
47. Replacement for loss, damage or functional defect of hearing aids. Batteries are not covered unless needed at the time of the initial placement of the hearing aid device(s).
48. Deluxe equipment such as motor driven wheelchairs and beds (unless determined to be Medically Necessary); comfort items; bedboards; bathtub lifts; over-bed tables; air purifiers; sauna baths; exercise equipment; stethoscopes and sphygmomanometers; Experimental and/or research items; and replacement, repairs or maintenance of the DME.

49. Over-the-counter supplies or medicines and prescription drugs and medications of any kind, except:
    a. as provided while confined as an inpatient;
    b. as provided under **Autism Spectrum Disorder**;
    c. as provided under **Diabetes Care**;
    d. contraceptive devices and FDA-approved over-the-counter contraceptives for women with a written prescription from a Participating Provider; or
    e. if covered under **PHARMACY BENEFITS.**
50. Abortions are limited to pregnancies that, as certified by a physician, places the woman in danger of death.
51. Self-administered drugs dispensed or administered by a Physician in their office.
52. Select medications may be excluded from the medical benefit when a self-administered formulation of the product is available.
53. Any services or supplies from more than one Provider on the same day(s) to the extent benefits were duplicated.
54. Some laboratory services are not covered by Your plan. The following laboratory services are not covered:
    a. Vitamin B12 testing or screening for a Vitamin B12 deficiency in healthy, asymptomatic individual; homocysteine or holotranscobalamin testing to screen for or confirm a Vitamin B 12 deficiency; or Vitamin B12 testing within three (3) months of beginning treatment for a B12 deficiency;
    b. Vitamin D testing - Routine screening for vitamin D deficiency with serum testing in asymptomatic individuals and/or during general encounters;
    c. Hemoglobin A1c testing in the following situations:
        - if You have had a blood transfusion within the past 120 days; or
        - if You have a condition associated with increased red blood cell turnover; or
        - if You are also being measured for fructosamine.
    d. influenza testing -Viral culture testing for influenza in an outpatient setting; outpatient influenza testing in asymptomatic patients; Serology testing for influenza under any circumstance;
    e. cardiac biomarkers - Measurement of cardiac biomarkers for the diagnosis a heart attack if You have symptoms of acute coronary syndrome such as chest pain; or Measurement of cardiac biomarkers if You have symptoms of acute coronary syndrome and received services in a setting that cannot perform an evaluation for a heart attack, such as an independent lab or Physician's office;
    f. drug testing in an outpatient setting is not covered in the following situations:
        - testing to confirm the presence and/or amount of drugs in Your system is not covered when laboratory-based definitive drug testing is requested without any prior screening test results, or when laboratory-based definitive drug testing is requested for larger than seven drug classes panels;
        - use of proprietary drug tests such as RiskviewRX Plus;
        - specific validity testing, including, but not limited to the following tests: urine specific gravity, urine creatinine, pH, urine oxidant level, and genetic identity testing, are included in the panel test and therefore will not be covered if submitted individually if a urine panel test was also ordered at the same time;
        - testing for any American Medical Association definitive drug class codes;
        - same-day testing for the same drug or metabolites from two different samples (e.g. both a blood and a urine specimen);
        - testing of samples with abnormal validity tests;
        - drug testing for patients in a facility setting (inpatient or outpatient) are not separately covered, as they are included in the daily charge at the facility;

g. folate testing - Measurement of RBC folate is not covered. Measurement of serum folate concentration is only covered when You have been diagnosed with megaloblastic or macrocytic anemia and those conditions do not resolve after folic acid treatment;

h. Pancreatic Enzyme testing is not covered the following situations:

- more than once per visit; or
- as part of ongoing assessment or therapy of chronic pancreatitis; or
- during a general exam without abnormal findings if You do not have symptoms and are not pregnant;
- for measurement of the following biomarkers for the diagnosis or assessment of acute pancreatitis, prognosis, and/or determination of severity of acute pancreatitis is not covered: measurement of both amylase AND serum lipase, serum trypsin/trypsinogen/TAP (trypsinogen activation peptide), C-Reactive Protein (CRP); Interleukin-6 (IL-6); Interleukin-8 (IL-8); or Procalcitonin.

i. Cardiovascular disease risk assessment testing is not covered in the following situations:

- High-sensitivity C-Reactive Protein is not covered except when a risk based treatment decision is not certain after having a quantitative risk assessment using American College of Cardiology/ American Heart Association (ACC/AHA)calculator to calculate 10-year risk of Cardiovascular disease CVD;
- testing for High-sensitivity C-Reactive Protein is not covered as a screening test for the general population or for monitoring response to therapy;
- measurement of High-sensitivity cardiac troponin T is not covered for cardiovascular risk assessment and stratification in the outpatient setting;
- Homocysteine testing for cardiovascular disease risk assessment screening, evaluation and management is not covered;
- novel cardiovascular biomarkers such as measurement of novel lipid and non–lipid biomarkers is not covered as an add on to LDL cholesterol in the risk assessment of cardiovascular disease;
- cardiovascular risk panels, consisting of multiple individual biomarkers intended to assess cardiac risk (other than simple lipid panels), are not covered;
- Serum Intermediate Density Lipoprotein is not covered as an indicator of cardiovascular disease risk;
- measurement of lipoprotein-associated phospholipase is not covered as an indicator of risk of cardiovascular disease;
- measurement of secretory type II phospholipase is not covered in the assessment of cardiovascular risk for all indications;
- measurement of long-chain omega-3 fatty acids in red blood cell membranes, including but not limited to its use as a cardiac risk factor is not covered;
- all other tests for assessing CHD risk are not covered.

j. Allergen testing is not covered in the following situations:

- routine re-testing for confirmed allergies to the same allergens **is not covered** except in children and adolescents with positive food allergen results to monitor for allergy resolution;
- the Antigen Leukocyte Antibody test (ALCAT) is not covered;
- in-vitro testing of allergen specific IgG or non-specific IgG, IgA, IgM, and/or IgD in the evaluation of suspected allergy is not covered;
- Basophil Activation flow cytometry testing for measuring hypersensitivity to allergens is not covered;
- in-vitro allergen testing using bead-based epitope assays is not covered;
- in-vitro testing of allergen non-specific IgE is not covered.

k. Testosterone testing – The following tests are not covered:

- testing for serum free testosterone and/or bioavailable testosterone as primary testing (i.e., in the absence of prior serum TOTAL testosterone testing);

- testing for serum total testosterone, free testosterone, and/or bioavailable testosterone in asymptomatic individuals or in individuals with non-specific symptoms;
- testing for serum testosterone for the identification of androgen deficiency in women;
- salivary testing for testosterone;
- measurement of serum dihydrotestosterone in individuals except in diagnosing 5-alpha reductase deficiency in individuals with ambiguous genitalia, hypospadias, or microphallus.

l. Thyroid Disease Testing is not covered in the following situations:

- Testing for thyrotropin-releasing hormone (TRH) or thyroxine-binding globulin (TBG) for the evaluation of the cause of hyperthyroidism or hypothyroidism is not covered.
- Testing for thyroid dysfunction during a general exam without abnormal findings for asymptomatic nonpregnant individuals is not covered.

m. Onychomycosis Testing is not covered in the following situations:

- Nucleic acid testing, attenuated total-reflectance fourier transform infrared (ATR-FTIR) spectroscopy and testing for the presence of fungal-derived sterols (e.g., ergosterol) to screen for, diagnose, or confirm onychomycosis is not covered.

55. Cannabis

- This plan does not cover 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.

56. Viscosupplementation (intra-articular hyaluronic acid injection), except for individuals currently receiving maintenance therapy.

57. Three-dimensional (3D), four-dimensional (4D), and five-dimensional (5D) obstetrical ultrasounds

Definitions

In addition to the applicable terms provided in the **DEFINITIONS** section of this Certificate, the following terms will apply specifically to this **PHARMACY BENEFITS** section.

Allowable Amount means the maximum amount determined by HMO to be eligible for consideration of payment for a particular Covered Drug. As applied to Participating Pharmacies the Allowable Amount is based on the provisions of the contract between HMO and the Participating Pharmacy in effect on the date of service. As applied to **Prescription Drugs Purchased Outside of the Service Area**, the Allowable Amount is based on the Participating Pharmacy contract rate.

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 two manufacturers will produce the same product under one license, known as a co-licensed product, which would also be considered as a Brand Name Drug. There may also be situations where a drug's classification changes from generic to brand name due to a change in the market resulting in the generic being a single source, or the drug product database information changing, which would also result in a corresponding change in Copayment obligations from generic to brand name.

Copayment or **Copay** means the dollar amount or percentage amount paid by the Member for each Prescription Order filled or refilled through a Participating Pharmacy.

Covered Drug(s) means any Legend Drug:

1. which is included on the applicable Drug List;
2. which is Medically Necessary and is ordered by an authorized Health Care Practitioner naming a Member as the recipient;
3. for which a written or verbal Prescription Order is provided by an authorized Health Care Practitioner;
4. for which a separate charge is customarily made;
5. which is not consumed at the time and place that the Prescription Order is written;
6. for which the U.S. Food and Drug Administration (FDA) has given approval for at least one indication; and
7. which is dispensed by a Participating Pharmacy and is received by the Member while covered under this Certificate, except when received from a Provider's office, or during confinement while a patient in a Hospital or other acute care institution or facility (refer to **Limitations and Exclusions**).

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

Drug List means a list of all drugs that may be covered under Your pharmacy benefits. The Drug List is available by accessing the website at www.bcbstx.com/rx-drugs/drug-lists/drug-lists . You may also contact customer service at the toll-free number on Your identification card for more information.

Generic Drug means a drug that has the same active ingredient as the 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, HMO 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 "generic" by the drug product database, manufacturer, Pharmacy, or Your Physician will adjudicate as generic by HMO. Generic Drugs are shown on the Drug List which is available by accessing the website at www.bcbstx.com/rx-drugs/drug-lists/drug-lists/drug-lists; or You may contact customer service at the toll-free number on Your identification card.

Health Care Practitioner means an Advanced Practice Nurse, doctor of medicine, doctor of dentistry, Physician Assistant, doctor of osteopathy, doctor of podiatry, or other licensed person with prescription authority.

Legend Drug means a drug, biological, or compounded prescription which is required by law to have a label stating "Caution - Federal Law Prohibits Dispensing Without a Prescription," and which are approved by the FDA for a particular use or purpose.

Brand Name Drug (Non-Preferred) means a Brand Name Drug which appears on the applicable Drug List as Non-Preferred Brand Name Drug. The Drug List is available by accessing the website at www.bcbstx.com/rx-drugs/drug-lists/drug-lists .

Generic Drug (Non-Preferred) means a Generic Drug which appears on the applicable Drug List as Non-Preferred Generic Drug. The Drug List is available by accessing the website at www.bcbstx.com/rx-drugs/drug-lists/drug-lists .

Specialty Drug (Non-Preferred) means a Specialty Drug which appears on the applicable Drug List as Non-Preferred Specialty Drug. The Drug List is available by accessing the website at www.bcbstx.com/rx-drugs/drug-lists/drug-lists.

Participating Pharmacy means an independent retail Pharmacy, chain of retail Pharmacies, mail-order program Pharmacy or a Specialty Pharmacy Provider which have entered into a written agreement with HMO to provide pharmaceutical services to Members under this Certificate.

Pharmacy means a state and federally licensed establishment where the practice of pharmacy occurs, 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 they practice.

Pharmacy Vaccine Network means the network of Participating Pharmacies which have entered into a written agreement with HMO to provide certain vaccinations to Members under this Certificate.

Brand Name Drug (Preferred) means a Brand Name Drug which appears on the applicable Drug List and is subject to the Preferred Brand Name Drug. The Drug List is available by accessing the website at www.bcbstx.com/rx-drugs/drug-lists/drug-lists.

Generic Drug (Preferred) means a Generic Drug which appears on the applicable Drug List as Preferred Generic Drug. The Drug List is available by accessing the website at www.bcbstx.com/rx-drugs/drug-lists/drug-lists.

Specialty Drug (Preferred) means a Specialty Drug which appears on the applicable Drug List as Preferred Specialty Drug. The Drug List is available by accessing the website at www.bcbstx.com/rx-drugs/drug-lists/drug-lists.

Preferred Participating Pharmacy means a Participating Pharmacy which has a written agreement with HMO to provide pharmaceutical services to Members or an entity chosen by HMO to administer its prescriptions drug program that has been designated as a Preferred Participating Pharmacy.

Prescription Order means a written or verbal order from Your authorized Health Care Practitioner to a pharmacist for a drug or device to be dispensed.

Specialty Drugs means a high cost prescription drug that meets any of the following criteria:

1. used in limited patient populations or indications;
2. typically self-injected;
3. limited availability, requires special dispensing, or delivery and/or patient support is required and therefore, they are difficult to obtain via traditional Pharmacy channels; and/or
4. complex reimbursement procedures are required.

To determine which drugs are Specialty Drugs, refer to the Drug List which is available by accessing the website at www.bcbstx.com/member/prescription-drug-plan-information/drug-lists.

Specialty Pharmacy Provider means a Participating Pharmacy which has entered into a written agreement with HMO to provide Specialty Drugs to Members under this Certificate.

Covered Drugs

Benefits for Medically Necessary Covered Drugs prescribed to treat You for a chronic, disabling, or life-threatening illness covered by HMO are available if the drug is on the applicable Drug List and has been approved by the United States Food and Drug Administration (FDA) for at least one indication and is recognized by the following for treatment of the indication for which the drug is prescribed:

- a prescription drug reference compendium approved by the Texas Department of Insurance; or
- substantially accepted peer-reviewed medical literature.

For a list of Covered Drugs, You can access the website at www.bcbstx.com/member/prescription-drug-plan-information/drug-lists or You can also contact customer service at the toll-free number on Your identification card.

You are responsible for any Copayments for Covered Drugs shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** and pricing differences that may apply to the Covered Drug dispensed.

Injectable Drugs. Injectable drugs approved by the FDA for self-administration are covered. Benefits will not be provided under **PHARMACY BENEFITS** for any self-administered drugs dispensed by a Physician.

Diabetes Supplies for Diabetes Care. Insulin, insulin analogs, insulin pens, insulin syringes, needles, injection devices, glucagon emergency kits, lancets, lancet devices, glucose meter solution, test strips specified for use with a corresponding blood glucose monitor, visual reading strips and urine and blood testing strips, and tablets which test for glucose, ketones, and protein, and prescriptive and nonprescriptive oral agents for controlling blood sugar levels are covered.

A separate Copayment will apply to each fill of a prescription purchased on the same day for insulin and insulin syringes.

All supplies, including medications and equipment for the control of diabetes will be dispensed as written, unless substitution is approved by Your prescribing Physician or other Health Care Practitioner who issues the written order for the supplies or equipment.

Emergency Refills of Insulin or Insulin-Related Equipment and Supplies

A pharmacist may exercise their professional judgement in refilling a Prescription Order for Insulin or Insulin-Related Equipment or Supplies without the authorization of the prescribing Health Care Practitioner in the following situations:

- the pharmacist is unable to contact your Health Care Practitioner after reasonable effort;
- the pharmacist has documentation showing the patient was previously prescribed insulin or insulin-related equipment or supplies by a Health Care Practitioner; and
- the pharmacist accesses the patient to determine whether the emergency refill is appropriate.

The quantity of an emergency refill will be the smallest available package and will not exceed a 30-day supply.

In addition to the applicable terms provided in the **DEFINITIONS** section of the Certificate, the following terms will apply specifically to this provision.

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

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

You are responsible for the same Copayment 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 **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**, 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 Your Drug List and does not include an insulin drug administered intravenously.

Insulin drugs obtained from a non-Participating Pharmacy or not identified as a Preferred insulin drug may be subject to Copayment or dollar maximum, if applicable.

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

Preventive Care. Prescription and over-the-counter drugs which have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF") (to be implemented in the quantities and within the time period allowed under applicable law) or as required by state law will be covered and will not be subject to any Copayment or dollar maximums.

Select Vaccinations obtained through certain Participating Pharmacies. Benefits for select vaccinations are shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS.** These vaccinations are available through certain Participating Pharmacies that have contracted with HMO to provide this service. To locate one of these Participating Pharmacies in the Pharmacy Vaccine Network in Your area and to determine which vaccinations are covered under this benefit, access the website at www.bcbstx.com or contact customer service at the toll-free number on Your identification card.

Each Participating Pharmacy included in the Pharmacy Vaccine Network that has contracted with HMO to provide this service may have age, scheduling, or other requirements that will apply, so You are encouraged to contact them in advance.

Formulas for the Treatment of Phenylketonuria or Other Heritable Diseases. Dietary formulas necessary for the treatment of phenylketonuria or other heritable diseases are covered to the same extent as any other Covered Drug available only on the orders of a Health Care Practitioner.

Amino Acid-Based Elemental Formulas. Formulas, regardless of the formula delivery method, used for the diagnosis and treatment of:

- immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
- severe food protein-induced enterocolitis syndromes;
- eosinophilic disorders, as evidenced by the results of biopsy; and
- disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

A Prescription Order from Your Health Care Practitioner is required.

Orally Administered Anticancer Medication. Benefits are available for Medically Necessary orally administered anticancer medication that is used to kill or slow the growth of cancerous cells. Copayments will not apply to certain orally administered anticancer 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 as described in **Specialty Pharmacy Program**.

Selecting a Pharmacy

When You need a Prescription Order filled, You should use a Participating Pharmacy. Each prescription or refill is subject to the Copayment shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** and any applicable pricing differences. You may be required to pay for limited or non-Covered Services. No claim forms are required.

Although You can go to any Participating Pharmacy, Your benefits for drugs and other items covered under this provision will be greater when You obtain them from a Preferred Participating Pharmacy. Your Copayment will be less when using a Preferred Participating Pharmacy.

If You are unsure whether a Pharmacy is a Participating Pharmacy, You may access the website at www.bcbstx.com/onlinedirectory/important_info_rx.htm. Preferred Participating Pharmacies will also be identified. You can also call customer service at the toll-free telephone number on the back of Your identification card for information regarding Participating Pharmacies and Preferred Participating Pharmacies.

Mail-Order Program. If You elect to use the mail-order service, You must mail Your Prescription Order to the address provided on the mail-order prescription form and send in Your payment for each prescription filled or refilled. Each prescription or refill is subject to the Copayment shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** and any applicable pricing differences, payable by Member directly to the mail order Pharmacy.

Some drugs may not be available through the mail-order program. If You have any questions about this mail-order program, need assistance in determining the amount of Your payment, or need to obtain the mail-order prescription claim form, access the website at www.bcbstx.com or contact customer service at the toll-free number on Your identification card. Mail the completed form, Your Prescription Order(s) and payment to the address indicated on the form.

Specialty Pharmacy Program

This program provides delivery of medications directly to Your Health Care Practitioner, administration location or to Your home if You are undergoing treatment for a complex medical condition. To determine which drugs are Specialty Drugs, You should refer to prescription drug section on the Plan's website at https://www.bcbstx.com/tx/documents/rx-drugs/specialty-drug-list-tx.pdf or call the customer service toll-free number on Your identification card.

In order to receive maximum benefits for Specialty Drugs, You must obtain the Specialty Drugs from a preferred Specialty Pharmacy Provider. When You obtain Specialty Drugs from a preferred Specialty Pharmacy Provider, You must pay the applicable Copayment in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** of this Certificate.

The Drug List which includes these Specialty Drugs is available by accessing the website at www.bcbstx.com/member/prescription-drug-plan-information/drug-lists or by contacting customer service at the toll-free number on Your identification card. Your cost will be the applicable Copayment shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** as well as any applicable pricing differences.

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.

Prescription Drugs Purchased Outside of the Service Area. HMO will reimburse You for the Allowable Amount of the prescription drugs less the Out-of-Area Drug Copayment shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS,** for covered prescription drugs which You purchase outside of the Service Area. You must submit a completed claim form to HMO, within ninety (90) days of the date of purchase to qualify for reimbursement under the **PHARMACY BENEFITS.** You may access the website at www.bcbstx.com/member/forms/formfinder to obtain a prescription drug claim form.

MedsYourWay™

MedsYourWay™ ("MedsYourWay") may lower Your out-of-pocket costs for select Covered Drugs purchased at select in-network 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 BCBSTX 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 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. 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. 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 plan's pharmacy benefit copay. MedsYourWay may not be available in all states or pharmacies and will be operated only to the extent permitted by law.

Your Cost

How Copayment Amounts Apply. If the Allowable Amount of the drug is less than the Copayment, You pay the lower cost. When that lower cost is more than the amount You would pay if You purchased the drug without using Your HMO pharmacy benefits or any other source of drug benefits or discounts, You pay such purchase price. You will pay no more than the applicable Brand Name Drug Copayment if the prescription has no generic equivalent. If You receive a Brand Name Drug when a generic equivalent is available, the Copayment will be the total of the Generic Drug Copayment plus the difference between the cost of the Generic Drug equivalent and the cost of the Brand Name Drug Exceptions to this may be allowed for certain preventive medications (including prescription contraceptive medications) if Your Health Care Practitioner submits a request to HMO indicating that the Generic Drug would be medically inappropriate, along with supporting documentation. If HMO grants the exception request, any difference between the Allowable Amount for the Brand Name Drug and the Generic Drug equivalent will be waived.

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 (e.g., adverse event) You need to take the Brand Name Drug and certain criteria are met. Your Health Care Practitioner can submit a request to waive the difference in cost between the Allowable Amount of the Brand Name Drug and Allowable Amount of the Generic Drug. In order for this request to be reviewed, Your Health Care Practitioner must send in a MedWatch form to the Food and Drug Administration (FDA) to let them know the issues You experienced with the generic equivalent. Your Health Care Practitioner must provide a copy of this form when requesting the waiver. The FDA MedWatch form is used to document adverse events, therapeutic inequivalence/failure, product quality problems, and product use/medication error. This form is available on the FDA website. If the waiver is granted, applicable Copayment amount 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.

How Member 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.

Copayments for Covered Drugs on each drug tier is shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS.** To determine the tier in which a drug is included, access the website at www.bcbstx.com/member/prescription-drug-plan-information/drug-lists or 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 Copayment, or out-of-pocket maximum).

About Your Benefits

Covered Drug List. Drugs listed on the Drug List are selected by HMO based upon the recommendations of a committee, which is made up of current and previously practicing Physicians and pharmacists from across the country, some of whom are employed by or affiliated with HMO. 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. Some of the factors committee members evaluate include each drug's safety, effectiveness, cost and how it compares with drugs currently on the Drug List.

Positive changes (e.g., adding drugs to the Drug List, drugs moving to a lower payment tier) occur quarterly after review by the committee. Changes to the Drug List that could have an adverse impact to You (e.g., drug exclusion, drug moving to a higher payment tier, or drugs requiring step therapy or Prior Authorization) occur annually upon coverage renewal and with a 60-day advance notice consistent with Texas Insurance Code, 1369.0541 and 1369.055.

The Drug List and any modifications will be made available to You. By accessing the Blue Cross and Blue Shield website at www.bcbstx.com/member/prescription-drug-plan-information/drug-lists or calling the customer service toll-free number on Your identification card, You will be able to determine the Drug List that applies to You and whether a particular drug is on the Drug List. Changes to the Drug List will be implemented on the next renewal date of the Group Agreement and are subject to the requirements of Texas Insurance Code, 1369.0541.

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

Drug List Exception Requests. You, or Your prescribing Physician or other Health Care Practitioner with prescriptive authority, can ask for a Drug List exception if Your drug is not on the Drug List (also known as a formulary). To request this exception, You, Your prescribing Physician or other Health Care Practitioner, can call the number on the back of Your identification card to ask for a review. You may be required to submit a supporting statement from Your prescribing Physician or other Health Care Practitioner.

If You have a health condition that may jeopardize Your life, health, Your ability to regain maximum function or You are undergoing a current course of treatment using a drug that is not on the Drug List, an expedited review may be requested. You, or Your prescribing Physician or other Health Care Practitioner, will be notified of the coverage decision within 24 hours after the request for expedited review is received. If Your request is granted, coverage will be provided for the duration of the exigency.

For requests that do not meet the criteria for expedited review, a standard review will be completed and You and Your prescribing Physician or other Health Care Practitioner will be notified of the coverage decision within 72 hours after the request for standard review is received. If Your request is granted, coverage will be provided for the duration of the prescription, including refills.

If Your expedited or standard Drug List exception request is denied, the decision notice will include information explaining Your right to request review by an Independent Review Organization (IRO). You and Your prescribing Physician or other Health Care Practitioner will be notified of the IRO's decision within 24 hours of an expedited review and within 72 hours for a standard review. If Your expedited exception request is granted, coverage will be provided for the duration of the exigency. If Your standard exception is granted, coverage will be provided for the duration of the prescription, including refills.

Day Supply. Benefits for Covered Drugs obtained from a Participating Pharmacy are provided up to the maximum day supply limit as shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**. HMO has the right to determine the day supply. Payment for benefits covered by HMO may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum day supply limitation. 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.

Extended Prescription Drug Supply Program. Your coverage includes benefits for up to a 90-day supply of covered maintenance type drugs purchased from a Participating Pharmacy (which may only include retail or mail order Pharmacies). Each prescription or refill is subject to the Copayment shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** and any applicable pricing differences.

Benefits will not be provided for more than a 30-day supply of drugs purchased from a Pharmacy not participating in the extended prescription drug supply program.

Prescription Refills. You may obtain prescription drug refills from any Participating 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, HMO will prorate the Copayment due for Covered Drugs based on the proportion of days the reduced Prescription Order covers to the regular day supply outlined in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**.

Refills for prescription eye drops to treat a chronic eye disease or condition will be refilled if: (1) the original Prescription Order states that additional quantities of the eye drops are needed; (2) the refill does not exceed the total quantity of dosage units authorized by the prescribing Health Care Practitioner on the original Prescription Order, including refills; and (3) 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; or
- not earlier than the 42nd day after the date a Prescription Order for a 60-day supply is dispensed; or
- not earlier than the 63rd day after the date a Prescription Order for 90-day supply is dispensed.

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
- Maximum of 12-month supply during each 12-month period

Dispensing Limits. Dispensing limits are based upon FDA dosing recommendations and nationally recognized guidelines. Coverage limits are placed on medications in certain drug categories. Limits may include: quantity of covered medication per prescription, quantity of covered medication in a given time period, coverage only for Members within a certain age range, or coverage only for Members of a specific gender. Quantities of some drugs are restricted regardless of the quantity ordered by the Health Care Practitioner. To determine if a specific drug is subject to this limitation, You may access the website at www.bcbstx.com or contact customer service at the toll-free number on Your identification card.

If You require a Prescription Order in excess of the dispensing limit established by HMO, ask Your Health Care Practitioner to submit a request for clinical review on Your behalf. The Health Care Practitioner can obtain an override request form by accessing our website at www.bcbstx.com/provider. Any pertinent medical information along with the completed form should be faxed to Clinical Pharmacy Programs at the fax number indicated on the form. The request will be approved or denied after evaluation of the submitted clinical information. HMO has the right to determine dispensing limits at its sole discretion. Payment for benefits covered by HMO may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum quantity limitation.

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. Your Copayments will be adjusted to align with the quantity of medication dispensed. If the medication is working for You and Your Physician 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, please visit the website at https://www.bcbstx.com/prescription-drugs/pharmacies/programs.

Controlled Substance Limits. In the event HMO determines that a Member may be receiving quantities of a Controlled Substance not supported by FDA approved dosages or recognized safety or treatment guidelines, any additional drugs may be subject to a review for medical necessity, appropriateness and other coverage restrictions which may include but not limited to limiting coverage to services by a certain Provider and/or Pharmacy for the prescribing and dispensing of the Controlled Substance and/or limiting coverage to certain quantities. Additional Copayment may apply.

Step Therapy. Coverage for certain prescription drugs or drug classes is subject to a Step Therapy program. Step Therapy programs favor the use of clinically acceptable alternative medications that may be less costly for You prior to those medications on the Step Therapy list of drugs being covered under HMO.

When You submit a Prescription Order to a Participating Pharmacy for one of these designated medications, the pharmacist will be alerted if the online review of Your prescription claims history indicates an acceptable alternative medication has not been previously tried. A list of Step Therapy medications is available to You and Your Health Care Practitioner on our website at https://www.bcbstx.com/prescription-drugs/managing-prescriptions/drug-lists or contact customer service at the toll-free number on Your identification card.

If it is Medically Necessary, coverage can be obtained for the prescription drugs subject to the Step Therapy program without trying an alternative medication first. In this case, Your Health Care Practitioner must contact HMO to obtain Prior Authorization for coverage of such drug. If authorization is granted, the Health Care Practitioner will be notified and the medication will then be covered at the applicable Copayment.

Although You may currently be on a drug that is part of the Step Therapy program, Your Claim may need to be reviewed to see if the criteria for coverage of further treatment has been met. A documented treatment with a generic or brand therapeutic alternative medication may be required for continued coverage of the Brand Name Drug.

Step Therapy programs do not apply to prescription drug treatment for the treatment of Stage-Four Advanced, Metastatic Cancer or Associated Conditions. Coverage for prescription drug treatment for Stage-Four Advanced, Metastatic Cancer or Associated Conditions do not require You to fail to successfully respond to a different drug or provide a history of failure of a different drug, before providing coverage of a prescription drug. This applies only to a prescription drug treatment that is consistent with best practices for the treatment of Stage-Four Advanced, Metastatic Cancer or an Associated Condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration.

In addition to the **DEFINITIONS** of this Certificate, the following definitions are applicable to this provision:

1. "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.
2. "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 health care practitioner, further jeopardize the health of a patient if left untreated.

For treatment of Serious Mental Illness for Members 18 years or older, for Covered Drugs approved by the FDA will not require that the Member:

1. fail to successfully respond to more than one different drug for each drug prescribed, excluding the generic or pharmaceutical equivalent of the prescribed drug; or
2. 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 a generic or pharmaceutical equivalent of a prescribed prescription drug as a condition of continued coverage of the prescribed drug only:

1. once in a plan year; and
2. if the generic or equivalent drug is added to the plan's Drug List.

Step Therapy Exception Requests: Your prescribing Physician or other Health Care Practitioner 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 Health Care Practitioner reasonably believe that denial of 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 also have the right to request review by an Independent Review Organization as explained in the **COMPLAINTS AND APPEAL PROCEDURE SECTION** of this Certificate of Coverage.

Prior Authorization. Coverage for certain designated prescription drugs is subject to Prior Authorization criteria. This means that in order to ensure that a drug is safe, effective, and part of a specific treatment plan, certain medications may require Prior Authorization and the evaluation of additional clinical information before dispensing. You and Your Health Care Practitioner may access a list of the medications which require Prior Authorization by accessing the website at www.bcbstx.com/member/prescription-drug-plan-information/drug-lists or contact customer service at the toll-free number on Your identification card.

When You submit a Prescription Order to a Participating Pharmacy for one of these designated medications, the pharmacist will be alerted online if Your Prescription Order is on the list of medications which require Prior Authorization before it can be filled. If this occurs, Your Health Care Practitioner will be required to submit an authorization form. This form may also be submitted by Your Health Care Practitioner in advance of the request to the Pharmacy. The Health Care Practitioner can obtain the authorization form by accessing our website at www.bcbstx.com/provider. The requested medication may be approved or denied for coverage by HMO based upon its accordance with established clinical criteria.

Prior Authorization will not be required more than once annually for Covered Drugs used to treat an autoimmune disease, hemophilia or Von Willebrand disease, except for:

1. opioids, benzodiazepines, barbiturates, or carisoprodol;
2. prescription drugs that have a typical treatment period of less than 12 months;
3. drugs that:
   a) have an FDA boxed warning for use; and
   b) must have specific provider assessment; or
4. use in a manner other than the FDA approved use.

Right of Appeal. You have the right to appeal as explained in the **COMPLAINT AND APPEAL PROCEDURES** section of this Certificate.

Limitations and Exclusions

Pharmacy benefits are not available for*:*

1. Drugs/products which are not included on the Drug List, unless specifically covered elsewhere in the Certificate of Coverage and/or such coverage is required in accordance with applicable law or regulatory guidance.
2. Non-FDA approved drugs.
3. Drugs which by law do not require a Prescription Order, except as indicated under Preventive Care in **PHARMACY BENEFITS,** from an authorized Health Care Practitioner and Legend Drugs or covered devices for which no valid Prescription Order is obtained. (Insulin, insulin analogs, insulin pens, prescriptive and nonprescriptive oral agents for controlling blood sugar levels, and select vaccinations administered through certain Participating Pharmacies shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** are covered.)
4. Prescription drugs if there is an over-the-counter product available with the same active ingredient(s) in the same strength, unless otherwise determined by HMO.
5. Drugs required by law to be labeled: "Caution - Limited by Federal Law to Investigational Use," or Experimental drugs, even though a charge is made for the drugs.
6. Drugs, that the use or intended use of would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.
7. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the identification card.
8. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction that is not covered under HMO, or for which benefits have been exhausted.
9. Drugs injected, ingested, or applied in a Physician's office or during confinement while a patient in a Hospital, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.
10. Drugs for which the Pharmacy's usual retail price to the general public is less than or equal to the Copayment.
11. Drugs purchased from a non-Participating Pharmacy in the Service Area, except as provided in the **Clinician-Administered Drugs** section in **COVERED SERVICES AND BENEFITS**.
12. Devices, Technologies, and/or Durable Medical Equipment (DME) such as but not limited to therapeutic devices including support garments and other non-medicinal substances, digital health technologies and/or applications, even though such devices may require a Prescription Order. (Disposable hypodermic needles, syringes for self-administered injections and contraceptive devices are covered). However, You do have certain DME benefits available under the **Durable Medical Equipment** section in **COVERED SERVICES AND BENEFITS.** Coverage for female contraceptive devices and the rental (or, at HMO's option the purchase) of manual or electric breast pumps is provided as indicated under the **Health Maintenance and Preventives Services** section in **COVERED SERVICES AND BENEFITS.**
13. Pharmaceutical aids such as excipients found in the USP-NF (United States Pharmacopeia - National Formulary), including but not limited to preservatives, solvents, ointment bases, and flavoring, coloring, diluting, emulsifying, and suspending agents.
14. Any special services provided by a Pharmacy, including but not limited to counseling and delivery. Select vaccinations shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** administered through certain Participating Pharmacies are an exception to this exclusion.
15. Drugs dispensed in quantities in excess of the day supply amounts indicated in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** or refills of any prescriptions in excess of the number of refills specified by the authorized Health Care Practitioner or by law, or any drugs or medicines dispensed more than one (1) year after the Prescription Order date.
16. Administration or injection of any drugs.

17. Injectable drugs except self-administered Specialty Drugs or those approved by the FDA for self-administration.
18. 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.)
19. Fluids, solutions, nutrients or medications (including all additives and chemotherapy) used or intended to be used by intravenous or intramuscular injection (unless approved by the FDA for self-administration), intrathecal, intraarticular injection or gastrointestinal (enteral) infusion in the home setting.
20. 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**).
21. Allergy serum and allergy testing materials. However, You do have certain benefits available under **Allergy Care** in **COVERED SERVICES AND BENEFITS**.
22. Athletic performance enhancement drugs.
23. 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.
24. Any prescription antiseptic or fluoride mouthwashes, mouth rinses or topical oral solutions or preparations.
25. Fluoride supplements except as required by law.
26. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
27. Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss or dietary control.
28. Drugs to treat sexual dysfunction including but not limited to sildenafil citrate, phentolamine, apomorphine, and alprostadil in oral and topical form.
29. Drugs for the treatment of Infertility (oral and injectable).
30. Prescription Orders which do not meet the required Step Therapy criteria.
31. Prescription Orders which do not meet the required Prior Authorization criteria.
32. Some therapeutic equivalents are manufactured under multiple names. In some cases, HMO may limit benefits to only one of the therapeutic equivalents available. If You do not accept the therapeutic equivalents that are covered under this Certificate, the drug purchased will not be covered under any benefit level.
33. Replacement of drugs or other items that have been lost, stolen, destroyed or misplaced.
34. Shipping, handling or delivery charges.
35. Certain drug classes where there is an over-the-counter alternative available.
36. Prescription Orders written by a member of Your immediate family, or a self-prescribed Prescription Order
37. Institutional packs and drugs which are repackaged by anyone other than the original manufacturer.
38. Drugs determined by HMO to have inferior efficacy or significant safety issues.
39. Bulk powders.
40. Diagnostic agents. This exclusion does not apply to diabetic test strips.
41. Self-administered drugs dispensed or administered by a Physician in their office.
42. Drugs that are not considered Medically Necessary or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines.
43. Some drugs have therapeutic equivalents/therapeutic alternatives. In some cases, HMO may limit benefits

to only certain therapeutic equivalents/therapeutic alternatives. If You do not choose the therapeutic equivalents/therapeutic alternatives that are covered under Your benefit, the drug purchased will not be covered under any Benefit level.

44. Certain prescription drugs administered by a health care professional may not be covered under the medical benefit, including those newly approved by the FDA, those approved through the FDA's accelerated approval program, or if there is a self-administered formulation of the drug available. For additional information, see the "Medical Drug Benefit Program" provision.

Termination of Coverage

Group is liable for Premium payments from the time You cease to be eligible for coverage until the end of the Contract Month in which Group notifies HMO that You are no longer covered by the Group and are not eligible for coverage. Group is required to provide coverage for You until the end of the Contract Month in which the termination notice or other such notice, if any, permitted by applicable law or regulatory guidance, is received by HMO.

Subject to the preceding paragraph, coverage of any Member who ceases to be eligible as determined in **WHO GETS BENEFITS; Eligibility,** will terminate on the last day of the Contract Month in which Group notifies HMO that the Member is no longer eligible for coverage and eligibility ceases unless otherwise specified and agreed upon by the Group and HMO. This paragraph also applies to a Dependent of Subscriber who has lost eligibility, for whatever reason, including the death of Subscriber.

If this Certificate is terminated for nonpayment of Premium, Your coverage shall be terminated effective after the last day of the Grace Period. Only Members for whom the stipulated payment is actually received by HMO shall be entitled to health services covered hereunder and then only for the Contract Month for which such payment is received. If any required payment is not received by the Premium due date, then You shall be terminated at the end of the Grace Period. You shall be responsible for the cost of services rendered to You during the Grace Period in the event Premium payments are not made by Group.

Your coverage is terminated upon the termination of the Group Agreement. The fact that Group does not notify You of the termination of Your coverage due to the termination of the Group Agreement shall not deem continuation of Your coverage beyond the date coverage terminates.

If Your coverage is terminated, Premium payments received on Your account applicable to periods after the effective date of termination shall be refunded to Group within thirty (30) days, and neither HMO nor Participating Providers shall have any further liability under this Certificate. Any claims for refunds by Group must be made within sixty (60) days from the effective day of termination of Your coverage or otherwise such claims shall be deemed waived.

Except as expressly provided below and elsewhere in this Certificate and subject to the provisions of **COBRA Continuation Coverage, State Continuation Coverage, or Transfer of Residence**, HMO may terminate coverage for Group upon sixty (60) days prior written notice.

Group Termination. HMO may terminate this Certificate for Group in the case of:

Cause	Effective Date of Termination
(1) Nonpayment of Premium	At the end of the Grace Period
(2) Fraud or intentional misrepresentation of a material fact on the part of Group	After fifteen (15) days written notice
(3) Non-compliance by Group with a material HMO provision relating to any employer contribution or Group participation rules	In accordance with applicable state law
(4) No Member residing or working in the Service Area	After thirty (30) days written notice
(5) Termination of membership of Group in an association, but only if coverage is terminated uniformly without regard to a health status related factor of a covered individual	After thirty (30) days written notice

Renewal of Group Coverage. HMO will renew this Certificate with Group unless Group was terminated under Termination of Coverage; Group Termination.

Non-Renewal of All Group Coverage

- HMO may not renew this Certificate if HMO elects to not renew all HMO contracts issued to other large or small employers, as applicable, in the Service Area. HMO must notify Group of such non-renewal at least one hundred eighty (180) days before the date on which coverage terminates for Group.
- HMO may elect to discontinue a particular type of coverage for all large or small employers only if notice is provided to each large or small employer, as applicable at least ninety (90) days before the date on which coverage terminates for Group. HMO must offer each employer the option to purchase other coverage offered at the time of discontinuation.

Member Termination. HMO may terminate this Certificate for a Member in the case of:

Cause	Effective Date of Termination
(1) Fraud or intentional misrepresentation of a material fact, except as described in **Incontestability** of this Certificate	After fifteen (15) days written notice
(2) Fraud in the use of services or facilities	After fifteen (15) days written notice
(3) Failure to meet eligibility requirements	Immediately, subject to **Continuation Coverage, State Continuation Coverage** or **Transfer of Residence** of this Certificate

Renewal of Member Coverage. HMO will renew Your Certificate unless You were terminated under **Termination of Coverage; Member Termination**.

COBRA Continuation Coverage

COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985 as modified by the Tax Reform Act of 1986. This Act permits You or covered Dependents to elect to continue Your Group coverage as follows:

Employees and their covered Dependents will not be eligible for the continuation of coverage provided by this section if the Group is exempt from the provisions of COBRA; however, they may be eligible for continuation of coverage as provided by **State Continuation Coverage** of this Certificate.

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 employees employed; not the number of employees covered by a Health Benefit Plan, and includes full-time and part-time employees.

Loss of Coverage. For loss of coverage due to termination (other than for gross misconduct) or reduction of hours of employment, You may elect to continue coverage for eighteen (18) months after eligibility for coverage under this Certificate would otherwise cease.

You may elect to continue coverage for thirty-six (36) months after eligibility for coverage under this Certificate would otherwise cease if coverage terminates as the result of:

- divorce;
- Subscriber's death;
- Subscriber's entitlement to Medicare benefits; or
- cessation of covered Dependent child status under **WHO GETS BENEFITS; Eligibility** of this Certificate.

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

- the last day of the continued coverage whether eighteenth (18) month or thirty-sixth (36) month period;
- the first day on which timely payment of Premium is not made subject to the Premium section of the Group Agreement;
- the first day on which the Group Agreement between Group and HMO is not in full force and effect;
- the first day on which You are actually covered by any other group Health Benefit Plan. In the event You have a preexisting condition and would be denied coverage under the new Health Benefit Plan for a preexisting condition, continuation coverage will not be terminated until the last day of the continuation

period, or the date upon which the preexisting condition becomes covered under the new Health Benefit Plan, whichever occurs first; or
- the date You are entitled to Medicare.

Extensions of Coverage Periods. The eighteen (18) month coverage period may be extended if an event which would otherwise qualify You 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 event which qualified You for continuation coverage initially.

In the event You are determined, within the meaning of the Social Security Act, to be disabled and You notify the Group before the end of the initial eighteen (18) month period, continuation coverage may be extended up to an additional eleven (11) months for a total of twenty-nine (29) months. This provision is limited to Members who are disabled at any time during the first sixty (60) days of continuation coverage under **COBRA Continuation Coverage** of this Certificate and only when the qualifying event is Member's reduction in hours or termination. You may be charged a higher rate for the extended period.

Responsibility to Provide Member with Notice of Continuation Rights. The Group is responsible for providing the necessary notification to Members, within sixty (60) days from the date of the COBRA qualifying event, as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986.

Responsibility to Pay Premiums to HMO. Coverage for the sixty (60) day period as described above to initially enroll will be extended only where Subscriber or You pay the applicable Premium charges due within forty-five (45) days of submitting the application to the Group and Group in turn remitting same to HMO.

Premiums due HMO for the continuation of coverage under this section shall be due in accordance with the procedures of the Premium section of the Group Agreement and shall be calculated in accordance with applicable federal law and regulations.

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

State Continuation Coverage

Continuation Privilege for Certain Dependents. A covered Dependent who has been a Member of HMO for at least one year or who is an infant under one year of age may be eligible to continue coverage under this Certificate if coverage would otherwise terminate because of:

- the death of Subscriber;
- the retirement of Subscriber; or
- divorce.

You must give written notice to Group within fifteen (15) days of the occurrence of any of the above to activate this continuation of coverage option. Upon receiving this written notice, Group will send You the forms that should be used to enroll for this continuation of coverage. If You do not submit this completed enrollment form to Group within sixty (60) days of the occurrence of any of the above, You will lose the right to this continuation of coverage under this section. Coverage remains in effect during this sixty (60) day period, provided any applicable Premiums and administrative charges are paid.

Continuation of coverage under this section will terminate on the earliest to occur of:

- the end of the three (3) year period after the date of Subscriber's death or retirement;
- the end of the three (3) year period after the date of the divorce or legal separation;
- the date You become eligible for similar coverage under any substantially similar coverage under another health insurance policy, Hospital or medical service Subscriber contract, medical practice or other prepayment Health Benefit Plan, or by any other program; or
- the end of the period for which You have paid any applicable Premiums.

Continuation of Group Coverage Privilege. In the event Your coverage has been terminated for any reason except: (i) involuntary termination for cause, or (ii) discontinuance of the Group Agreement, either in its entirety or with respect to an insured class, You shall be entitled to continuation of Group coverage if You have been continuously insured under the Certificate or under any group policy providing similar benefits which it replaces for at least three (3) consecutive months immediately prior to the termination.

You must request continuation of Group coverage, in writing, to the Group or HMO within sixty (60) days following the later of the date the Group coverage would otherwise terminate or the date You are given notice by the Group. Your first monthly Premium required to establish continuation coverage must be given to the Group within forty-five (45) days of the initial election of continuation coverage. All subsequent payments must be made no later than thirty (30) days after the payment due date.

Continuation of coverage under this section will terminate on the earliest to occur of:

- the date on which You exhaust the maximum continuation period which is:
  - if You are not eligible for COBRA continuation coverage, nine months after the date of state continuation coverage;
  - if You are covered under COBRA continuation coverage, six additional months following any period of COBRA continuation coverage;
- the date on which failure to make timely payments would terminate coverage;
- the date on which the Group coverage terminates in its entirety; or
- the date on which You are covered for similar benefits by another Hospital, surgical, medical, or major medical expense insurance policy or Hospital or medical service Subscriber contract or medical practice or other prepayment Health Benefit Plan or any other program.

Transfer of Residence

- **Within the HMO Service Area**: If Subscriber changes primary residence, notification must be made to HMO within thirty (30) days of such change.
- **Outside the HMO Service Area**: If Subscriber no longer resides, lives or works in the Service Area, such change will result in loss of eligibility and Subscriber must notify HMO within thirty (30) days of such change.

Coordination of Benefits

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

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

Allowable Expense means a health care expense, including Deductibles, Coinsurance, and Copayments, that is covered at least in part by any Health Care Plan covering the person for whom claim is made. When a Health Care Plan (including this Health Care Plan) provides benefits in the form of services, the reasonable cash value of each service rendered is considered to be both an Allowable Expense and a benefit paid. An expense that is not covered by any plan covering the person is not an Allowable Expense. In addition, any expense that a health care Provider or Physician by law or in accord with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

1. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable Expense, unless one of the plans provides coverage for private Hospital room expenses.
2. If a person is covered by two or more plans that do not have negotiated fees and compute their benefit payments based on the usual and customary fees, Allowed Amounts, or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
3. If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. If a person is covered by one plan that does not have negotiated fees and that calculates its benefits or services based on usual and customary fees, Allowed Amounts, relative value schedule reimbursement

methodology, or other similar reimbursement methodology, and another plan that provides its benefits or services based on negotiated fees, the primary plan's payment arrangement must be the Allowable Expense for all plans. However, if the health care Provider or Physician has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the health care Provider's or Physician's contract permits, the negotiated fee or payment must be the Allowable Expense used by the secondary plan to determine its benefits.

5. The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, Prior Authorization of admissions, and preferred health care Provider and Physician arrangements.

Allowed Amount means the amount of a billed charge that a carrier determines to be covered for services provided by a nonpreferred health care Provider or Physician. The Allowed Amount includes both the carrier's payment and any applicable Copayments for which the insured is responsible.

Closed Panel Health Care Plan means a plan that provides health care benefits to covered persons primarily in the form of services through a panel of health care Providers and Physicians that have contracted with or are employed by the Health Care Plan, and that excludes coverage for services provided by other health care Providers and Physicians, except in cases of emergency or referral by a panel member.

Custodial Parent means the parent with the right to designate the primary residence of a child by a court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the Calendar Year, excluding any temporary visitation.

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

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

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

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

This **Health Care Plan** means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

The order of benefit determination rules determine whether this Health Care Plan is a primary plan or secondary plan when the person has health care coverage under more than one plan. When this Health Care Plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this Health Care Plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits equal 100 percent of the total Allowable Expense.

HMO has the right to coordinate benefits between this Health Care Plan and any other Health Care Plan covering You.

When a person is covered by two or more plans, the rules establishing the order of benefit determination between this Certificate and any other Health Care Plan covering You on whose behalf a claim is made are as follows:

1. the benefits of a Health Care Plan that does not have a Coordination of Benefits provision shall in all cases be determined before the benefits of this Certificate unless the provisions of both Health Care Plans state that the complying Health Care Plan is primary.
2. if according to the rules set forth below in this section the benefits of another Health Care Plan that contains a provision coordinating its benefits with this Health Care Plan would be determined before the benefits of this Health Care Plan have been determined, the benefits of the other Health Care Plan will be considered before the determination of benefits under this Health Care Plan.
3. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage must be excess to any other parts of the Health Care Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Health Care Plan to provide out-of-network benefits.
4. A Health Care Plan may consider the benefits paid or provided by another Health Care Plan in calculating payment of its benefits only when it is secondary to that other Health Care Plan.
5. If the primary Health Care Plan is a Closed Panel Health Care Plan and the secondary Health Care Plan is not, the secondary Health Care Plan must pay or provide benefits as if it were the primary Health Care Plan when a covered person uses a noncontracted health care Provider or Physician, except for emergency services or authorized referrals that are paid or provided by the primary Health Care Plan.
6. When multiple contracts providing coordinated coverage are treated as a single Health Care Plan under this subchapter, this section applies only to the Health Care Plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the Health Care Plan, the carrier designated as primary within the Health Care Plan must be responsible for the Health Care Plan's compliance with this subchapter.
7. If a person is covered by more than one secondary Health Care Plan, the order of benefit determination rules below of this subchapter decide the order in which secondary Health Care Plans' benefits are determined in relation to each other. Each secondary Health Care Plan must take into consideration the benefits of the primary Health Care Plan or Health Care Plans and the benefits of any other Health Care Plan that, under the rules of this contract, has its benefits determined before those of that secondary Health Care Plan.

The order of benefits for Your claim relating to **paragraphs 1 through 7** above, is determined using the first of the following rules that applies:

1. Nondependent or Dependent. The Health Care Plan that covers the person other than as a Dependent, for example as an employee, Member, policyholder, Subscriber, or retiree, is the primary plan, and the Health Care Plan that covers the person as a Dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Health Care Plan covering the person as a Dependent and primary to the Health Care Plan covering the person as other than a Dependent, then the order of benefits between the two plans is reversed so that the Health Care Plan covering the person as an employee, Member, policyholder, Subscriber, or retiree is the secondary plan and the other Health Care Plan is the primary plan. An example includes a retired employee.
2. Dependent Child Covered Under More Than One Health Care Plan. Unless there is a court order stating otherwise, Health Care Plans covering a Dependent child must determine the order of benefits using the following rules that apply.
    a. for a Dependent child whose parents are married or are living together, whether or not they have ever been married:
        1. the Health Care Plan of the parent whose birthday falls earlier in the Calendar Year is the primary plan; or
        2. if both parents have the same birthday, the Health Care Plan that has covered the parent the longest is the primary plan.
    b. for a Dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:
        1. if a court order states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Health Care Plan of that parent has actual knowledge of those terms, that Health Care Plan is primary. This rule applies to plan years commencing after the Health Care Plan is given notice of the court decree.
        2. if a court order states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of **2.a**. must determine the order of benefits.
        3. if a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of **2.a**. must determine the order of benefits.
        4. if there is no court order allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
            - the Health Care Plan covering the Custodial Parent;
            - the Health Care Plan covering the spouse of the Custodial Parent;
            - the Health Care Plan covering the non-Custodial Parent; then
            - the Health Care Plan covering the spouse of the non-Custodial Parent.
    c. for a Dependent child covered under more than one Health Care Plan of individuals who are not the parents of the child, the provisions of **2.a or 2.b**. must determine the order of benefits as if those individuals were the parents of the child.
    d. for a Dependent child who has coverage under either or both parents' Health Care Plans and has their own coverage as a Dependent under a spouse's Health Care Plan, **paragraph 5**. below applies.
    e. in the event the Dependent child's coverage under the spouse's Health Care Plan began on the same date as the Dependent child's coverage under either or both parents' Health Care Plans, the order of benefits must be determined by applying the birthday rule in **2.a**. to the Dependent child's parent(s) and the Dependent's spouse.
3. Active, Retired, or Laid-off Employee. The Health Care Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The Health Care Plan that covers that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a

person is a Dependent of an active employee and that same person is a Dependent of a retired or laid-off employee. If the Health Care Plan that covers the same person as a retired or laid-off employee or as a Dependent of a retired or laid-off employee does not have this rule, and as a result, the Health Care Plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if **paragraph 1.** above can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another Health Care Plan, the Health Care Plan covering the person as an employee, member, Subscriber, or retiree or covering the person as a Dependent of an employee, member, Subscriber, or retiree is the primary plan, and the COBRA, state, or other federal continuation coverage is the secondary plan. If the other Health Care Plan does not have this rule, and as a result, the Health Care Plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if **paragraph 1.** above can determine the order of benefits.
5. Longer or Shorter Length of Coverage. The Health Care Plan that has covered the person as an employee, Member, policyholder, Subscriber, or retiree longer is the primary plan, and the Health Care Plan that has covered the person the shorter period is the secondary plan.
6. If the preceding rules do not determine the order of benefits, the Allowable Expenses must be shared equally between the Health Care Plans meeting the definition of Health Care Plan. In addition, this Health Care Plan will not pay more than it would have paid had it been the primary plan.

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

If a covered person is enrolled in two or more Closed Panel Health Care Plans and if, for any reason, including the provision of service by a nonpanel Provider, benefits are not payable by one Closed Panel Health Care Plan, COB must not apply between that Health Care Plan and other Closed Panel Health Care Plans.

If inpatient care began when You were enrolled in a previous Health Care Plan, after You make Your Copayment under this Certificate, HMO will pay the difference between benefits under this Certificate and benefits under the previous contract or insurance policy for services on or after the effective date of this Certificate.

Benefits provided directly through a specified Provider of an employer shall in all cases be provided before the benefits of this Certificate.

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

None of the above rules as to Coordination of Benefits shall delay Your health services covered under this Certificate.

Whenever payments have been made by HMO with respect to Allowable Expenses in a total amount, at any time, in excess of 100% of the amount of payment necessary at that time to satisfy the intent of this Part, HMO shall have the right to recover such payment, to the extent of such excess, from among one or more of the following as HMO shall determine: any insurance company or companies; or any Physician or Provider to which such payments were made.

A payment made under another Health Care Plan may include an amount that should have been paid under this Health Care Plan. If it does, HMO 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 Health Care Plan. HMO will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

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

Reimbursement - Acts of Third Parties

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

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

Actuarial Value

The use of a metallic name, such as Platinum, Gold, Silver or Bronze, or other statements with respect to a Health Benefit Plan's actuarial value, is not an indicator of the actual amount of expenses that a particular person will be responsible to pay out of their own pocket. A person's out of pocket expenses will vary depending on many factors, such as the particular health care services, health care Providers and particular benefit plan chosen. Please note that metallic names reflect only an approximation of the actuarial value of a particular benefit plan.

Assignment

This Certificate is not assignable by Group without the written consent of HMO. The coverage and any benefits under this Certificate are not assignable by any Member without the written consent of HMO.

Cancellation

Except as otherwise provided herein, HMO shall not have the right to cancel or terminate any Certificate issued to any Subscriber while the Group Agreement remains in force and effect, and while said Subscriber remains in the eligible class of employees of Group, and Premiums are paid in accordance with the terms of this Certificate.

Clerical Error

Clerical error, of Group or HMO in keeping any records pertaining to the coverage hereunder will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

Entire Certificate

This Certificate, any attachments, amendments, the Group Agreement, and the individual applications, if any, of Subscribers constitute the entire contract between the parties and as of the effective date hereof, supersede all other contracts between the parties.

Force Majeure

In the event that due to circumstances not within the commercially reasonable control of HMO, the rendering of professional or Hospital Services provided under this Certificate is delayed or rendered impractical, HMO shall make a good faith effort to arrange for an alternative method of providing coverage. These circumstances may include, but are not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of the Participating Providers' personnel or similar causes. In such event, Participating Providers shall render the Hospital and Professional Services provided for under the Certificate in so far as practical, and according to their best judgment; but HMO and Participating Providers shall incur no liability

or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Form or Content of Certificate

No agent or employee of HMO is authorized to change the form or content of this Certificate except to make necessary and proper insertions in blank spaces. Changes can be made only through endorsement authorized and signed by an officer of HMO. No agent or other person, except an authorized officer of HMO, has authority to waive any conditions or restrictions of this Certificate, to extend the time for making a payment, or to bind HMO by making any promise or representation or by giving or receiving any information.

Gender

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

Identity Theft Protection

As a Member, 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 Member. Members who wish to accept such identity theft protection services will need to individually enroll in the program online at www.bcbstx.com or telephonically by calling the phone number on the back of Your identification card. Services may automatically end when the person is no longer an eligible Member. 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.

Incontestability

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

Interpretation of Certificate

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

Limitation of Liability

Liability for any errors or omissions by HMO (or its officers, directors, employees, agents, or independent contractors) in the administration of this Certificate, or in the performance of any duty of responsibility contemplated by this Certificate, shall be limited to the maximum benefits, which should have been paid under the Certificate had the errors or omissions not occurred, unless any such errors or omissions are adjudged to be the result of willful misconduct or gross negligence of HMO.

Member Data Sharing

You may, under certain circumstances, as specified below, apply for and obtain, subject to any applicable terms and conditions, replacement coverage. The replacement coverage will be that which is offered by Blue Cross and Blue Shield of Texas, a division of Health Care Service Corporation, or, if You do not reside in the Blue Cross and Blue Shield of Texas Service Area, by the Host Blues whose Service Area covers the geographic area in which You

reside. The circumstances mentioned above may arise in various circumstances, such as from involuntary termination of Your health coverage sponsored by the Group/Employer. As part of the overall plan of benefits that Blue Cross and Blue Shield of Texas offers to, You, if You do not reside in the Blue Cross and Blue Shield of Texas Service Area, Blue Cross and Blue Shield of Texas may facilitate Your right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Host Blue in which You reside. To do this we may: (1) communicate directly with You and/or (2) provide the Host Blues whose Service Area covers the geographic area in which You reside, with Your personal information and may also provide other general information relating to Your coverage under the Certificate the Group/Employer has with Blue Cross and Blue Shield of Texas to the extent reasonably necessary to enable the relevant Host Blues to offer You coverage continuity through replacement coverage.

Wellbeing and Prevention Member Rewards

The Plan may offer well-being, wellness, or prevention programs to help support your health and wellbeing. These programs may include activities such as, but not limited to, health screenings, preventive services, wellness coaching, self-guided educational content or condition management programs. The purpose of these programs is to encourage healthy behaviors and improve overall health outcomes.

These programs are optional and may be offered by the Plan or by a vendor we choose.

To receive an incentive, you must:

- Enroll in a program, if enrollment is required;
- Complete the required activities or program steps; and
- Submit any required information or verification using the method we specify or that the vendor provides (for example, an online tool, mobile-app or other approved process)

Participation in any program or acceptance of any related incentive is voluntary. You are not required to participate to maintain your coverage.

If you take part in a program, you may be eligible for incentives, such as:

- Merchandise
- Coupons
- Points or credits to exchange for gift cards or debit cards
- A mix of these incentives

There is no additional charge for participating in these programs or for receiving incentives.

At times, the Plan may also offer discounts or incentives for health-related, wellness-related, or insurance-related items or services.

Rewards or incentives are not based on your health status. If a medical condition makes it unreasonably difficult for you to participate and satisfy applicable wellness program standards, we will offer a reasonable alternative when required by law. You will not lose access to an incentive based on your health status.

Limitations:

- Incentives are only available for programs and activities we designate
- Incentive types and amounts may change
- Incentives are not guaranteed and depend on completion of program requirements
- Availability may vary by plan and by employer selection

If a vendor provides part of this benefit and fails to provide or continue it, you may contact us directly. We will provide access to the benefit or a comparable alternative, where available.

These programs and related incentives may end if:

- We discontinue the program;
- You are no longer eligible for coverage:
- You do not follow the program requirements; or

- You stop participating in the program.

If we decide to discontinue a program, we will provide at least 60 days' advance notice.

If you have questions about these programs, call Customer Service or visit our website at www.bcbstx.com.

Modifications

This Certificate shall be subject to amendment, modification, and termination in accordance with any provision hereof or by mutual agreement between HMO and Group without the consent or concurrence of Members. By electing medical and Hospital coverage under HMO or accepting HMO benefits, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, and provisions hereof.

Notice

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

HMO, or Group by agreement between HMO and Group, may send You notices under this Certificate. These notices may be delivered:

- through the United States Postal Service at the last address known to HMO; or
- electronically, if permitted by applicable law.

Paper Check – Automatic Clearing House/Electronic Funds Transfer

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.

In addition to the **DEFINITIONS** of this Certificate, the following definition is applicable to this provision:

- "**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.

Patient/Provider Relationship

Participating Providers maintain a Provider-patient relationship with Members and are solely responsible to You for all health services. If a Participating Provider cannot establish a satisfactory Provider-patient relationship, the Participating Provider may send a written request to HMO to terminate the Provider-patient relationship, and this request may be applicable to other Providers in the same group practice, if applicable.

Refund of Benefit Payments

If Your Group's benefit plan or BCBSTX pays benefits for Covered Services incurred by You or Your Dependents and it is found that the payment was more than it should have been, or was made in error ("Overpayment"), Your Group's Plan and BCBSTX have the right to obtain a refund of the Overpayment from: (i) any insurance company or plan, or (ii) any other persons, entities or organizations, including, but not limited to, Participating Providers or non-Participating Providers to which such payments were made.

If no refund is received, Your Group's benefit plan and/or BCBSTX (in its capacity as HMO, insurer, or administrator) have the right to deduct any refund for any Overpayment due, up to an amount equal to the Overpayment, from:

a. any future benefit payment made to any person or entity under this Certificate, whether for the same or a different Member; or

b. any future benefit payment made to any person or entity under another BCBSTX-administered ASO benefit program and/or BCBSTX-administered insured benefit program or policy; or

c. any future benefit payment made to any person or entity under another BCBSTX-insured group benefit plan or individual policy; or

d. any future benefit payment, or other payment, made to any person or entity; or

e. any future payment owed to one or more Participating Providers or non-Participating Providers.

Further, BCBSTX has the right to reduce Your benefit plan's or policy's payment to a Provider by the amount necessary to recover another BCBSTX plan's or policy's overpayment to the same Provider and to remit the recovered amount to the other BCBSTX plan or policy.

Relationship of Parties

The relationship between HMO and Participating Providers is that of an independent contractor relationship. Participating Providers are not agents or employees of HMO; HMO or any employee of HMO is not an employee or agent of Participating Providers. HMO shall not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by You while receiving care from any Participating Provider. HMO makes no express or implied warranties or representations concerning the qualifications, continued participation, or quality of services of any Physician, Hospital or other Participating Provider.

Reports and Records

HMO is entitled to receive from any Provider of services to Members, information reasonably necessary to administer this Certificate subject to all applicable confidentiality requirements described below. By accepting coverage under this Certificate, the Subscriber, for himself or herself, and for all Dependents covered hereunder, authorizes each and every Provider who renders services to You hereunder to:

- disclose all facts pertaining to Your care, treatment and physical condition to HMO, or a medical, dental, or mental health professional that HMO may engage to assist it in reviewing a treatment or claim;
- render reports pertaining to Your care, treatment and physical condition to HMO, or a medical, dental, or mental health professional that HMO may engage to assist it in reviewing a treatment or claim; and
- permit copying of Your records by HMO.

Information contained in Your medical records and information received from Physicians, surgeons, Hospitals or other Health Care Professionals incident to the Physician-patient relationship or Hospital-patient relationship shall be kept confidential in accordance with applicable law.

Rescission

Rescission is the retroactive cancellation or discontinuance of coverage due to an act, practice, or omission that constitutes fraud or an intentional misrepresentation of a material fact by You or by a person seeking coverage on Your behalf. A retroactive cancellation or discontinuance of coverage due to failure to timely pay required Premiums or contributions toward the cost of coverage (including COBRA Premiums), a cancellation or discontinuance initiated by You or Your authorized representative, a cancellation initiated by the Exchange, or a prospective cancellation or discontinuance of coverage is not considered a Rescission. Rescission is subject to 30 days' prior notification and is retroactive to the Effective Date. In the event of such cancellation, BCBSTX may deduct from the Premium refund any amounts made in claim payments during this period and You may be liable for any claims payment amount greater than the total amount of Premiums paid during the period for which cancellation is affected. At any time when BCBSTX is entitled to rescind coverage already in force or is otherwise permitted to make retroactive changes to this Certificate of Coverage, BCBSTX may at its option make an offer to reform the Certificate of Coverage already in force and/or change the rating category/level. In the event of reformation, the Certificate of Coverage will be reissued retroactive in the form it would have been issued had the misstated or omitted information been known at the time of application. Please call BCBSTX at the toll-free number listed on the back of Your identification card for additional information regarding Your appeal rights concerning Rescission and/or reformation. If the decision to rescind coverage is upheld at the completion of the internal appeal process, external review by an Independent Review Organization may be requested.

Subtitles

The subtitles included within this Certificate are provided for the purpose of identification and convenience and are not part of the complete Certificate as described in **Entire Certificate.**

PEDIATRIC VISION CARE BENEFITS

PEDIATRIC VISION CARE BENEFITS

Pediatric Vision Care is made part of and is in addition to any information You may have in Your HMO Certificate. Information about coverage for the routine vision care services are outlined below and are specifically excluded under Your medical health care plan. (Services that are covered under Your medical plan are not covered under this *Pediatric Vision Care Benefit*.) All provisions in the Certificate apply to *Pediatric Vision Care Benefits* unless specifically indicated otherwise below.

Definitions

Eye Care Expenses – *For purposes of this Pediatric Vision Care Benefit* - Expenses related to vision or medical eye care services, procedures, or products.

Medically Necessary Contact Lenses– Contact lenses may be determined to be Medically Necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be Medically Necessary in the treatment of the following conditions: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism.

Provider – For purposes of this *Pediatric Vision Care Benefit,* a licensed optometrist, ophthalmologist or therapeutic optometrist operating within the scope of their license, or a dispensing optician.

Vision Materials – Corrective lenses and/or frames or contact lenses.

Eligibility

Children who are covered under Your Certificate, to age 19, are eligible for coverage under this *Pediatric Vision Care Benefit.* NOTE: Once coverage is lost under Your Certificate, all benefits cease under this *Pediatric Vision Care Benefit.*

Limitations and Exclusions

The limitations and exclusions in this section apply to all pediatric vision benefits. Although HMO may list a specific service as a benefit, HMO will not cover it unless we determine it is necessary for the prevention, diagnosis, care or treatment of a covered condition.

We do not cover the following:

- any vision service, treatment or materials not specifically listed as a covered service;
- services and materials that are Experimental/Investigational;
- services and materials that are rendered prior to Your effective date;
- services and materials incurred after the termination date of Your coverage unless otherwise indicated;
- services and materials not meeting accepted standards of optometric practice;
- services and materials resulting from Your failure to comply with professionally prescribed treatment;
- telephone consultations;
- any charges for failure to keep a scheduled appointment;
- any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of Prosthetic Appliances;
- office infection control charges;
- charges for copies of Your records, charts, or any costs associated with forwarding/mailing copies of Your records or charts;
- state or territorial taxes on vision services performed;
- medical treatment of eye disease or injury;
- visual therapy;
- special lens designs or coatings other than those described in this benefit;
- replacement of lost/stolen eyewear;
- non-prescription (Plano) lenses;
- non-prescription sunglasses;
- two pairs of eyeglasses in lieu of bifocals;
- services not performed by licensed personnel;
- prosthetic devices and services;
- insurance of contact lenses;

- Professional Services You receive from immediate relatives or household members, such as a spouse, parent, child, brother or sister, by blood, marriage or adoption;
- orthoptic or vision training;
- aniseikonic spectacle lenses.

How the Vision Benefits Work

You may visit any Participating Provider and receive benefits for a vision examination and covered Vision Materials.

Before You go to a Participating Provider for an eye examination, eyeglasses, or contact lenses, please call ahead for an appointment. When You arrive, show the receptionist Your identification card. If You forget to take Your card, be sure to say that You are a Member of the HMO vision care plan so that Your eligibility can be verified.

For the most current list of Participating Providers visit the website at www.bcbstx.com. You may also refer to Your Provider directory or call customer service at the toll-free telephone number on the back of Your identification card.

You may receive Your eye examination and eyeglasses/contacts on different dates or through different Provider locations, if desired. However, complete eyeglasses must be obtained at one time, from one Participating Provider. Continuity of care will best be maintained when all available services are obtained at one time from one Participating Provider and there may be additional professional charges if You seek contact lenses from a Participating Provider other than the one who performed Your eye examination.

Fees charged for services other than a covered vision examination or covered Vision Materials and amounts in excess of those payable under this *Pediatric Vision Care Benefit,* must be paid in full by You to the Provider, whether or not the Provider participates in the vision care plan. These *Pediatric Vision Care Benefits* may not be combined with any discount, promotional offering, or other group benefit plans. Allowances are one-time use benefits; no remaining balances are carried over to be used later.

Coordination of Benefits

If You are covered by at least two different benefit plans that provide benefits for Eye Care Expenses and each plan provides coverage for the same vision or medical eye care services, procedures or products:

- The issuer of the primary Health Benefit Plan or vision benefit plan, as described in the **COORDINATION OF BENEFITS** section of this Certificate of Coverage, is responsible for Eye Care Expenses covered under the plan up to the full amount of any plan coverage limit applicable to the covered Eye Care Expenses.
- Before the plan coverage limit described above is reached, the issuer of a secondary Health Benefit Plan or vision benefit plan is responsible only for Eye Care Expenses covered under the plan that are not covered under the Health Benefit Plan or vision benefit plan issued by the primary plan issuer.
- After the plan coverage limit described above has been reached, the secondary plan issuer, in addition to the responsibilities for services not covered by the primary plan but covered by the secondary plan, is responsible for any Eye Care Expenses covered by both plans that exceed the plan coverage limit of the primary plan, up to the coverage limit of the secondary plan.
- When an You are covered by more than one Health Benefit Plan or vision benefit plan that provides benefits for Eye Care Expenses, You may use each plan on the same date of service up to the coverage limit of each plan.
- A vision benefit plan issuer shall coordinate benefits with a Health Benefit Plan issuer if both provide benefits for Eye Care Expenses.
- A vision benefit plan issuer may not require a claim denial before adjudicating a claim up to the coverage limit of the plan.
- Nothing in this section prevents a secondary plan issuer from requiring proof that a related claim has been submitted to a primary plan issuer for purposes of determining the remaining balance up to the secondary plan's coverage limits.
- If a secondary plan issuer requires proof that a related claim has been submitted to a primary plan issuer, the mechanism of providing proof must be through an online submission.

PEDIATRIC VISION CARE BENEFITS

Schedule of Pediatric Vision Copayments and Benefit Limits

Vision Care Services	Member Cost or Discount (When a fixed-dollar Copay is due from the Member, the remainder is payable by HMO up to the covered charge*)	Out-of-Network Allowance (maximum reimbursement amount payable by HMO, not to exceed the retail cost)**
Exam (with dilation as necessary):	No Copay	$30 reimbursement
Frames:		
Provider Designated frame	No Copay	$75 reimbursement
Non-Provider Designated frame	You receive 20% off balance of retail cost over $150 allowance	$75 reimbursement
Frequency:		
Examination, Lenses/Frames, or Contact Lenses	Once every 12 months	
Standard Plastic, Glass, or Poly Spectacle Lenses:		
Single Vision	No Copay	$25 reimbursement
Bifocal	No Copay	$40 reimbursement
Trifocal	No Copay	$55 reimbursement
Lenticular	No Copay	$55 reimbursement
Note: Lenses include ultraviolet protective coating, fashion and gradient tinting, oversized and glass-grey #3 prescription sunglasses lenses.		
Lens Options (added to lens prices above):		
Tint (Solid and Gradient)	No Copay	$12 reimbursement
Standard Plastic Scratch Coating	No Copay	$12 reimbursement
Standard Polycarbonate	No Copay	$32 reimbursement
Contact Lenses: covered once every Calendar Year – in lieu of spectacle lenses		
Elective		
Conventional	You receive 15% off balance of retail cost over $150 allowance	$150 reimbursement
Disposable	$150 allowance	$150 reimbursement
Medically Necessary Contact Lenses – Prior Authorization is required	No Copay	$210 reimbursement
Note: Additional benefits over allowance are available from Participating Providers.		
Routine eye exams do not include Professional Services for contact lens evaluations. Any applicable fees are the responsibility of the patient.		

PEDIATRIC VISION CARE BENEFITS

Additional Benefits
Medically Necessary Contact Lenses are dispensed in lieu of other eyewear. Participating Providers will obtain the necessary Prior Authorization for these services.
Low Vision: Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices and provide training and instruction to maximize the remaining usable vision for our Members with low vision. After Prior Authorization, covered low vision services will include one comprehensive low vision evaluation every 5 years, low vision aid items such as high-power spectacles, magnifiers and telescopes; and follow-up care – four visits in any five-year period. Participating Providers will obtain the necessary Prior Authorization for these services.
Warranty: Warranty limitations may apply to Provider or retailer supplied frames and/or eyeglass lenses. Please ask Your Provider for details of the warranty that is available to You.

* The “covered charge” is the rate negotiated with Participating Providers for a particular covered service.

** HMO pays the lesser of the maximum allowance noted or the retail cost. Retail prices vary by location.

RIDERS
and
AMENDMENTS

PEDIATRIC DENTAL CARE BENEFITS

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

In the event that there is a conflict between PEDIATRIC DENTAL CARE BENEFITS and the HMO Certificate of Coverage, the provision that is most favorable to the Participant will apply.

PEDIATRIC DENTAL CARE BENEFITS (herein called the Plan) are made part of, and are in addition to any information you may have in your Blue Cross and Blue Shield of Texas (BCBSTX or Carrier) HMO Certificate of Coverage (Certificate). Coverage for dental care services is outlined below and is specifically excluded under your medical/surgical health care plan. (Services that are covered under your medical/surgical plan are not covered under the **PEDIATRIC DENTAL CARE BENEFITS**). All provisions in your Certificate apply to the **PEDIATRIC DENTAL CARE BENEFITS** unless indicated otherwise below.

Eligibility

Participants who are covered under the Certificate, up to age 19, are eligible for coverage under the **PEDIATRIC DENTAL CARE BENEFITS**. NOTE: Once coverage is lost under the Certificate, all benefits cease under this **PEDIATRIC DENTAL CARE BENEFITS.**

Important Contact Information

Resource	Contact Information	Accessible Hours
Dental Customer Service Helpline	**1-800-521-2227**	**Monday – Friday 8:00 a.m. – 6:00 p.m.**
Website Visit the BCBSTX website for information and to access forms referenced in this Rider, and much more.	**www.bcbstx.com**	**24 hours a day 7 days a week**

How The Plan Works

Allowable Amount

The Allowable Amount is the maximum amount of benefits BCBSTX will pay for Eligible Dental Expenses you incur under the Plan. The portion of the charges by your Dentist that exceeds the Allowable Amount of BCBSTX will be your responsibility to pay to your Dentist, except when you have used a Contracting Dentist. You will also be responsible for charges for services, supplies, and procedures limited or not covered under the Plan and any applicable Deductibles.

Review the definition of Allowable Amount in the **Dental Definitions** section of this Rider to understand the guidelines used by BCBSTX.

Course of Treatment

Your Dentist may decide on a planned series of dental procedures or treatment. In cases where there is more than one professionally acceptable Course of Treatment or service to treat the dental condition, benefits will be covered for the least costly Course of Treatment or service.

Current Dental Terminology (CDT)

The most recent edition of the manual published by the American Dental Association (ADA) entitled "*Current Dental Terminology and Procedure Codes (CDT)*" is used when classifying dental services.

The Allowable Amount for an Eligible Dental Expense will be based on the most inclusive procedure codes.

Freedom of Choice

Each time you need dental care, you can choose to:	
See a Contracting Dentist	**See a Non-Contracting Dentist**
• Your out-of-pocket maximum will generally be the least amount because Contracting Dentists have contracted to accept a lower Allowable Amount as payment in full for Eligible Dental Expenses • You are not required to file claim forms • You are not balance billed for costs exceeding the BCBSTX Allowable Amount for Contracting Dentists • No referral required	• Your out-of-pocket maximum may be greater because Non-Contracting Dentists have not entered into a contract with BCBSTX to accept any Allowable Amount determination as payment in full for Eligible Dental Expenses • You are required to file claim forms • You may be balance billed by Non-Contracting Dentists for costs exceeding the BCBSTX Allowable Amount • No referral required

In each event as described above, you will be responsible for the following:

- any applicable Deductibles;
- Coinsurance Amounts;
- services that are limited or not covered under the Plan.

If your Dentist is not a Contracting Dentist, you may be responsible for filing your claim. You may also be responsible for payment in full at the time services are rendered.

To find a Contracting Dentist, you may look up a dental provider in the Dental Directory, log on to the Blue Cross and Blue Shield of Texas website at www.bcbstx.com and search for a Dentist using Provider Finder, or call the Dental Customer Service Helpline number located in this booklet or on your Identification Card.

How Benefits are Calculated

Your benefits are based on a percentage of the Dentist's Allowable Amount. To determine your benefits, subtract the Deductible (if not previously satisfied) from your Eligible Dental Expenses, then, multiply the difference by the Coinsurance Amount percentage applicable to the benefit category of services shown on your **DENTAL SCHEDULE OF COVERAGE**. The resulting total is the amount of benefits available.

The remaining unpaid amounts, including any excess portion above the Allowable Amount, except when you have used a Contracting Dentist, any Deductible, and your Coinsurance Amount will be your responsibility to pay to your Dentist.

When using a Non-Contracting Dentist, your out–of-pocket cost will be greater because Non-Contracting Dentists have not entered into a contract with BCBSTX to accept any Allowable Amount determination as payment in full for Eligible Dental Expenses. You may be balance billed by Non-Contracting Dentists for costs exceeding the BCBSTX Allowable Amount.

Identification Card

The Identification Card tells Providers that you are entitled to benefits under your employer's dental care plan with BCBSTX. The card offers a convenient way of providing important information specific to your coverage including, but not limited to, the following:

- ***Your Subscriber identification number.*** This unique identification number is preceded by a three character alpha prefix that identifies Blue Cross and Blue Shield of Texas as your Carrier.
- ***Your group number.*** This is the number assigned to identify your employer's dental care plan with BCBSTX.
- ***important telephone numbers.***

Always remember to carry your Identification Card with you and present it to your Dentist when receiving dental care services or supplies.

Please remember that any time a change in your family takes place it may be necessary for a new Identification Card to be issued to you. Upon receipt of the change in information, the Carrier will provide a new Identification Card.

Predetermination of Benefits

Predetermination is an estimate by BCBSTX of your eligibility under the Plan for Dental benefits or covered Dental services, the amount of your Deductible, Copayment or Coinsurance Amount related to Dental benefits or covered Dental services and the maximum benefit limits for Dental benefits or covered Dental services.

If a Course of Treatment for non-emergency services can reasonably be expected to involve Eligible Dental Expenses in excess of $300, a description of the procedures to be performed and an estimate of the Dentist's charge should be filed with BCBSTX prior to the commencement of treatment.

BCBSTX may request copies of existing x-rays, photographs, models, and any other records used by the Dentist in developing the Course of Treatment. BCBSTX will review the reports and materials, taking into consideration alternative Courses of Treatment.

BCBSTX will notify you and the Dentist of:

- Your eligibility under the Plan;
- Your Deductible, Copayment and Coinsurance Amount related to Dental benefits or covered Dental services; and
- the maximum benefit limits for Dental benefits or covered Dental services.

Benefit payments may be reduced based on any claims paid after a predetermination estimate is provided.

Eligible Dental Expenses

The Plan provides coverage for services and supplies that are considered Dentally Necessary. The benefit percentage to be applied to each category of service is shown on the **DENTAL SCHEDULE OF COVERAGE**.

For benefits available for Eligible Dental Expenses, please refer to the **DENTAL SCHEDULE OF COVERAGE** in this Rider. 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.

Deductibles

The benefits of the Plan will be available after satisfaction of the applicable Deductibles as shown on your **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**. Eligible Dental Expenses will apply to the In-Network Deductible amount for an individual and family shown on the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS.**

Out-of-Pocket Maximum

Your Eligible Dental Expenses payment obligation is applied to the out-of-pocket maximum as shown on your **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**. Eligible Dental Expenses will apply to the In-Network out-of-pocket maximum amount for an individual and family shown on the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS.** Eligible Dental Expenses applied toward satisfying the In-Network out-of-pocket maximum will only apply to the In-Network out-of-pocket maximum.

Changes in Benefits

Benefits for Eligible Dental Expenses incurred during a Course of Treatment that begins before the change will be those benefits in effect on the day the Course of Treatment was started.

Claim Filing and Appeals Procedures

Filing of Claims Required

Notice of Claim

You must give written notice to BCBSTX within 20 days, or as soon as reasonably possible, after any Participant receives services for which benefits are provided under the Plan. Failure to give notice within this time will not invalidate or reduce any claim if you show that it was not reasonably possible to give notice and that notice was given as soon as it was reasonably possible.

Claim Forms

When BCBSTX receives notice of claim, it will furnish to you, or to your employer for delivery to you, or to the Dentist, the dental claim forms that are usually furnished by it for filing Proof of Loss. If the forms are not furnished within 15 days after receipt of notice by BCBSTX, you have complied with the requirements of the Plan for Proof of Loss by submitting, within the time fixed under the Plan for filing Proof of Loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

BCBSTX must receive claims prepared and submitted in the proper manner and form, in the time required, and with the information requested before it can consider any claim for payment of benefits.

Who Files Claims

Provider-filed claims

Contracting Dentists will usually submit your claims directly to BCBSTX for services provided to you or any of your covered Dependents. At the time services are provided, inquire if they will file claim forms for you. To assist Dentists in filing your claims, you should carry your Identification Card with you.

Participant-filed claims

If your Dentist does not submit your claims, you will need to submit them to BCBSTX using a Subscriber-filed claim form provided by BCBSTX. You can obtain a Dental Claim Form from the BCBSTX website. Follow the instructions on the reverse side of the form to complete the claim. Remember to file each Participant's expenses separately because any Deductibles, maximum benefits, and other provisions are applied to each Participant separately. Include itemized bills from the Dentist printed on their letterhead and showing the services performed, dates of service, charges, and name of the Participant involved.

VISIT THE BCBSTX WEBSITE FOR SUBSCRIBER CLAIM FORMS AND OTHER USEFUL INFORMATION

www.bcbstx.com

Where to Mail Completed Claim Forms

Blue Cross and Blue Shield of Texas
Dental Claims Division
P.O. Box 660247
Dallas, Texas 75266-0247

Who Receives Payment

Benefit payments will be made directly to the Dentists when they submit your claim to BCBSTX. Written agreements between BCBSTX and some Dentists may require payment directly to them. Any benefits payable to you, if unpaid at your death, will be paid to your beneficiary or to your estate, if no beneficiary is named.

Except as provided in the section **Assignment and Payment of Benefits,** rights and benefits under the Plan are assignable, either 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 or administrative order as managing or possessory conservator of the child; and
- BCBSTX has not already paid any portion of the claim.

In order for benefits to be payable to a managing or possessory conservator of a child, the managing or possessory conservator must submit to BCBSTX, with the claim form, proof of payment of the expenses and a certified copy of the court order or administrative order naming that person the managing or possessory conservator.

BCBSTX may deduct from its benefit payment any amounts it is owed by the recipient of the payment. Payment to you or your Dentist, or deduction by BCBSTX from benefit payments of amounts owed to BCBSTX, will be considered in satisfaction of its obligations to you under the Plan.

An *Explanation of Benefits (EOB) for Dental Care* summary is sent to you so you will know what has been paid.

When to Submit Claims

All claims for benefits under the Plan must be properly submitted within 90 days of the date you receive the services or supplies. Claims not submitted and received by BCBSTX within twelve (12) months after that date will not be considered for payment of benefits except in the absence of legal capacity.

Receipt of Claims by BCBSTX

A claim will be considered received by BCBSTX for processing upon actual delivery to the BCBSTX Administrative Office in the proper manner and form and with all of the information required. If the claim is not complete, it may be denied or BCBSTX may contact either you or the Dentist for the additional information.

Interpretation of Employer's Plan Provisions

The operation and administration of the Plan require uniformity regarding the intent of the Plan and the interpretation of the Plan provisions. Your employer has given BCBSTX full and complete authority to make decisions regarding the Plan provisions and determining questions of eligibility and benefits.

Actions Against BCBSTX

No lawsuit or action in law or equity may be brought by you or on your behalf prior to the expiration of 60 days after Proof of Loss has been filed in accordance with the requirement of the Plan and no such action will be brought at all unless brought within three years from the expiration of the time within which Proof of Loss is required by the Plan.

Covered Dental Services

The Plan will provide benefits for the following Eligible Dental Expenses, subject to the limitations and exclusions described in this booklet, only if the category of service is shown on your **DENTAL SCHEDULE OF COVERAGE**. The benefit percentage applicable to each category of service is also shown on your **DENTAL SCHEDULE OF COVERAGE**.

You are covered only for those categories of services shown on the DENTAL SCHEDULE OF COVERAGE issued with this Rider.

Diagnostic Evaluations

Diagnostic evaluations aid the Dentist in determining the nature or cause of a dental disease and include:

- periodic oral evaluations for established patients.
- problem focused oral evaluations, whether limited, detailed or extensive.
- comprehensive oral evaluations for new or established patients.
- comprehensive periodontal evaluations for new or established patients.
- oral evaluations of children under the age of three, including counseling with primary caregiver.
- oral Examinations – Oral exams are limited to two every benefit period.

Benefits for periodic and comprehensive oral evaluations are limited to a combined maximum of two every 12 months.

Benefits will not be provided for comprehensive periodontal evaluations or problem-focused evaluations if Eligible Dental Expenses are rendered on the same date as any other oral evaluation and by the same Dentist.

Benefits will not be provided for tests and oral pathology procedures, or for re-evaluations.

Preventive Services

Preventive services are performed to prevent dental disease. Eligible Dental Expenses include:

- prophylaxis – Professional cleaning and polishing of the teeth. Benefits are limited to two cleanings every 12 months.
- topical fluoride application – Benefits for fluoride application are only available for Participants under age 19 and are limited to two applications every 12 months.

Special Provisions Regarding Preventive Services

Cleanings include associated scaling and polishing procedures.

Following active periodontal treatment, benefits are available for a combination of two prophylaxes, scaling in the presence of inflammation and two periodontal maintenance treatments (see "Non-Surgical Periodontic Services") every 12 months.

Diagnostic Radiographs

Diagnostic radiographs are x-rays taken to diagnose a dental disease, including their interpretations, and include:

- full-mouth (intraoral complete series) and panoramic films – Benefits are limited to a combined maximum of one every 60 months.
- bitewing films – Benefits are limited to two sets per Calendar Year.
- intraoral periapical films, as necessary for diagnosis.

Benefits will not be provided for any radiographs taken related to the diagnosis of Temporomandibular Joint (TMJ) Dysfunction.

Miscellaneous Preventive Services

Miscellaneous preventive services are other services performed to prevent dental disease and include:

- sealants – Benefits for sealants are limited to one per tooth every 36 months.
- space maintainers.

Benefits are not available for nutritional, tobacco and oral hygiene counseling.

Basic Restorative Services

Basic restorative services are restorations necessary to repair basic dental decay, including tooth preparation, all adhesives, bases, liners and polishing. Eligible Dental Expenses include:

- amalgam restorations.
- resin-based composite restorations.

Non-Surgical Extractions

Non-surgical extractions are non-surgical removal of tooth and tooth structures and include:

- removal of retained coronal remnants – deciduous tooth.
- removal of erupted tooth or exposed root.

Non-Surgical Periodontal Services

Non-surgical periodontal service is the non-surgical treatment of a dental disease in the supporting and surrounding tissues of the teeth (gums) and includes:

- periodontal scaling and root planing – Benefits are limited to one per quadrant every 24 months.
- scaling in the presence of generalized moderate to severe gingival inflammation is limited to once every 6 months combined with prophylaxes and periodontal maintenance.
- full mouth debridement to enable comprehensive periodontal evaluation and diagnosis limited to once per lifetime.
- periodontal maintenance procedures –Benefits are limited to four every 12 months combined with prophylaxis and must be performed following active periodontal treatment.

Adjunctive Services

Adjunctive general services include:

- palliative treatment (emergency) of dental pain, and when not performed in conjunction with a definitive treatment.
- deep sedation/general anesthesia and intravenous/non-intravenous conscious sedation – By report only and when determined to be Dentally Necessary for documented Participants with a disability or for a justifiable medical or dental condition. A person's apprehension does not constitute Dental Necessity.
- therapeutic parenteral drugs – Therapeutic parenteral drugs will be covered for a Participant under age 19.

Benefits will not be provided for local anesthesia, nitrous oxide analgesia, or other drugs or medicaments and/or their application.

Endodontic Services

Endodontics is the treatment of dental disease of the tooth pulp and includes:

- therapeutic pulpotomy and pulpal debridement, when performed as a final endodontic procedure. These services are considered part of the root canal procedure if root canal therapy is performed within 45 days of services.
- root canal therapy, including treatment plan, clinical procedures, working and post-operative radiographs and follow-up care.
- apexification/recalcification procedures and apicoectomy/periradicular services including surgery, retrograde filling, root amputation and hemisection.

Benefits will not be provided for the following "*Endodontic Services*":

- endodontic retreatments provided within 12 months of the initial endodontic therapy by the same Dentist on the same tooth.
- pulp vitality tests, endodontic endosseous implants, intentional reimplantations, canal preparation, fitting of preformed dowel and post, or post removal.
- endodontic therapy if You discontinue endodontic treatment.

Oral Surgery Services

Oral surgery means the procedures for surgical extractions and other dental surgery under local anesthetics and includes:

- surgical tooth extractions.
- alveoloplasty and vestibuloplasty.
- excision of benign odontogenic tumor/cysts.
- excision of bone tissue.
- incision and drainage of an intraoral abscess.
- other Dentally Necessary surgical and repair procedures not specifically excluded in this contract.

Intraoral soft tissue incision and drainage is only covered when it is provided as the definitive treatment of an abscess. Routine follow-up care is considered part of the procedure.

Benefits will not be provided for the following Oral Surgery procedures:

- surgical services related to a congenital malformation.
- prophylactic removal of third molars or impacted teeth (asymptomatic, nonpathological), or for complete bony impactions covered by another benefit plan.
- excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses);
- treatment of fractures of facial bones;

- external incision and drainage of cellulitis;
- incision of accessory sinuses, salivary glands or ducts;
- reduction of dislocation, or excision of the temporomandibular joints.

Surgical Periodontal Services

Surgical periodontal service is the surgical treatment of a dental disease in the supporting and surrounding tissues of the teeth (gums) and includes:

- gingivectomy or gingivoplasty and gingival flap procedures (including root planing) – Benefits are limited to one quadrant every 24 months.
- clinical crown lengthening.
- osseous surgery, including flap entry and closure – Benefits are limited to one per quadrant every 24 months.

  In addition, osseous surgery performed in a limited area and in conjunction with crown lengthening on the same date of service, by the same Dentist, and in the same area of the mouth, will be processed as crown lengthening in the absence of periodontal disease.
- osseous grafts – Benefits are limited to one per site every 24 months. Benefits are not available for bone grafts in conjunction with extractions, apicoectomy or any non-covered service or non-covered implants.
- soft tissue grafts/allografts (including donor site).
- distal or proximal wedge procedure.

Surgical periodontal services performed in conjunction with the placement of crowns, inlays, onlays, crown buildups, posts and cores, or basic restorations are considered part of the restoration.

Benefits will not be provided for guided tissue regeneration, or for biologic materials to aid in tissue regeneration.

Major Restorative Services

Restorative services restore tooth structures lost as a result of dental decay or fracture and include:

- single crown restorations.
- inlay/onlay restorations.
- labial veneer restorations.

Benefits will not be provided for the replacement of a lost, missing or stolen appliance and those for replacement of appliances that have been damaged due to abuse, misuse, or neglect.

Benefits will not be provided to alter, restore, or correct vertical dimension of occlusion. Such procedures may include, but are not limited to equilibration dentures, crowns, inlays, onlays, bridgework, or dimension or to restore occlusion or to correct attrition, abrasion, erosion, or abfractions.

Benefits will not be provided for the restoration of occlusion or incisal edges due to bruxism or harmful habits.

Benefits for major restorations are limited to one per tooth every 60 months whether placement was provided under this contract or under any prior dental coverage, even if the original crown was stainless steel.

Prosthodontic Services

Prosthodontics involve procedures necessary for providing artificial replacements for missing natural teeth and includes:

- complete and removable partial dentures – Benefits will be provided for the initial installation of removable complete, immediate or partial dentures, including any adjustments, relines or rebases during the six-month period following installation. Benefits for replacements are limited to once in any 60-month period, whether placement was provided under this contract or under any prior dental coverage. Benefits will not be provided for replacement of complete or partial dentures due to theft, misplacement or loss.
- denture reline/rebase procedures – Benefits will be limited to one in a 36 month period after the initial 6 month period following initial placement.

- fixed bridgework – Benefits will be provided for the initial installation of a bridgework, including inlays/onlays and crowns. Benefits will be limited to once every 60 months whether placement was under this contract or under any prior dental coverage.

NOTE: Tissue conditioning is part of a denture or a reline/rebase, when performed on the same day as the delivery.

NOTE: An implant is a covered procedure of the Plan only if determined to be a Dental Necessity. Claim review for implant services are conducted by licensed Dentists who review the clinical documentation submitted by your treating Dentist. If the dental consultants determine an arch can be restored with a standard prosthesis or restoration, no benefit will be allowed for the individual implant or implant procedure. Only the second phase of treatment (the prosthodontic phase-placement of the implant crown, bridge, or partial denture) may be subject to the alternate benefit provision of the Plan.

- implant retained crowns, bridges, and dentures are subject to the alternate benefit provision of the Plan.
- endosteal, eposteal, and transosteal implants – one every 60 months only if determined to be a Dental Necessity.

Benefits will not be provided for the following Prosthodontic Services:

- treatment to replace teeth which were missing prior to the Effective Date.
- congenitally missing teeth.
- splinting of teeth, including double retainers for removable partial dentures and fixed bridgework.

Miscellaneous Restorative and Prosthodontic Services

Other restorative and prosthodontics services include:

- prefabricated crowns – Benefits for stainless steel and resin-based crowns are limited to one per tooth every 60 months. These crowns are not intended to be used as temporary crowns.
- recementation of inlays/onlays, crowns, bridges, and post and core –Any recementation provided within six months of an initial placement by the same Dentist is considered part of the initial placement.
- core build up, post and core, and prefabricated post and core are limited to 1 per tooth every 60 months.
- crown and bridge repair services.
- pulp cap – direct and indirect.
- prosthodontic service adjustments.
- repairs of inlays, onlays, veneers, crowns, fixed or removable dentures, including replacement or addition of missing or broken teeth or clasp.

Medically Necessary Orthodontic Services

Benefits for Medically Necessary orthodontic services are limited to Participants who meet the Plans criteria related to a medical condition such as:

- cleft palate or other congenital craniofacial or dentofacial malformations requiring reconstructive surgical correction in addition to orthodontic services.
- trauma involving the oral cavity and requiring surgical treatment in addition to orthodontic services.
- skeletal anomaly involving maxillary and/or mandibular structures.
- orthodontic treatment for dental conditions that are primarily cosmetic in nature or when self-esteem is the primary reason for treatment that is not Medically Necessary.

Benefits for Medically Necessary orthodontic procedures and treatment include examination records, tooth guidance and repositioning (straightening) of the teeth for Participants covered for orthodontics.

Covered orthodontic services include:

- diagnostic orthodontic records and radiographs.
- limited, interceptive and comprehensive orthodontic treatment.

- orthodontic retention.

Special Provisions Regarding Orthodontic Services:

- orthodontic services are paid over the Course of Treatment. Benefits cease when the Participant is no longer covered, whether or not the entire benefit has been paid out.
- orthodontic treatment is started on the date the bands or appliances are inserted.
- payment for diagnostic services performed in conjunction with orthodontics is applied to the orthodontic benefit.
- if orthodontic treatment is terminated for any reason before completion, benefits will cease on the date of termination.
- if the Participant's coverage is terminated prior to the completion of the orthodontic treatment plan, the Participant is responsible for the remaining balance of treatment costs.
- recementation of an orthodontic appliance by the same Dentist who placed the appliance and/or who is responsible for the ongoing care of the Participant is not covered.
- benefits are not available for replacement or repair of an orthodontic appliance.
- for services in progress on the Effective Date, benefits will be reduced based on the benefits paid prior to this coverage beginning.

Implant Services

Benefits are available for Dentally Necessary Covered Services incurred for an artificial device specifically designed to be placed surgically in the mouth as a means of replacing missing teeth.

Dental Limitations and Exclusions

These general limitations and exclusions apply to all services described in this dental contract. Dental coverage is limited to services provided by a Dentist, a dental auxiliary, (as defined in the **Dental Definitions** section) licensed to perform services covered under this dental contract.

Important Information About Your Dental Benefits

- ***Dental Procedures Which Are Not Dentally Necessary***

  Please note that in order to provide you with dental care benefits at a reasonable cost, this contract provides benefits only for those Eligible Dental Expenses that are determined to be Dentally Necessary.

  No benefits will be provided for procedures which are not Dentally Necessary.

  The fact that a Dentist may prescribe, order, recommend or approve a procedure does not of itself make such a procedure or supply Dentally Necessary.

- ***Care By More Than One Dentist***

  If you change Dentists in the middle of a particular Course of Treatment, benefits will be provided as if you had stayed with the same Dentist until your treatment was completed. There will be no duplication of benefits.

- ***Alternate Benefits***

  In all cases in which there is more than one Course of Treatment or service to treat a Participant's dental condition, the benefit will be based on the least costly Course of Treatment or covered service, as determined by the Plan.

  When two or more services are submitted and the services are considered part of the same service, the Plan will pay the most comprehensive service as determined by the Plan.

  When two or more services are submitted on the same day and the services are considered mutually exclusive (one service contradicts the need for the other service), the Plan will pay for the service that represents the final treatment as determined by the Plan.

  If you and your Dentist decide on personalized restorations, or personalized complete or partial dentures and overdentures, or to employ specialized techniques for dental services rather than standard procedures,

the benefits provided will be limited to the benefit for the least costly Course of Treatment procedures for dental services, as determined by the Plan.

- ***Non-Compliance with Prescribed Care***

  Any additional treatment and resulting liability which is caused by the lack of a Participant's cooperation with the Dentist or from non-compliance with prescribed dental care will be the responsibility of the Participant.

Exclusions — What Is Not Covered

No benefits will be provided under this contract for:

1. services or supplies not specifically listed as an Eligible Dental Expense, or when they are related to a non-covered service.
2. amounts which are in excess of the Allowable Amount, as determined by the Plan.
3. dental services for treatment of congenital or developmental malformation, or services performed for cosmetic purposes, including but not limited to bleaching teeth, lack of tooth enamel and grafts to improve aesthetics, except as described in the **Pediatric Medically Necessary Orthodontic Services** section of **PEDIATRIC DENTAL CARE BENEFITS**.
4. dental services or appliances for the diagnosis and/or treatment of temporomandibular joint dysfunction and related disorders, unless specifically mentioned in this Rider or if resulting from accidental injury. Dental services or appliances to increase vertical dimension, unless specifically mentioned in this Rider.
5. services and supplies for any illness or injury suffered after the Participant's Effective Date:
   - as a result of war or any act of war, declared or undeclared; or
   - while on active or reserve duty in the armed forces of any country or international authority.
6. services or supplies that do not meet accepted standards of dental practice.
7. services or supplies which are Experimental/Investigational in nature or not fully approved by a Council of the American Dental Association.
8. hospital and ancillary charges.
9. services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
10. services or supplies for which "discounts" or waiver of Deductible or Coinsurance Amounts are offered.
11. services or supplies received from someone other than a Dentist, except for those services received from a licensed dental hygienist under the supervision and guidance of a Dentist, where applicable.
12. claims for a service, which is for the same services performed on the same date for the same Participant.
13. services or supplies received for behavior management or consultation purposes.
14. 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.
15. any services or supplies for which benefits are, or could upon proper claim be, provided under any laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical/dental assistance (Medicaid); provided, however, that this exclusion shall not be applicable to any coverage held by the Participant for dental expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
16. charges for nutritional, tobacco or oral hygiene counseling.
17. charges for local, state or territorial taxes on dental services or procedures.
18. charges for the administration of infection control procedures as required by OSHA, local, state or federal mandates.

19. charges for duplicate, temporary or provisional prosthetic device or other duplicate, temporary or provisional appliances.
20. charges for audio-only telephone consultations, text-only email messages, facsimile transmissions, missed appointments, completion of a claim form or forwarding requested records or x-rays.
21. charges for prescription or non-prescription mouthwashes, irrigation, mouth rinses, topical solutions, preparations or medicament carriers.
22. charges for personalized complete or partial dentures and overdentures, related services and supplies, or other specialized techniques.
23. charges for athletic mouth guards, isolation of tooth with rubber dam, metal copings, mobilization of erupted/malpositioned tooth, precision attachments for partials and/or dentures and stress breakers.
24. any services, treatments or supplies included as Eligible Dental Expenses under other hospital, medical and/or surgical coverage.
25. case presentations or detailed and extensive treatment planning when billed for separately.
26. charges for occlusion analysis, diagnostic casts, or occlusal adjustments.
27. orthodontic treatment that is not Medically Necessary.
28. gold foil restorations.
29. cone beam imaging and cone beam MRI procedures.
30. sealants for teeth other than permanent molars.
31. localized delivery of antimicrobial agents or chemotherapeutic agents.
32. comprehensive periodontal evaluations or problem-focused evaluations if Eligible Dental Expenses are rendered on the same date as any other oral evaluation and by the same Dentist.
33. tests and oral pathology procedures, or for re-evaluations.
34. any radiographs taken related to the diagnosis of Temporomandibular Joint (TMJ) Dysfunction.
35. local anesthesia, nitrous oxide analgesia, or other drugs or medicaments and/or their application.
36. endodontic retreatments provided within 12 months of the initial endodontic therapy by the same Dentist on the same tooth.
37. pulp vitality tests, endodontic endosseous implants, intentional reimplantations, canal preparation, fitting of preformed dowel and post, or post removal.
38. endodontic therapy if you discontinue endodontic treatment.
39. surgical services related to a congenital malformation.
40. prophylactic removal of third molars or impacted teeth (asymptomatic, nonpathological), or for complete bony impactions covered by another benefit plan.
41. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
42. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bones; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of the temporomandibular joints.
43. bone grafts in conjunction with extractions, apicoectomy or any non-covered service or non-covered implants.
44. guided tissue regeneration, or for biologic materials to aid in tissue regeneration.
45. the replacement of a lost, missing or stolen appliance and those for replacement of appliances that have been damaged due to abuse, misuse, or neglect.
46. to alter, restore, or correct vertical dimension of occlusion. Such procedures may include, but are not limited to equilibration dentures, crowns, inlays, onlays, bridgework, or dimension or to restore occlusion or to correct attrition, abrasion, erosion, or abfractions.

47. the restoration of occlusion or incisal edges due to bruxism or harmful habits.
48. congenitally missing teeth.
49. splinting of teeth, including double retainers for removable partial dentures and fixed bridgework.
50. recementation of an orthodontic appliance by the same Dentist who placed the appliance and/or who is responsible for the ongoing care of the Participant is not covered.
51. benefits are not available for replacement or repair of an orthodontic appliance.

Dental Definitions

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

- ***for certain Dentists contracting with BCBSTX*** – The Allowable Amount is based on the terms of the Dentist's contract and BCBSTX's methodology in effect on the date of service.
- ***for Dentists not contracting with BCBSTX*** **–** The Allowable Amount is described on the **DENTAL SCHEDULE OF COVERAGE**.

Coinsurance Amount means the dollar amount (expressed as a percentage) of Eligible Dental Expenses incurred by a Participant during a Calendar Year that exceeds benefits provided under the Plan.

Contracting Dentist means a Dentist who has entered into a written agreement with BCBSTX, who has contracted directly with any division or subsidiary of Health Care Service Corporation (HCSC) and/or who has entered into an agreement with another entity with which HCSC or any of its subsidiaries has contracted.

Course of Treatment means any number of dental procedures or treatments performed by a Dentist in a planned series resulting from a dental examination concurrently revealing the need for such procedures or treatments.

Dentally Necessary or Dental Necessity means those services, supplies, or appliances covered under the Plan which are:

1. essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the dental condition or injury; and
2. provided in accordance with and are consistent with generally accepted standards of dental practice in the United States; and
3. not primarily for the convenience of the Participant or their Dentist; and
4. the most economical supplies, appliances, or levels of dental service that are appropriate for the safe and effective treatment of the Participant.

Dentist means a person, when acting within the scope of their license, who is a Doctor of Dentistry (D.D.S. or D.M.D. degree) and shall also include a person who is a Doctor of Medicine or a Doctor of Osteopathy.

Effective Date means the date when your coverage begins.

Eligible Dental Expenses means the professionally recognized dental services, supplies, or appliances for which a benefit is available to a Participant when provided by a Dentist on or after the Effective Date of coverage and for which the Participant has an obligation to pay.

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

Medically Necessary (or Medical Necessity) means a specific procedure or supply provided to you that is reasonably required, in the judgment of the Plan, for the treatment or management of your specific dental symptom, injury, or condition and is the most efficient and economical procedure that can safely be provided to you. The fact that a Dentist or Physician may prescribe, order, recommend or approve a procedure does not make such a procedure Medically Necessary. To be Medically Necessary, the procedure or supply must also conform to approved and generally accepted standards of accepted dental practice prevailing in the state when and where the procedure or supply is ordered. Such procedures or supplies are also subject to review and analysis by dental consultants, retained by the Plan. These consultants review the claim and diagnostic materials submitted in support of the claim, and based upon their professional opinions, determine the necessity and propriety of treatment.

Non-Contracting Dentist means a Dentist who is not a Contracting Dentist as defined herein.

Participant means an employee or a Qualified Employee, as appropriate or Dependent whose coverage has become effective under this contract.

Pediatric Orthodontic Services means coverage limited to children under age 19 with an orthodontic condition meeting Dental Necessity criteria (e.g., severe, dysfunctional malocclusion).

Proof of Loss means written evidence of a claim including:

1. the form on which the claim is made;
2. 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; and
3. correct diagnosis code(s) and procedure code(s) for the services and items.

Teledentistry Dental Service means a health care service delivered by a Dentist, or a Health Care Professional acting under the delegation and supervision of a Dentist, acting within the scope of the Dentist's or Health Care Professional's license or certification to a patient at a different physical location than the Dentist or Health Care Professional using telecommunications or information technology.

General Provisions

Agent

The employer is not the agent of the Carrier.

Amendments

The Plan may be amended or changed at any time by agreement between the employer and BCBSTX. No notice to or consent by any Participant is necessary to amend or change the Plan.

Assignment and Payment of Benefits

If a written assignment of benefits is made by a Participant to a Dentist and the written assignment is delivered to the BCBSTX with the claim for benefits, the BCBSTX will make any payment directly to the Dentist. Payment to the Dentist discharges BCBSTX's responsibility to Participant for any benefits available under the Plan.

Disclosure Authorization

If you file a claim for benefits, it will be necessary that you authorize any Dentist, insurance carrier, or other entity to furnish BCBSTX 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.

Participant/Dentist Benefit Website

Information concerning covered Dental services is available to you and your Dentist on our website www.bcbstx.com

Participant/Dentist Relationship

The choice of a Dentist should be made solely by you or your Dependents. BCBSTX does not furnish services or supplies but only makes payment for Eligible Dental Expenses incurred by Participants. BCBSTX is not liable for any act or omission by any Dentist. BCBSTX does not have any responsibility for a Dentist'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 Dentist selected and are available only for treatment acceptable to the Dentist.

Payment or Reimbursement of Dentist

The payment or reimbursement process for a Non-Contracting Dentist will be the same as the payment or reimbursement for a Contracting Dentist.

The Plan provides one or more methods of payment or reimbursement that provide the Dentist the full contracted amount of the payment or reimbursement without the Dentist incurring a fee to access payment or reimbursement.

Refund Of Benefit Payments

If BCBSTX pays benefits for Eligible Dental Expenses incurred by you or your Dependents and it is found that the payment was more than it should have been, or was made in error, BCBSTX has the right to a refund from the Participant for whom such benefits were paid, any other insurance company, any other organization, or from the Dentist who received the overpayment. If no refund is received, BCBSTX may deduct any refund due it from any future benefit payment.

Reimbursement

When BCBSTX pays benefits under the contract and it is determined that a negligent third party is liable for the same expenses, BCBSTX has the right to receive reimbursement from the monies payable from the negligent third party equal to the amount BCBSTX has paid for such expenses. The Participant hereby agrees to reimburse BCBSTX from any monies recovered from a negligent third party as a result of a judgment against, settlement with, or otherwise paid by the third party. The Participant agrees to take action against the third party, furnish all information, and provide assistance to BCBSTX regarding the action taken, and execute and deliver all documents and information necessary for BCBSTX to enforce our rights of reimbursement.

BCBSTX's process to recover by subrogation or reimbursement will be conducted in accordance with Texas Civil Practice and Remedies Code Title 6, Chapter 140.

State Government Programs

- if a Participant under the Plan is also a Medicaid recipient, any benefits for services, supplies, or appliances under the Plan will not be excluded solely because benefits are paid or payable for such services, supplies, or appliances under Medicaid. Any benefits available under the Plan will be payable to the Texas Department of Human Services to the extent required by the *Texas Insurance Code*; and
- all benefits paid on behalf of a child or children under the Plan must be paid to the Texas Department of Human Services where:
    a. the Texas Department of Human Services is paying benefits pursuant to provisions in the *Human Resources Code*; and
    b. the parent who is covered under the Plan has possession or access to the child pursuant to a court order or administrative order, or is not entitled to access or possession of the child and is required by the court to pay child support; and
    c. the Carrier receives written notice at its Administrative Office affixed to the benefit claim when the claim is first submitted, that the benefits claimed must be paid directly to the Texas Department of Human Services.

PEDIATRIC DENTAL CARE BENEFITS

DENTAL SCHEDULE OF COVERAGE

The Copayment Amount and Annual Maximum below are subject to change as permitted by applicable law.

Covered Dental Services	Member Copayment Amount Member
Diagnostic Evaluations	No Charge
Preventive Services Periodic Oral Evaluation and Fluoride treatment covered at 100%	No Charge
Diagnostic Radiographs	No Charge
Miscellaneous Preventive Services	No Charge
Basic Restorative Services	No Charge
Non-Surgical Extractions	No Charge
Non-Surgical Periodontal Services	No Charge
Adjunctive Services	No Charge
Endodontic Services	No Charge
Oral Surgery Services	No Charge
Surgical Periodontal Services	No Charge
Major Restorative Services	No Charge
Prosthodontic Services	No Charge
Miscellaneous Restorative and Prosthodontic Services	No Charge
Implants	No Charge
Orthodontia	
Pediatric Orthodontic Services	No Charge
Annual Maximum	Unlimited

All benefits are based upon the Allowable Amount, which is the amount determined by BCBSTX as the maximum amount eligible for payment of benefits. A Contracting Dentist cannot balance bill for charges in excess of the Allowable Amount. Benefits for services provided by a Non-Contracting Dentist will be based upon the same Allowable Amount, and it is likely that the Non-Contracting Dentist will balance bill for amounts above this, resulting in higher out-of-pocket expenses.

Your Dentist may provide Teledentistry Dental Services, which may also include Teledentistry Dental Services which are delegated and supervised by your Dentist on the same basis and to the same extent that this Policy provides coverage for the service or procedure in an in-person setting. Copayments or Annual Maximum Benefits for Eligible Expenses will be the same as required for an in-person consultation.

Eligible Dental Expenses will apply to the In-Network Out-of-Pocket Maximum amount for an individual and family shown on the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**. Eligible Dental Expenses applied toward satisfying the In-Network Out-of-Pocket Maximum will only apply to the In-Network Out-of-Pocket Maximum.

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

Blue Cross and Blue Shield of Texas (BCBSTX)

By: James Springfield
President, Blue Cross and Blue Shield of Texas

IN VITRO FERTILIZATION

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

The **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**, **Maternity Care and Family Planning Services** section is amended to add the following provision:

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

The **Covered Services and Benefits**, **Maternity Care and Family Planning Services** section is amended to add the following provision:

In Vitro Fertilization. The PCP must authorize services and a Specialist must render them in an approved facility. If You meet all the following requirements, outpatient benefits are covered to the same extent as other pregnancy-related procedures.

1. The patient for the in vitro fertilization procedure must be a Member of the HMO and otherwise entitled to pregnancy-related benefits.
2. Member must have a history of Infertility of at least five (5) continuous years' duration, or the Infertility must be associated with one or more of the following conditions:
    - endometriosis;
    - exposure in utero to diethylstilbestrol (DES);
    - blockage or surgical removal of one or both fallopian tubes; or
    - oligospermia.
3. Member must have been unable to attain a successful pregnancy through any less costly applicable Infertility treatments for which coverage is available under this Certificate.
4. The in vitro fertilization procedures must be performed at a Participating medical facility approved by HMO that conforms to the American College of Obstetrics and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

The **Limitations and Exclusions;** section is amended to remove exclusion 26 and replace with the following:

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

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

Blue Cross and Blue Shield of Texas (BCBSTX)

James Springfield
President, Blue Cross and Blue Shield of Texas

NOTICES

BlueCross BlueShield of Texas

Non-Discrimination Notice

Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

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

If you believe we have failed to provide a service, or think we have discriminated in another way, you can file a grievance with:

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
Attn: Office of Civil Rights Coordinator	TTY/TDD:	855-661-6965
300 E. Randolph St., 35th Floor	Fax:	855-661-6960
Chicago, IL 60601	Email:	civilrightscoordinator@bcbsil.com

You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

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

US Dept of Health & Human Services	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building	Complaint Portal:	
Washington, DC 20201	ocrportal.hhs.gov/ocr/smartscreen/main.jsf	
	Complaint Forms:	
	hhs.gov/civil-rights/filing-a-complaint/index.html	

This notice is available on our website at bcbstx.com/legal-and-privacy/non-discrimination-notice

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 855-710-6984 (TTY: 711) or speak to your provider.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-710-6984 (TTY: 711) o hable con su proveedor.
لعربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة.

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中文 Chinese	注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 855-710-6984（文本电话：711）或咨询您的服务提供商。
Français French	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-710-6984 (TTY : 711) ou parlez à votre fournisseur.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 855-710-6984 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Italiano Italian	ATTENZIONE: se parli italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'855-710-6984 (tty: 711) o parla con il tuo fornitore.
한국어 Korean	주의: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-710-6984(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	SHOOH: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.
فارسي Farsi	توجه: اگر فارسي صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 855-710-6984 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.
Polski Polish	UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 855-710-6984 (TTY: 711) lub porozmawiaj ze swoim dostawcą.
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-710-6984 (TTY: 711) или обратитесь к своему поставщику услуг.
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider.
اردو Urdu	توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔855-710-6984 (711:TTY) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 855-710-6984 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

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NOTICE

CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

You're receiving this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more 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.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called 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're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- 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 entitled to 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 lose coverage under the Plan because of the following qualifying events:

- 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 entitled to Medicare benefits (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. 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 CONTINUATION 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. The employer must notify the Plan Administrator of the following qualifying events:

- 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).

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For all 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 CONTINUATION 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 that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

DISABILITY EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a 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 COBRA 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 during the 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 the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

CAN I ENROLL IN MEDICARE INSTEAD OF COBRA CONTINUATION COVERAGE AFTER MY GROUP HEALTH PLAN COVERAGE ENDS?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends,

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit
https://www.medicare.gov/medicare-and-you.

IF YOU HAVE QUESTIONS

Questions concerning your Plan, or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect your family's rights, let the Plan Administrator know about 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.

NOTICE
Adverse Benefit Determinations

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

Review of Claim Determinations

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

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

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

NOTICE
Adverse Benefit Determinations

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

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

Urgent Care Clinical Claims*

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

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

Pre-Service Claims

Type of Notice or Extension	Timing
if Your claim is filed improperly, HMO must notify You within:	**5 days**
if Your claim is incomplete, HMO must notify You within:	**15 days**
if You are notified that Your claim is incomplete, You must then provide completed claim information to HMO within:	**45 days** after receiving notice
HMO must notify You of the claim determination (whether adverse or not):	
if the initial claim is complete, within:	**15 days***
after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
if You require post-stabilization care after an Emergency within:	**the time appropriate to the circumstance not to exceed one hour after the time of request**

- This period may be extended one time by HMO for up to 15 days, provided that HMO both (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies You, prior

to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which HMO expects to render a decision.

Post-Service Claims

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

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

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

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

Claim Appeal Procedures

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

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

Expedited Clinical Appeals. If Your situation meets the definition of an expedited clinical appeal, You may be entitled to an appeal on an expedited basis. An "expedited clinical appeal" is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care Provider, the denial of Emergency Care or continued hospitalization, or the discontinuance by HMO of prescription drugs or intravenous infusions for which You were receiving health benefits under the plan. Before authorization of benefits for an ongoing course of treatment/continued hospitalization is terminated or reduced, HMO will provide You with notice and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

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

How to Appeal to an Adverse Benefit Determination. You have the right to seek and obtain a review of any determination of a claim, any determination of a request for Prior Authorization, or any other determination made

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

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

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

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

  During the course of Your internal appeal(s), HMO will provide You or Your authorized representative (free of charge) with any new or additional evidence considered, relied upon or generated by HMO in connection with the appealed claim, as well as any new or additional rationale for a denial at the internal appeals stage. Such new or additional evidence or rationale will be provided to You or Your authorized representative as soon as possible and sufficiently in advance of the date a final decision on appeal is made in order to give You a reasonable opportunity to respond. HMO may extend the time period described in this Certificate for its final decision on appeal to provide You with a reasonable opportunity to respond to such new or additional evidence or rationale. If the initial benefit determination regarding the claim is based in whole or in part on a medical judgment, the appeal will be conducted by individuals associated with HMO and/or by external advisors, but who were not involved in making the initial denial of Your claim. No deference will be given to the initial Adverse Determination. Before You or Your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by the HMO.
- If You have any questions about the claims procedures or the review procedure, write to the HMO's Administrative Office or call the toll-free Customer Service Helpline number shown on Your identification card.
- If You have a claim for benefits which is denied or ignored, in whole or in part, and Your health plan is governed by the Employee Retirement Income Security Act (ERISA), You have the right to bring civil action under 502 (a) of ERISA.

Timing of Appeal Determinations

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

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

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

NOTICE
Adverse Benefit Determinations

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

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

Notice of Appeal Determination

HMO will notify the party filing the appeal, You, and, if a clinical appeal, any health care Provider who recommended the services involved in the appeal, orally of its determination followed-up by a written notice of the determination.

The written notice to You and Your authorized representative will include:

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

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

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

NOTICE
Adverse Benefit Determinations

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

External Review Criteria

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

Standard External Review

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

1. **Request for external review.** Within four months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination from the HMO, You or Your authorized representative must file Your request for standard external review.
2. **Preliminary review.** Within five business days following the date of receipt of the external review request, the HMO must complete a preliminary review of the request to determine whether:
    a. You are, or were, covered under the plan at the time the health care item or service was requested;
    b. The Adverse Benefit Determination or the Final Adverse Internal Benefit Determination does not relate to Your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination);
    c. You have exhausted the HMO's internal appeal process unless You are not required to exhaust the internal appeals process under the interim final regulations. Please read the **Exhaustion** section below for additional information and exhaustion of the internal appeal process; and
    d. You or Your authorized representative have provided all the information and forms required to process an external review.

    You will be notified within one business day after we complete the preliminary review if Your request is eligible or if further information or documents are needed. You will have the remainder of the four-month external review request period (or 48 hours following receipt of the notice), whichever is later, to perfect the request for external review. If Your claim is not eligible for external review, we will outline the reasons it is ineligible in the notice, and provide contact information for the Department of Labor's Employee Benefits Security Administration (toll-free number 1-866-444-EBSA (3272)) and or state consumer ombudsman as appropriate.
3. **Referral to Independent Review Organization (IRO).** When an eligible request for external review is completed within the time period allowed, the HMO will assign the matter to an IRO. The IRO assigned will be accredited by URAC or by similar nationally-recognized accrediting organization. Moreover, the HMO will ensure that the IRO is unbiased and independent. Accordingly, the HMO must contract with at least three IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

    The IRO must provide the following:

    a. Utilization of legal experts where appropriate to make coverage determinations under the plan.
    b. Timely notification to You or Your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that You may submit in writing to the assigned IRO within 10 business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO

is not required to, but may, accept and consider additional information submitted after 10 business days.

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

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

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

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

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

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

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

meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

2. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
3. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
4. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
5. A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the HMO or You or Your authorized representative;
6. A statement that judicial review may be available to You or Your authorized representative; and
7. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

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

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

Expedited External Review

1. **Request for expedited external review.** You may request for an expedited external review with the HMO at the time You receive:
   a. An Adverse Benefit Determination, if the Adverse Benefit Determination involved a medical condition of Yours for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function and You have filed a request for an expedited internal appeal; or
   b. A Final Internal Adverse Benefit Determination, if the determination involved a medical condition of Yours for which the timeframe for completion of a standard external review would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which You received emergency services, but have not been discharged from a facility.
2. **Preliminary review**. Immediately upon receipt of the request for expedited external review, the HMO must determine whether the request meets the reviewability requirements set forth in the **Standard External Review** section above. The HMO must immediately send You a notice of its eligibility determination that meets the requirements set forth in **Standard External Review** section above.
3. **Referral to Independent Review Organization (IRO).** Upon a determination that a request is eligible for external review following the preliminary review, the HMO will assign an IRO pursuant to the requirements set forth in the **Standard External Review** section above. The HMO must provide or transmit all necessary documents and information considered in making the Adverse. Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

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

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

Exhaustion

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

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

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

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

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your HMO contract with Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of Blue Cross and Blue Shield Association.

Mastectomy or Lymph Node Dissection

Minimum Inpatient Stay: If due to treatment of breast cancer, any person covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of:

a. 48 hours following a mastectomy

b. 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the covered person receiving the treatment and the attending physician determine that a shorter period of inpatient care is appropriate.

Prohibitions: We may not (a) deny any covered person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours; (b) provide money payments or rebates to encourage any covered person to accept less than the minimum inpatient hours; (c) reduce or limit the amount paid to the attending physician, or otherwise penalize the physician, because the physician required a covered person to receive the minimum inpatient hours; or (d) provide financial or other incentives to the attending physician to encourage the physician to provide care that is less than the minimum hours.

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy - Enrollment

Coverage and/or benefits are provided to each covered person for reconstructive surgery after mastectomy, including;

a. all stages of the reconstruction of the breast on which the mastectomy was performed;

b. surgery and reconstruction of the other breast to achieve a symmetrical appearance; and

c. prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy.

The coverage and/or benefits must be provided in a manner determined to be appropriate in consultation with the covered person and the attending physician.

Deductibles, coinsurance and copayment amounts will be the same as those applied to other similarly covered medical services as shown on the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**.

Prohibitions: We may not (a) offer the covered person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above; (b) condition, limit, or deny any covered person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above; or (c) reduce or limit the amount paid to the physician or provider, nor otherwise penalize, or provide a financial incentive to induce the physician or provider to provide care to a covered person in a manner inconsistent with the coverage and/or benefits shown above.

Examinations for Detection of Prostate Cancer

Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include:

a. a physical examination for the detection of prostate cancer; and

b. a prostate-specific antigen test for each covered male who is

    1. at least 50 years of age; or

    2. at least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

NOTICE OF CERTAIN MANDATORY BENEFITS

Inpatient Stay following Birth of a Child

For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother/birthing parent and their newborn child in a health care facility for a minimum of:

a. 48 hours following an uncomplicated vaginal delivery, and

b. 96 hours following an uncomplicated delivery by cesarean section.

This benefit does not require a covered member who is eligible for maternity/childbirth benefits to (a) give birth in a hospital or other health care facility or (b) remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

If a covered mother/birthing parent or their newborn child is discharged before the 48 or 96 hours has expired, we will provide coverage for post-delivery care. Post-delivery care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. Care will be provided by a physician, registered nurse or other appropriate licensed health care provider, and the mother/birthing parent will have the option of receiving the care at their home, the health care provider's office or a health care facility.

Since we provide in-home post-delivery care, we are not required to provide the minimum number of hours outlined above unless (a) the mother/birthing parent's or child's physician, determines the inpatient care is medically necessary, or (b) the mother/birthing parent requests the inpatient stay.

Prohibitions. We may not (a) modify the terms of this coverage based on any covered person requesting less than the minimum coverage required; (b) offer the mother/birthing parent financial incentives or other compensation for waiver of the minimum number of hours required; (c) refuse to accept a physician's recommendation for a specified period of inpatient care made in consultation with the mother/birthing parent if the period recommended by the physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians; (d) reduce payments or reimbursements below the usual and customary rate; or (f) penalize a physician for recommending inpatient care for the mother/birthing parent and/or the newborn child.

Coverage for Tests for Detection of Colorectal Cancer

Benefits are provided, for each person enrolled in the plan who is 45 years of age or older and at normal risk for developing colon cancer, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include the covered person's choice of:

a. a fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years, or

b. a colonoscopy performed every 10 years.

Coverage of Tests for Detection of Human Papillomavirus, Ovarian Cancer, and Cervical Cancer

Coverage is provided for each woman enrolled in the plan who is 18 years of age or older for expenses incurred for an annual, medically recognized diagnostic examination for the early detection of ovarian and cervical cancer. Coverage required under this section includes a CA 125 blood test and, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the FDA, alone or in combination with a test approved by the FDA for the detection of the human papillomavirus.

NOTICE OF CERTAIN MANDATORY BENEFITS

Treatment of Acquired Brain Injury

Your health benefit plan coverage for an acquired brain injury includes the following services:

a. cognitive rehabilitation therapy;

b. cognitive communication therapy;

c. neurocognitive therapy and rehabilitation;

d. neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing and treatment;

e. neurofeedback therapy, remediation;

f. post-acute transition services and community reintegration services, including outpatient day treatment services or other post-acute care treatment services; and

g. reasonable expenses related to periodic reevaluation of the care of an individual covered under the plan who has incurred an acquired brain injury, has been unresponsive to treatment, and becomes responsive to treatment at a later date, at which time the cognitive rehabilitation services would be a covered benefit.

The fact that an acquired brain injury does not result in hospitalization or acute care treatment does not affect the right of the insured or the enrollee to receive the preceding treatments or services commensurate with their condition. Post-acute care treatment or services may be obtained in any facility where such services may legally be provided, including acute or post-acute Rehabilitation Hospitals and assisted living facilities regulated under the Health and Safety Code.

If any person covered by this plan has questions concerning the information above, please call Blue Cross and Blue Shield of Texas at 1-877-299-2377 or write us at P.O. Box 660044, Dallas, Texas 75266-0044.

INTER-PLAN ARRANGEMENTS NOTICE

BLUE CROSS AND BLUE SHIELD OF TEXAS,
A DIVISION OF HEALTH CARE SERVICE CORPORATION

Inter-Plan Arrangements

Out-of-Area Services

Overview

Texas ("BCBSTX"), a division of Health Care Service Corporation has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." These Inter-Plan Programs work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you obtain healthcare services outside of BCBSTX's service area, the claim for those services may be processed through one of these Inter-Plan Programs.

When you receive care outside of BCBSTX's service area, you will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some providers ("nonparticipating providers") don't contract with the Host Blue. BCBSTX explains how BCBSTX pays both kinds of providers below.

BCBSTX covers only limited healthcare services received outside of BCBSTX's service area. As used in this section, "Out-of-Area Covered Healthcare Services" include emergency care, urgent care and follow up care obtained outside the geographic area BCBSTX serves. Any other services will not be covered when processed through any Inter-Plan Programs, unless authorized by your primary care physician ("PCP")/BCBSTX.

Inter-Plan Programs Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Programs, as described above, except for all dental care benefits, except when paid as medical claims/benefits, and those prescription drug benefits or vision care benefits that may be administered by a third party contracted by BCBSTX to provide the specific service or services.

Inter-Plan Programs

Under the Inter-Plan Programs, when you receive Out-of-Area Covered Healthcare Services within the geographic area served by a Host Blue, BCBSTX will remain responsible for doing what BCBSTX agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

Inter-Plan Programs enable you to obtain Out-of-Area Covered Healthcare Services, as defined above, from a healthcare provider participating with a Host Blue, where available. The participating provider will automatically file a claim for the Out-of-Area Covered Healthcare Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the copayment amount, as stated in your plan summary.

Emergency Care Services: If you experience a medical emergency while traveling outside BCBSTX's service area, go to the nearest emergency or urgent care facility.

When you receive Out-of-Area Covered Healthcare Services outside BCBSTX's service area and the claim is processed through Inter-Plan Programs, the amount you pay for the Out-of-Area Covered Healthcare Services, if not a flat dollar copayment, is calculated based on the lower of:

- The billed charges for your Out-of-Area Covered Healthcare Services; or
- The negotiated price that the Host Blue makes available to BCBSTX.

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 considers 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 considering the same types of transactions as with an estimated price.

Estimated pricing and average pricing also consider adjustments to correct for over or underestimation of modifications of past pricing of claims, as noted above. However, such adjustments will not affect the price BCBSTX has used for your claim because they will not be applied after a claim has already been paid.

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to fully insured accounts. If applicable, BCBSTX will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

Nonparticipating Providers Outside BCBSTX's Service Area

Member Liability Calculation

When Out-of-Area Covered Healthcare Services are provided outside of BCBSTX's service area by nonparticipating providers, the amount(s) you pay for such services will normally be based on either the Host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the nonparticipating provider bills and the payment BCBSTX will make for the Out-of-Area Covered Healthcare Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

In certain situations, BCBSTX may use other payment methods, such as billed charges for Out-of-Area Covered Healthcare Services, the payment BCBSTX would make if the healthcare services had been obtained within BCBSTX's service area, or a special negotiated payment to determine the amount BCBSTX will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment BCBSTX will make for the Out-of-Area Covered Healthcare Services as set forth in this paragraph.

Blue Cross Blue Shield Global® Core (Blue Cross Blue Shield Global Solutions℠)

General Information

If you are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, (hereinafter: "domestic service area"), you may be able to take advantage of Blue Cross Blue Shield Global® Core when accessing covered healthcare services. Blue Cross Blue Shield Global® Core is unlike the Inter-Plan Programs available in the domestic service area in certain ways. For instance, although Blue Cross Blue Shield Global® Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the domestic 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 United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, will arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

  In most cases, if you contact the service center for assistance, hospitals outside the domestic service area

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 initiate claims processing. However, if you paid in full at the time of service, you must submit a claim to obtain reimbursement for covered healthcare services.

- **Outpatient Services**

  Physicians, urgent care centers and other outpatient providers located outside the domestic 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 healthcare services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**

  When you pay for covered healthcare services outside the domestic 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 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 BCBSTX, 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

Your rights with a Health Maintenance Organization (HMO) plan

Notice from the Texas Department of Insurance

Your plan

Your HMO plan contracts with doctors, facilities, and other health care providers to treat its members. Providers that contract with your health plan are called "contracted providers" (also known as "in-network providers"). Contracted providers make up a plan's network. Your plan will only pay for health care you get from doctors and facilities in its network.

However, there are some exceptions, including for emergencies, when you didn't pick the doctor, and for ambulance services.

Your plan's network

Your health plan must have enough doctors and facilities within its network to provide every service the plan covers. You shouldn't have to travel too far or wait too long to get care. This is called "network adequacy." If you can't find the care you need, ask your health plan for help. You have the right to receive the care you need under your in-network benefit.

If you don't think the network is adequate, you can file a complaint with the Texas Department of Insurance at www.tdi.texas.gov or by calling 800-252-3439.

List of doctors

You can get a directory of health care providers that are in your plan's network.

You can get the directory online at www.bcbstx.com/find-care/find-a-doctor-or-hospital or by calling the toll-free telephone number on the back of your identification card.

If you used your health plan's directory to pick an in-network health care provider and they turn out to be out-of-network, you might not have to pay the extra cost that out-of- network providers charge.

Bills for health care

If you got health care from a doctor that was out-of-network when you were at an in- network facility, and you didn't pick the doctor, you won't have to pay more than your regular copay, coinsurance, and deductible. Protections also apply if you got emergency care at an out-of-network facility or lab work or imaging in connection with in-network care.

If you get a bill for more than you’re expecting, contact your health plan. Learn more about how you’re protected from surprise medical bills at tdi.texas.gov.

PLAN DESCRIPTION AND MEMBER HANDBOOK

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

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

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

Plan Description and Member Handbook

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

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

You may also write HMO at:

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

Again, thank You for considering us for Your health care coverage.

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

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

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MEDICALLY NECESSARY COVERED SERVICES AND BENEFITS

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

The copayment and any other coinsurance or deductible amount is determined by your plan. Consumer Choice plans do not include all state mandated health insurance benefits which means these plans may include deductibles and benefit limits that are not included on other plans.

Hospitalization

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

During an inpatient stay at a participating hospital, skilled nursing facility or other participating facility, it may be appropriate for a physician other than your PCP to direct and oversee your care, if your PCP does not do so. However, upon discharge, you must return to the care of your PCP or have your PCP coordinate care that may be medically necessary.

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

Other Medical Services

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

Preventive Care

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

- Well-child care, including immunizations;
- Prenatal and postnatal care;
- Hearing loss screenings through 24 months;
- Periodic health assessments;
- Eye and ear screenings;
- Annual well-woman exams, including, but not limited to, a conventional Pap smear;
- Annual screening mammograms for individuals age 35 and older or with other risk factors. Also covers additional imaging and pathology evaluation, if indicated to complete the initial screening for malignancies.;
- Annual in-home health assessment;
- Bone mass measurement for osteoporosis;
- Colorectal cancer exams, preventive services, and lab tests that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Task Force ("USPSTF") for persons 45 years of age and older;
- Any other evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Task Force ("USPSTF") or as required by state law.

Behavioral Health Care

Your mental health benefits include outpatient and depending on your plan inpatient visits for crisis intervention and evaluation. Please refer to Your Certificate of Coverage for additional information. To access mental health services, call the behavioral health toll-free telephone number on the back of Your ID card.

Prescription Drugs

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

REMEMBER:

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

EMERGENCY CARE, AFTER HOURS CARE AND URGENT CARE

Medical Emergencies

Emergency care is defined as health care services provided in a participating or non-participating hospital emergency facility, freestanding emergency medical care facility, or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that their condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in placing the patient's health in serious jeopardy, cause serious impairment to bodily function, cause serious dysfunction of any organ or part of the body, cause serious disfigurement or, in the case of a pregnant member, cause serious jeopardy to the health of the fetus.

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

REMEMBER:

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

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

After Hours Care

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

Urgent Care Services

Urgent care services are covered when rendered by a participating urgent care center provider for the immediate treatment of a medical condition that requires prompt medical attention but where a brief time lapse

before receiving services will not endanger life or permanent health and does not require emergency care services. A PCP referral is not required.

Retail Health Clinics

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

Virtual Visits

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

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

Out-of-Area Services and Benefits

Emergency Services Outside the Service Area

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

Urgent Care Outside the Service Area

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

Follow these easy steps:

1. locate a participating provider by calling BlueCard Access at 1-800-810-BLUE (2583) or visit the BlueCard Doctor and hospital finder website (www.bcbs.com).
2. call your PCP for referrals and for care requiring prior authorization.
3. schedule an appointment directly with the provider.
4. present Your ID card.
5. pay any applicable copayments, coinsurance or deductible.
6. discuss follow-up care with your PCP.

OUT-OF-NETWORK FACILITY-BASED PROVIDERS AND DIAGNOSTIC IMAGING AND LAB PROVIDERS

In some instances you may not have the ability to choose a network provider, such as when you receive services from a non-participating facility-based provider in a network facility, or when you receive services from a non-participating laboratory or diagnostic imaging facility in connection with care provided by Your Participating Provider. In these instances, your services may be covered and you would not be responsible for any amounts beyond the copayment/coinsurance or any deductibles. If you receive a bill from an out-of-network provider in such circumstances, please contact HMO. If you elect to use out-of-network providers for non-emergency care services and supplies available from participating providers, benefits will not be covered.

YOUR FINANCIAL RESPONSIBILITIES

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

your plan. Consumer Choice plans do not include all state mandated health insurance benefits which means these plans may include deductibles and benefit limits that are not included on other plans. Also, you will have to pay for services not covered by HMO.

HMO network physicians and providers have agreed to look only to HMO and not to its members for payment of covered services. Usually, you are expected to pay nothing more than a copayment and any applicable coinsurance or deductible to participating providers. You should not receive a bill for services received from participating providers. If this occurs, call customer service to help determine if the service is a covered benefit and/or to correct the problem.

LIMITATIONS AND EXCLUSIONS

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

PRIOR AUTHORIZATION REQUIREMENTS, REFERRAL PROCEDURES AND OTHER REVIEW REQUIREMENTS

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

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

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

Concurrent Review

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

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

Retrospective Review

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

Case Management Review

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

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

If you receive notice that your provider is no longer participating with HMO, it is important to understand that there are special circumstances that allow the provider to continue treatment for a limited time.

If you are under the care of a participating provider who stops participating in HMO's network, (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or for fraud), HMO will continue coverage for that Provider's Covered Services if all the following conditions are met:

- You are undergoing a course of treatment for a serious and complex condition, you have an acute condition, you are undergoing institutional or inpatient care, you are scheduled to undergo nonelective surgery from the provider (including receipt of postoperative care from such Provider with respect to such surgery), You are pregnant or undergoing a course of treatment for the pregnancy, or 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 care (for example, 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;
- HMO may request provider submits a request to HMO to continue coverage of your care that identifies the condition for which you are being treated and, where required, indicates that the provider reasonably believes that discontinuing treatment could cause you harm; and
- the provider agrees to continue accepting the same reimbursement that applied when participating in HMO's network, and not to seek payment from you for any amounts for which you would not be responsible if the provider were still participating in HMO's network.

Continuity coverage shall continue until the treatment is complete but shall not extend for more than ninety (90) days (or more than nine (9) months if you have been diagnosed with a terminal illness) beyond the date the Provider's termination takes effect. If you are past the thirteenth (13th) week of pregnancy when the Provider's termination takes effect, coverage may be extended through delivery, 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 subsection as explained in the **Complaint and Appeal Procedure for ENROLLEES** section of this Handbook.

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

Claim or Benefit Reconsideration

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

Complaints

There may be times when you find that You don't agree with a particular HMO policy or procedure or benefit decision, or you are not satisfied with some aspect of the treatment by a participating provider. We encourage you to communicate your dissatisfaction promptly and directly to the source of the problem. The goal of customer service is to prevent small problems from becoming large issues. To express a complaint regarding any aspect of the HMO program, call or write Customer Service.

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

Complaint Procedure

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

that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to your satisfaction.

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

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

After receiving your written complaint or the written complaint form, HMO will investigate your concerns and send you a letter outlining and explaining the resolution. The letter includes a statement of the specific medical and contractual reasons for the resolution including any benefit exclusion, limitation or medical circumstance; additional information required to adjudicate a claim, if applicable, and the specialization of any provider consulted. The total time for acknowledging, investigating and resolving Your written complaint will not exceed thirty calendar days from the date HMO receives your written complaint or complaint form.

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

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

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

Complaint Appeals to HMO

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

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

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

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

You are entitled to:

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

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

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

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

Filing Complaints with the Texas Department of Insurance

There are two methods of filing a TDI complaint:

Any person, including those who have attempted to resolve complaints through HMO's complaint process, who is dissatisfied with the resolution, may report their dissatisfaction to the Texas Department of Insurance, Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2023

- via mail
- via online at www.TDI.texas.gov

The Texas Department of Insurance will investigate complaints against HMO within sixty (60) days of receiving the complaint. The time necessary to complete an investigation may be extended if:

- additional information is needed;
- an on-site review is necessary;
- complainant, HMO, or the physician or provider does not provide all documentation necessary to complete the investigation; or
- other circumstances beyond the control of the Texas Department of Insurance occur.

Appeal of Adverse Determinations

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

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

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

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

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

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

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

Expedited Appeal of Adverse Determination Procedures

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

Appeals Process to Independent Review Organization

An independent review organization is an organization independent of HMO that may perform a final administrative review of an adverse determination made by us.

In a circumstance involving a life-threatening or urgent care circumstances, if HMO has discontinued coverage of prescription drugs or intravenous infusions for which you were receiving health benefits under the Certificate, or if you do not receive a timely decision, you are entitled to an immediate appeal to an independent review organization rather than going through HMO's appeal of an adverse determination process.

The independent review organization process is not part of the complaint process but is available only for appeals of adverse determination. You may request a review of an appeal of an adverse determination by the independent review organization. HMO will adhere to the following guidelines/criteria:

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

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

- Information relied upon in making the benefit determination;
- Information submitted, considered or generated in the course of making the benefit determination, whether or not it was relied upon in making the benefit determination;
- Descriptions of the administrative process and safeguards used in making the benefit determination;
- Records of any independent reviews conducted by HMO;
- Medical judgments, including determinations about whether a particular service is experimental, investigational or not medically necessary or appropriate; and
- Expert advice and consultation obtained by HMO in connection with the denied claim, whether or not the advice was relied upon in making the benefit determination. The appeal process does not prohibit you from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or relief available under law, if exhausting the procedures of HMO's process for appeal and review places your health in serious jeopardy.

NETWORK PROVIDERS

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

Your (PCP) will be the one you call when You need medical advice, when you are sick and when you need preventive care such as immunizations. Your PCP will play a key role in the delivery of your health care. The network to which your PCP belongs will provide or arrange for all of your care, so make sure that your PCP's network includes the specialists and hospitals that you prefer.

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

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

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

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

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

SERVICE AREA

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

GENERAL INFORMATION

Identification (ID) Card

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

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

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

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

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

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

REMEMBER:

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

RECEIVING CARE

Your Primary Care Physician (PCP)

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

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

REMEMBER:

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

Changing PCPs

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

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

Once you've made your decision, either call Customer Service or complete a change form and submit it to the Membership Department, P.O. Box 660044, Dallas, Texas 75266-0044 . You may also request the transfer of your medical records from your previous PCP to the newly selected physician.

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

Making Appointments

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

If the nature of an illness warrants an urgent appointment, your PCP can generally fit you into their schedule within a reasonable period of time. If your PCP cannot fit you in, they may direct you to a designated back-up physician. If you need assistance, you may call Customer Service at the telephone number on the back of your ID card. If you need to change or cancel an appointment, be sure to call our PCP as soon as you can. When you visit your PCP's office for covered services, you will pay only a copayment and any other applicable coinsurance or deductibles for the office visit. There are no claims to file. If You need the care of a specialist, your PCP will refer You and will handle any prior authorization requirements for you.

REMEMBER:

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

Telehealth and Telemedicine Medical Services

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

Telehealth Service means a health service, other than a Telemedicine Medical Service, delivered by a health professional licensed, certified, or otherwise entitled to practice in Texas and acting within the scope of the health professional's license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.

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

ADDITIONAL INFORMATION

Status Changes

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

will affect eligibility. Completed forms must be received by HMO within 31 days from the date of any change listed below:

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

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

must be made to the Exchange within 30 days and You must make or agree to make any additional Premium payments in accordance with this Certificate.

Duplication of Coverage and Coordination of Benefits

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

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

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

Continuation of Benefits

Under the Consolidated Omnibus Budget Reconciliation Act (federal legislation called COBRA), many employers offer a continuation of group coverage if You become ineligible for group membership. Ask your employer if this coverage is available to you. You also may be able to continue Your coverage under State Continuation guidelines, as explained in your Certificate of Coverage.

REMEMBER:

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

New Medical Technology

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

YOUR RIGHTS AND RESPONSIBILITIES

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

Your Rights

You have the right to:

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

Your Responsibilities

You have the responsibility to:

- Meet all eligibility requirements;
- Identify Yourself by presenting Your ID card and pay the copayment and any other applicable amount due at the time of service for network benefits;
- Establish a physician/patient relationship with your PCP and seek Your PCP's medical advice/referral for network services prior to receiving medical care, unless it is an emergency situation or services are performed by your HMO Participating OB/GYN;
- Understand the medications you are taking and receive proper instructions on how to take them;
- Communicate complete and accurate medical information to health care providers;
- Call in advance to schedule appointments with network providers and notify them prior to canceling or rescheduling appointments;
- Ask questions and follow instructions and guidelines given by providers to achieve and maintain good health;

- Discuss disagreements and/or misunderstandings regarding treatment from providers;
- Notify your PCP or HMO within 48 hours or as soon as reasonably possible after receiving emergency care services;
- Provide, to the extent possible, information that HMO needs in order to administer your benefit plan, including changes in Your family status, address and phone numbers ;
- Read your Certificate of Coverage for information about HMO benefits, limitations, and exclusions; and
- Understand Your health conditions, and participate to the degree possible in the development of treatment goals mutually agreed upon between you and your provider.

CONFIDENTIALITY AND ACCESS TO RECORDS

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

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

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

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

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

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

CUSTOMER SERVICE

Questions

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

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

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

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

Your rights with a Health Maintenance Organization (HMO) plan

Notice from the Texas Department of Insurance

Your plan

Your HMO plan contracts with doctors, facilities, and other health care providers to treat its members. Providers that contract with your health plan are called "contracted providers" (also known as "in-network providers"). Contracted providers make up a plan's network. Your plan will only pay for health care you get from doctors and facilities in its network.

However, there are some exceptions, including for emergencies, when you didn't pick the doctor, and for ambulance services.

Your plan's network

Your health plan must have enough doctors and facilities within its network to provide every service the plan covers. You shouldn't have to travel too far or wait too long to get care. This is called "network adequacy." If you can't find the care you need, ask your health plan for help. You have the right to receive the care you need under your in-network benefit.

If you don't think the network is adequate, you can file a complaint with the Texas Department of Insurance at www.tdi.texas.gov or by calling 800-252-3439.

List of doctors

You can get a directory of health care providers that are in your plan's network.

You can get the directory online at www.bcbstx.com/find-care/find-a-doctor-or-hospital or by calling the toll-free telephone number on the back of your identification card.

If you used your health plan's directory to pick an in-network health care provider and they turn out to be out-of-network, you might not have to pay the extra cost that out-of- network providers charge.

Bills for health care

If you got health care from a doctor that was out-of-network when you were at an in- network facility, and you didn't pick the doctor, you won't have to pay more than your regular copay, coinsurance, and deductible. Protections also apply if you got emergency care at an out-of-network facility or lab work or imaging in connection with in-network care.

If you get a bill for more than you’re expecting, contact your health plan. Learn more about how you’re protected from surprise medical bills at tdi.texas.gov.

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

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

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

The following demographics describe the network as of July 2026, that your Texas HMO Plan provides access to for the provision of Covered Services.

Network	Enrollees	Specialty	Participating Providers	Access
Blue Advantage HMO Network	419,399	Internal Medicine	13,291	Yes
		Family/Gen. Practice	19,088	Yes
		Pediatrics	4659	Yes
		Obstetrics and Gynecology	3564	Yes
		Anesthesiology	4963	Yes
		Psychiatry	2515	Yes
		General Surgery	2289	Yes
		Acute Care Hospitals	309	Yes

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

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

Blue Cross and Blue Shield of Texas (BCBSTX)

By:
James Springfield
President, Blue Cross and Blue Shield of Texas

bcbstx.com