BlueCross BlueShield of Texas

Your Health Care Benefits Program

Managed Health Care Pharmacy Benefits

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

CERTIFICATE OF COVERAGE

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
(herein called "BCBSTX" or "Carrier")

Hereby certifies that it has issued a Group **Managed Health Care, and Pharmacy Benefits** Contract (herein called the "Plan"). Subject to the provisions of the Plan, each Employee (Subscriber) to whom a Blue Cross and Blue Shield Identification Card is issued, together with their eligible Dependents for whom application is initially made and accepted, shall have coverage under the Plan, beginning on the Effective Date shown on the Identification Card, if the Employer makes timely payment of total premium due to the Carrier. Issuance of this Benefit Booklet by BCBSTX does not waive the eligibility and Effective Date provisions stated in the Plan. Any reference to "applicable law" will include applicable laws and rules, including but not limited to statutes, ordinances, and administrative decisions and regulations.

James Springfield
President of Blue Cross and Blue Shield of Texas

The Schedule(s) of Coverage enclosed with this Benefit Booklet indicate benefit percentages, Deductibles, Copayment Amounts, maximums, and other benefit and payment issues that apply to the Plan.

The Schedule(s) of Coverage specify benefits for:

Managed Health Care (In-Network) and (Out-of-Network) coverage

Pharmacy Benefit coverage

NOTICE OF SEPARATE AVAILABLE COVERAGE

This notice is required by Texas legislation to be provided to you. It is to inform you, the Employee, that your Employer has selected this health benefit coverage. BCBSTX does not offer a rider or separate insurance contract through your Employer that would provide coverage in addition to the coverage under this Contract.

THE INSURANCE CONTRACT UNDER WHICH THIS BENEFIT BOOKLET IS ISSUED IS NOT A CONTRACT OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

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
To get information or file a complaint with your insurance company or HMO:

Call: Blue Cross and Blue Shield of Texas
Toll-Free: 1-800-521-2227
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, PO 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
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: 1-800-521-2277
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-CP,
Texas Department of Insurance, PO Box 12030, Austin, TX 78711-2030

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Schedule of Coverage

BlueCross BlueShield of Texas

The following information summarizes the benefits available under the Managed Health Care Benefits section of your coverage. To get the most out of your coverage, it is important that you carefully read your Benefit Booklet so you are aware of plan requirements, provisions and limitations and exclusions.

(Blue Choice Gold PPO℠ 204) **Blue Choice PPO℠ Network**

Overall Payment Provisions	In-Network Benefits	Out-of-Network Benefits
Copayment Amounts, Deductibles and Out-of-Pocket Maximums are subject to change or increase as permitted by applicable law		
Deductibles		
Calendar Year Deductible Applies to all Eligible Expenses	$3,000 Individual/$9,000 Family	$6,000 Individual/$18,000 Family
Out-of-Pocket Maximum	$5,500 Individual/$11,000 Family	Unlimited Individual/Unlimited Family
Copayment Amounts Required		
Primary Care Copayment Amount for office visit/consultation when services rendered by a Family Practitioner, OB/GYN, Pediatrician, Behavioral Health Practitioner or Internist and Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these listed Physicians	$30 Primary Care Copayment Amount	
Specialty Copayment Amount for office visit/consultation when services rendered by a Specialty Care Provider.	$50 Specialty Copayment Amount	
Telehealth and Telemedicine Services Copayment Amount	$30/$50 Copayment Amount	
Virtual Visits Copayment Amount	$30 Copayment Amount	
Urgent Care center visit	$75 Copayment Amount	
Infusion Therapy in the home, office, or in an Infusion Suite	$50 Outpatient Infusion Therapy Copayment Amount	
Outpatient Infusion Therapy - Hospital Setting	$500 Outpatient Infusion Therapy Copayment Amount	
Outpatient surgery Copayment Amount (facility charges only)		$300 Copayment Amount
Outpatient Hospital emergency room visit	$300 outpatient Hospital emergency room visit Copayment Amount	$300 outpatient Hospital emergency room visit Copayment Amount
X-ray and other diagnostic imaging	$100 Copayment Amount	
Imaging Services	$100 Copayment Amount	

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Calendar Year Maximum amounts indicated

*****After the age of 3, when services under the individualized family service plan are completed, Eligible Expenses, as otherwise covered under the Policy, will be available. All contractual provisions of the Policy will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximum.

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Inpatient Hospital Expenses	In-Network Benefits	Out-of-Network Benefits
Inpatient Hospital Expenses All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	90% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after $400 per-admission Copayment Amount and after Calendar Year Deductible
Penalty for failure to prior authorize services	None	$250
Medical/Surgical Expenses	**In-Network Benefits**	**Out-of-Network Benefits**
Primary Care office visit/consultation when services rendered by a Family Practitioner, OB/GYN, Pediatrician, Behavioral Health Practitioner or Internist and Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these listed Physicians.	100% of Allowable Amount after $30 Primary Care Copayment Amount	80% of Allowable Amount after Calendar Year Deductible
Specialty office visit/consultation when services rendered by a Specialty Care Provider.	100% of Allowable Amount after $50 Specialty Copayment Amount	80% of Allowable Amount after Calendar Year Deductible
Outpatient Surgery facility charges	90% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after $300 Outpatient Surgery Copayment Amount after Calendar Year Deductible
Outpatient Surgery Physician charges	90% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
X-ray and other diagnostic imaging charges	90% of Allowable Amount after $100 Copayment Amount and after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
Lab services charges	90% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
Inpatient visits	90% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
Imaging Services	100% of Allowable Amount after $100 Copayment Amount	80% of Allowable Amount after Calendar Year Deductible
Home Infusion Therapy	90% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
Infusion Therapy in the home, office, or in an Infusion Suite	100% of Allowable Amount after $50 Outpatient Infusion Therapy Copayment Amount	80% of Allowable Amount after Calendar Year Deductible
Outpatient Infusion Therapy Drug (non-maintenance)	90% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible

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Outpatient Infusion Therapy - Hospital Setting	100% of Allowable Amount after $500 Outpatient Infusion Therapy Copayment Amount	80% of Allowable Amount after Calendar Year Deductible
Physician surgical services performed in any setting	90% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
Extended Care Expenses	**In-Network Benefits**	**Out-of-Network Benefits**
Certain Services will require Prior Authorization	90% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
Skilled Nursing Facility	25 days per Calendar Year*	
Home Health Care	60 visits per Calendar Year*	
Hospice Care	Unlimited	
Hospice Care that is provided in a Hospital will include charges as described in Inpatient Hospital Expense		
Special Provisions	**In-Network Benefits**	**Out-of-Network Benefits**
Behavioral Health Services		
Treatment of Chemical Dependency (Substance Use Disorder (SUD)) Certain Services will require Prior Authorization		
Inpatient Services		
Inpatient treatment must be provided in a Chemical Dependency (SUD) Treatment Center / Hospital (facility)	90% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after $400 per admission Copayment Amount and after Calendar Year Deductible
Penalty for failure to prior authorize inpatient services (facility) same as for medical services	None	$250
Behavioral Health Practitioner services	90% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
Outpatient Services		
Behavioral Health Practitioner expenses (office setting)	100% of Allowable Amount after $30 Copayment Amount	80% of Allowable Amount after Calendar Year Deductible
Other outpatient services	90% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Calendar Year Maximum amounts indicated

*****After the age of 3, when services under the individualized family service plan are completed, Eligible Expenses, as otherwise covered under the Policy, will be available. All contractual provisions of the Policy will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximum.

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Mental Health Care (Including Serious Mental Illness) Certain Services will require Prior Authorization		
Inpatient Services Hospital services (facility)	90% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after $400 per-admission Copayment Amount and after Calendar Year Deductible
Penalty for failure to prior authorize inpatient services (facility) same as for medical services	None	$250
Behavioral Health Practitioner services	90% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
Outpatient Services Behavioral Health Practitioner expenses (office setting)	100% of Allowable Amount after $30 Copayment Amount	80% of Allowable Amount after Calendar Year Deductible
Other outpatient services	90% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
Emergency Room		
Emergency Care (including Emergency Care for Accidental Injury and Emergency and Non-Emergency Care for Behavioral Health Services)		
Facility charges (excluding Certain Diagnostic Procedures)	90% of Allowable Amount after $300 outpatient Hospital emergency room Copayment Amount (waived if admitted, and Inpatient Hospital Expenses will apply) after Calendar Year Deductible	
Physician charges	90% of Allowable Amount after Calendar Year Deductible	
X-ray and other diagnostic imaging charges	90% of Allowable Amount after $100 Copayment Amount and after Calendar Year Deductible	
Lab services charges	90% of Allowable Amount after Calendar Year Deductible	
Non-Emergency Care		
Facility charges (excluding Certain Diagnostic Procedures)	90% of Allowable Amount after $300 outpatient Hospital emergency room Copayment Amount (waived if admitted, and Inpatient Hospital Expenses will apply) after Calendar Year Deductible	80% of Allowable Amount after $300 outpatient Hospital emergency room Copayment Amount (waived if admitted, and Inpatient Hospital Expenses will apply) after Calendar Year Deductible
Physician charges	90% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Calendar Year Maximum amounts indicated

*****After the age of 3, when services under the individualized family service plan are completed, Eligible Expenses, as otherwise covered under the Policy, will be available. All contractual provisions of the Policy will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximum.

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X-ray and other diagnostic imaging charges	90% of Allowable Amount after $100 Copayment Amount and after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
Lab services charges	90% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
Urgent Care Services		
Urgent Care center visit	100% of Allowable Amount after $75 Copayment Amount	80% of Allowable Amount after Calendar Year Deductible (Urgent Care Copayment Amount will apply to Accidental Injury and Emergency Care services provided Out-of-Network)
Services received during an Urgent Care visit	90% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
Ambulance Services	90% of Allowable Amount after Calendar Year Deductible	
Retail Health Clinic		
	Paid as any other Primary Care Copayment Amount	80% of Allowable Amount after Calendar Year Deductible
Telehealth and Telemedicine Services		
	100% of Allowable Amount after $30/$50 Copayment Amount	80% of Allowable Amount after Calendar Year Deductible
Virtual Visits		
	100% of Allowable Amount after $30 Copayment Amount	XXXXXXXXXX
Preventive Care Services		
	100% of Allowable Amount	80% of Allowable Amount after Calendar Year Deductible
Speech and Hearing Services		
Services to restore loss of or correct an impaired speech or hearing function with hearing aids Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any speech services visits maximum.	Covered as any other sickness	Covered as any other sickness
Hearing Aids	90% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
Hearing Aids maximum	Limited to one hearing aid per ear each 36-month period*	

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Calendar Year Maximum amounts indicated

*****After the age of 3, when services under the individualized family service plan are completed, Eligible Expenses, as otherwise covered under the Policy, will be available. All contractual provisions of the Policy will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximum.

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BlueCross BlueShield of Texas

(Blue Choice Gold PPO℠ 204) **Blue Choice PPO℠ Network**

Cardiovascular Tests		
One of the following early detection tests for cardiovascular disease will be covered for a Participant who meets the age requirements and is a diabetic or has been determined to have a risk of developing coronary heart disease:	Maximum benefit of 1 test every 5 years*	
• Computed tomography (CT) scanning measuring coronary artery calcification	100% of Allowable Amount after $100 Copayment Amount	80% of Allowable Amount after Calendar Year Deductible
• Ultrasonography measuring carotoid intima-media thickness and plaque.	90% of Allowable Amount after $100 Copayment Amount and after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
Habilitation Services		
Habilitation Services (includes, but is not limited to physical, occupational, and manipulative therapy)	90% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
Calendar Year maximum	35 visits each Calendar Year* The visit limit does not apply to an individualized family service plan as issued by the Texas Interagency Council on Early Childhood Intervention as provided for in the benefit for **Certain Therapies for Children with Developmental Delays***** This limit does not apply to services associated with Autism Spectrum Disorder This limit does not apply to services associated with Acquired Brain Injury This limit does not apply to services associated with Behavioral Health Services	
Rehabilitation Services		
Rehabilitation Services (includes, but is not limited to physical, occupational, and manipulative therapy)	90% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
Calendar Year maximum	35 visits each Calendar Year* The visit limit does not apply to an individualized family service plan as issued by the Texas Interagency Council on Early Childhood Intervention as provided for in the benefit for **Certain Therapies for Children with Developmental Delays***** This limit does not apply to services associated with Autism Spectrum Disorder This limit does not apply to services associated with Acquired Brain Injury This limit does not apply to services associated with Behavioral Health Services	
Prior Authorization Requirements	**In-Network**	**Out-of-Network**
Inpatient Admissions		
Penalty for failure to prior authorize inpatient admissions shown in the Prior Authorization Requirements section of the Benefit Booklet	None	$250

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Calendar Year Maximum amounts indicated

*****After the age of 3, when services under the individualized family service plan are completed, Eligible Expenses, as otherwise covered under the Policy, will be available. All contractual provisions of the Policy will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximum.

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Schedule of Coverage

BlueCross BlueShield of Texas

The following chart summarizes the pharmacy benefits available under your coverage. To get the most out of your coverage, it is important that you carefully read the **PHARMACY BENEFITS** section of your Benefit Booklet so you are aware of plan requirements, provisions, limitations and exclusions.

Pharmacy Benefits			
Retail Pharmacy	**Preferred Participating Pharmacy**	**Participating Pharmacy**	**Non-Participating Pharmacy**
One Copayment Amount per 30-day supply, up to a 30-day supply.	$0 Copayment Amount – Tier 1 $10 Copayment Amount – Tier 2 $50 Copayment Amount – Tier 3 $100 Copayment Amount* – Tier 4	$10 Copayment Amount – Tier 1 $20 Copayment Amount – Tier 2 $70 Copayment Amount – Tier 3 $120 Copayment Amount* – Tier 4	50% of Allowable Amount minus Participating Pharmacy Copayment Amount *
Extended Prescription Drug Supply Program	**Preferred Participating Pharmacy**	**Participating Pharmacy**	**Non-Participating Pharmacy**
One Copayment Amount per 30-day supply, up to a 90-day supply. Cost share will be based on day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.	$0 Copayment Amount – Tier 1 $10 Copayment Amount – Tier 2 $50 Copayment Amount – Tier 3 $100 Copayment Amount* – Tier 4	**XXXXXXXXXXXXX**	**XXXXXXXXXXXXX**
Mail-Order Program	**Mail-Order Program**		**Other Pharmacy**
One Copayment Amount per 90-day supply, up to a 90-day supply Cost share will be based on day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.	$0 Copayment Amount – Tier 1 $30 Copayment Amount – Tier 2 $150 Copayment Amount – Tier 3 $300 Copayment Amount* – Tier 4		**XXXXXXXXXXXXX**
Specialty Drugs Available In-Network through Specialty Pharmacy Program	**Specialty Pharmacy Provider**		**Other Pharmacy**
One Copayment Amount per 30-day supply – limited to a 30-day supply 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	$150 Copayment Amount – Tier 5 $250 Copayment Amount – Tier 6		50% of Allowable Amount minus Copayment Amount

be based on day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.		
Select Vaccinations obtained through Pharmacies**	**Pharmacy Vaccine Network Pharmacy**	**Other Pharmacy**
	$0 Copayment Amount	50% of Allowable Amount minus Copayment Amount
Diabetes Supplies are available under the Pharmacy Benefits portion of your Plan. All provisions of this portion of the Plan will apply including any Deductibles, Copayment Amounts Coinsurance Amounts, and any pricing differences. The Copayment Amount for insulin included in the Drug List will not exceed $25 per prescription for a 30-day supply, regardless of the amount or type of insulin needed to fill the prescription.		
Certain Covered Drugs may be available at no cost through a Participating Pharmacy for the following categories of medication: severe allergic reactions, hypoglycemia, opioid overdoses and nitrates. For further information, call the number on the back of your Identification Card. Select Covered drugs, determined by BCBSTX, may be available at no cost, to make these medications more affordable to Participants.		

*If you receive a Brand Name Drug when a Generic Drug is available, you may incur additional costs. Refer to the Pharmacy Benefits portion of your booklet for details.

**Each Participating Pharmacy that has contracted with BCBSTX to provide this service may have age, scheduling, or other requirements that will apply, so you are encouraged to contact them in advance.

INTRODUCTION

This Plan is offered by your Employer as one of the benefits of your employment. The benefits provided are intended to assist you with many of your health care expenses for Medically Necessary services and supplies. Coverage under this Plan is provided regardless of your race, color, national origin, disability, age, sex, gender identity or sexual orientation. There are provisions throughout this Benefit Booklet that affect your health care coverage. Changes in state or federal law or regulations, or interpretation thereof, may change the terms and conditions of coverage. It is important that you read the Benefit Booklet carefully so you will be aware of the benefits and requirements of this Plan. In the event of any conflict between any components of this Plan, the *Small Employer Benefit Program Application* prevails.

The defined terms in this Benefit Booklet are capitalized and shown in the appropriate provision in the Benefit Booklet or in the **DEFINITIONS** section of the Benefit Booklet. Whenever these terms are used, the meaning is consistent with the definition given. Terms in italics may be section headings describing provisions or they may be defined terms. The terms "you" and "your" as used in this Benefit Booklet refer to the Employee..

Managed Health Care

In-Network Benefits

To receive In-Network Benefits as indicated on your Schedule of Coverage, **you must** choose Providers within the Network for all care **(other than for emergencies**). The Network has been established by BCBSTX and consists of Physicians, Specialty Care Providers, Hospitals, and other health care facilities to serve Participants throughout the Network Plan Service Area. Refer to your Provider directory or visit the BCBSTX website at www.bcbstx.com to make your selections. The listing may change occasionally, so make sure the Providers you select are still Network Providers. An updated directory will be available at least annually or you may access our website, www.bcbstx.com, for the most current listing to assist you in locating a Provider.

If you choose a Network Provider, the Provider will bill BCBSTX - not you - for services provided.

The Provider has agreed to accept as payment in full the least of...

- The billed charges, or
- The Allowable Amount as determined by BCBSTX, or
- Other contractually determined payment amounts.

You are responsible for paying any Deductibles, Copayment Amounts and Coinsurance Amounts. You may be required to pay for limited or non-covered services. No claim forms are required. However, if you

- pay the Provider a rate less than the average discounted rate which would be paid by BCBSTX to a Network Provider directly for a covered and Medically Necessary service or supply, and;
- the Provider does not submit a claim to BCBSTX for that service or supply;

then you may submit the appropriate documentation with a claim form to BCBSTX, and allowable credit will, as applicable, be applied towards you**r** in-network annual Deductible and Out-of-Pocket Maximums.

Managed Health Care
Out-of-Network Benefits

If you choose Out-of-Network Providers, only Out-of-Network Benefits will be available. If you go to a Provider outside the Network, benefits will be paid at the Out-of-Network Benefits level. If you choose a health care Provider outside the Network, you may have to submit claims for the services provided.

You will be responsible for…

- Billed charges above the Allowable Amount as determined by BCBSTX,
- Coinsurance Amounts, and Deductibles,
- Prior Authorization, and
- Limited or non-covered services.

However, if you

- pay the Provider a rate less than the average discounted rate which would be paid by BCBSTX to a Network Provider directly for a covered and Medically Necessary service or supply, and;

- the Provider does not submit a claim to BCBSTX for that service or supply;

then you may submit the appropriate documentation with a claim form to BCBSTX, and allowable credit will, as applicable, be applied towards your in-network annual Deductible and Out-of-Pocket Maximums.

Pharmacy Benefits

- Benefits are provided for those Covered Drugs as explained in the **PHARMACY BENEFITS** section and shown on your Schedule of Coverage in this Benefit Booklet. The amount of your payment under the Plan depends on where the Prescription Order is filled, the type of drug dispensed and if your Plan includes a Deductible.

Important Contact Information

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

Customer Service Helpline

Customer Service Representatives can:

- Identify your Plan Service Area;
- Give you information about Network and *ParPlan*, and Other Providers contracting with BCBSTX;
- Distribute claim forms;
- Answer your questions on claims;
- Assist you in identifying a Network Provider (but will not recommend specific Network Providers);
- Provide information on the features of the Plans;
- Record comments about Providers;
- Assist you with questions regarding Physician after-hours access;
- Assist you with questions regarding the **PHARMACY BENEFITS.**

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 are available in Spanish through Customer Service. Members may also ask for access to a telephone-based translation service to assist with other languages.

BCBSTX provides TDD/TTY 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.

BCBSTX Website

Visit the BCBSTX website at www.bcbstx.com for information about BCBSTX, access to forms referenced in this Benefit Booklet, and much more.

Mental Health/Chemical Dependency (SUD) Prior Authorization Helpline

To satisfy Prior Authorization requirements for Participants seeking treatment for Mental Health Care, Serious Mental Illness, or Chemical Dependency (SUD), you, your Behavioral Health Practitioner, or a family member may call the Mental Health/Chemical Dependency (SUD) Prior Authorization Helpline at any time, day or night.

Medical Prior Authorization Helpline

To satisfy all medical Prior Authorization requirements, call the **Medical Prior Authorization Helpline**.

Eligibility Requirements for Coverage

The Eligibility Date is the date a person becomes eligible to be covered under the Plan. A person becomes eligible to be covered when they become an Employee or a Dependent under the Plan. The Eligibility Date is:

1. The date the Employee, including any Dependents to be covered, completes the Waiting Period, if any, for coverage;
2. Described in the ***Dependent Enrollment Period*** section for a new Dependent of an Employee already having coverage under the Plan.

No eligibility rules or variations in premium will be imposed based on your health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other Health Status Related Factor. Coverage under this Plan is provided regardless of your race, color, national origin, disability, age, sex, gender identity, sexual orientation, political affiliation or expression. Coverage under this Plan does not require documentation certifying a COVID-19 vaccination or require documentation of post-transmission recovery as a condition for obtaining coverage or receiving benefits under this plan. Variations in the administration, processes or benefits of this Plan that are based on clinically indicated, reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

Employee Eligibility
Any person eligible under this Contract and covered by the Employer's previous Health Benefit Plan on the date prior to the Contract Date, including any person who has continued group coverage under applicable federal or state law, is eligible on the Contract Date. Otherwise, you are eligible for coverage under the Plan when you satisfy the definition of an Employee and you reside or work in the Plan Service Area.

Dependent Eligibility
If you apply for coverage, you may include your Dependents. Eligible Dependents are:

1. Your spouse or your Domestic Partner (Note: Domestic Partner coverage is available at your Employer's discretion. Contact your Employer for information on whether Domestic Partner coverage is available for your Group.); or
2. A child under the limiting age shown in the definition of Dependent; or
3. A child of any age who is medically certified as Disabled and dependent on the parent; or
4. A child of your child who is your Dependent for federal income tax purposes at the time application for coverage of the child is made; and
5. Any other child included as an eligible Dependent under the Contract. A detailed description of Dependent is in the **DEFINITIONS** section of this Benefit Booklet.

An Employee must be covered first in order to cover their eligible Dependents. No Dependent shall be covered hereunder prior to the Employee's Effective Date.

Effective Dates of Coverage

In order for an Employee's coverage to take effect, the Employee must submit enrollment for coverage for himself and any Dependents.

The Effective Date is the date the coverage for a Participant actually begins. The Effective Date under the Contract is shown on your Identification Card. It may be different from the Eligibility Date.

Timely Applications
It is important that your application for coverage under the Plan is received timely by the Carrier.

If you apply for coverage and pay any required premium for yourself or for yourself and your eligible Dependents and if you:

1. Are eligible on the Contract Date and the application is received by the Carrier prior to or within 31 days following such date, your coverage will become effective on the Contract Date; or
2. Enroll for coverage for yourself or for yourself and your Dependents during an Open Enrollment Period, coverage shall become effective on the Contract Anniversary.

Initial Enrollment for New Employees
The Carrier must receive your written application within 31 days of your date of employment unless you have a Waiting Period in excess of 31 days. If your Waiting Period exceeds 31 days, the Carrier must receive your written application within 31 days after the end of the Waiting Period. Your coverage will become effective on the first day of the Contract Month following: (1) the date the written application for coverage for you and any Dependents is received; and (2) any Waiting Period, if applicable, has been satisfied, unless otherwise agreed upon by your Employer and the Carrier.

Effective Dates - Delay of Benefits Provided
Coverage becomes effective for you and/or your Dependents on the Contract Date upon completion of an application for coverage. If you or your eligible Dependent(s) are confined in a Hospital or Facility Other Provider on the Contract Date, your coverage is effective on the Contract Date. However, if this Contract is replacing a discontinued Health Benefit Plan or self-funded Health Benefit Plan, benefits for any Employee or Dependent may be delayed until the expiration of any applicable extension of benefits provided by the previous Health Benefit Plan or self-funded Health Benefit Plan.

Effective Dates - Late Enrollee
If your application is not received within 31 days from the Eligibility Date, you will be considered a Late Enrollee. You will become eligible to apply for coverage during your Employer's next Open Enrollment Period. Your coverage will become effective on the Contract Anniversary.

Loss of Other Health Insurance Coverage
An Employee who is eligible, but not enrolled for coverage under the terms of the Plan (or/and a Dependent, if the Dependent is eligible, but not enrolled for coverage under such terms) shall become eligible to apply for coverage if each of the following conditions are met:

1. The Employee or Dependent were covered under a Health Benefit Plan, self-funded Health Benefit Plan, or had other health insurance coverage at the time this coverage was previously offered; and
2. Coverage was declined under this Plan in writing, on the basis of coverage under another Health Benefit Plan or self-funded Health Benefit Plan; and
3. There is a loss of coverage under such prior Health Benefit Plan or self-funded Health Benefit Plan as a result of:
    a. Under Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended, or the applicable continuation provisions of the *Texas Insurance Code* have been exhausted; or
    b. Cessation of Dependent status (such as divorce or attaining the maximum age to be eligible as a dependent child under the Plan), termination of employment, a reduction in the number of hours of employment, or employer contributions toward such coverage were terminated; or
    c. Termination of the other plan's coverage, a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits, a situation in which the other plan no longer offers any benefits to the class of similarly situated individuals that include you or your Dependent, or, in the case of coverage offered through an HMO, you or your Dependent no longer reside, live, or work in the service area of that HMO and no other benefit option is available; and
4. You request to enroll no later than 31 days after the date coverage ends under the prior Health Benefit Plan or self-funded Health Benefit Plan or, in the event of the attainment of a lifetime limit on all benefits, the request to enroll is made not later than 31 days after a claim is denied due to the attainment of a lifetime

limit on all benefits. Coverage will become effective the first day of the calendar month following receipt of the application by the Carrier.

If all conditions described above are not met, you will be considered a Late Enrollee.

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 the Carrier within sixty (60) days after the date on which such individual loses coverage. Coverage will be effective the day after prior coverage terminated.

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 the Carrier receives (1) written notice from the Texas Health and Human Services Commission, or (2) enrollment forms, from you, provided such forms and applicable Premium payments are received by the Carrier within sixty (60) days after the date the individual becomes eligible for participation in the HIPP Reimbursement Program.

Dependent Enrollment Period

1. ***Special Enrollment Period for Newborn Children***
   Coverage of a newborn child will be automatic for the first 60 days following the birth of your newborn child or your Dependent's newborn child. For coverage to continue beyond this time, you or your Dependent must notify the Carrier within 60 days of birth and pay any required premium within that 60-day period or a period consistent with the next billing cycle. Coverage will become effective on the date of birth. If the Carrier is notified after that 60-day period, the newborn child's coverage will become effective on the Contract Anniversary following the Employer's next Open Enrollment Period.

2. ***Special Enrollment Period for Adopted Children or Children Involved in a Suit for Adoption***
   Coverage of an adopted child or child involved in a suit for adoption will be automatic for the first 60 days following the adoption or date on which a suit for adoption is sought. For coverage to continue beyond this time, the Carrier must receive all necessary forms and the required premium within the 60-day period or a period consistent with the next billing cycle. Coverage will become effective on the date of adoption or date on which a suit for adoption is sought. If you notify the Carrier after that 60-day period, the child's coverage will become effective on the Contract Anniversary following the Employer's next Open Enrollment Period.

3. ***Court Ordered Dependent Children***
   If a court has ordered an Employee to provide coverage for a child, coverage will be automatic for the first 31 days after the date the Employer receives notification of the court order. To continue coverage beyond the 31 days, the Carrier must receive all necessary forms and the required premium within the 31-day period. If you notify the Carrier after that 31-day period, the Dependent child's coverage will become effective on the Contract Anniversary following the Employer's next Open Enrollment Period.

4. ***Court Ordered Coverage for a Spouse***
   If a court has ordered you, the Employee, to provide coverage for a spouse, enrollment must be received within 31 days after issuance of the court order. Coverage will become effective on the first day of the month following the date the application for coverage is received and the required premium is paid within the 31-day period. If application is not made within the initial 31 days, your spouse's coverage will become effective on the Contract Anniversary following the Employer's next Open Enrollment Period.

5. ***Other Dependents***
   Application must be received within 31 days of the date that a spouse or Domestic Partner or child first qualifies as a Dependent. If the application is received within 31 days, coverage will become effective on the date the child or spouse or Domestic Partner first becomes an eligible Dependent. If application is not made within the initial 31 days, then your Dependent's coverage will become effective on the Contract Anniversary following the Employer's Open Enrollment Period.

   If you ask that your Dependent be insured after having canceled their coverage while your Dependent was still entitled to coverage, your Dependent's coverage will become effective in accordance with the provisions for Late Enrollees.

In no event will your Dependent's coverage become effective prior to your Effective Date.

Other Employee Enrollment Period

1. As a special enrollment period event, if you acquire a Dependent through birth, adoption, or through suit for adoption, and you previously declined coverage for reasons other than under ***Loss of Other Health Insurance Coverage***, as described above, you may apply for coverage for yourself, your spouse or Domestic Partner, and a newborn child, adopted child, or child involved in a suit for adoption. If the application is received within 31 days of the birth, adoption, or suit for adoption, coverage for the child, you, or your spouse or Domestic Partner will become effective on the date of the birth, adoption, or date suit for adoption is sought.
2. If you marry or enter into a domestic partnership and you previously declined coverage for reasons other than under ***Loss of Other Health Insurance Coverage*** as described above, you may apply for coverage for yourself and your spouse or Domestic Partner. If the application is received within 31 days of the marriage or establishment of a domestic partnership, coverage for you and your spouse or Domestic Partner will become effective on the first day of the month following receipt of the application by the Carrier.
3. If you are required to provide coverage for a child as described in ***Court Ordered Dependent Children*** above, and you previously declined coverage for reasons other than under ***Loss of Other Health Insurance Coverage***, you may apply for coverage for yourself. If the application is received within 31 days of the date your Employer receives notification of the court order, coverage for you will become effective on the date your Employer receives notification of the court order.

Employee Application/Change Form

Use this form to:

- Notify the Plan and BCBSTX of a change to your name;
- Add Dependents (other than a newborn child where notification only is required);
- Drop Dependents;
- Cancel all or a portion of your coverage; or
- Notify BCBSTX of all changes in address for yourself and your Dependents. An address change may result in benefit changes for you and your Dependents if you move out of the Plan Service Area of the Network.

You may obtain this form from your Employer, by calling the BCBSTX Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card, or by accessing the BCBSTX website. If a Dependent's address and zip code are different from yours, be sure to indicate this information on the form. After you have completed the form, return it to your Employer.

Changes in Your Family

You should promptly notify the Carrier in the event of a birth or follow the instructions below when events, such as but not limited to, the following take place:

1. If you are adding a Dependent due to marriage or establishment of domestic partnership, adoption, or a child being involved in a suit for which an adoption of the child is sought, or your Employer receives a

court order to provide health coverage for a Participant's child or your spouse, you must submit an *Employee Application/Change Form* and the coverage of the Dependent will become effective as described in ***Dependent Enrollment Period***.

2. When you divorce or terminate a domestic partnership, your child reaches the age indicated in the definition of Dependent, or a Participant in your family dies, coverage under the Plan terminates in accordance with the **Termination of Coverage** provisions selected by your Employer.

   Notify your Employer promptly if any of these events occur. Benefits for expenses incurred after termination are not available. If your Dependent's coverage is terminated, premium refunds will not be made for any period before the date of notification. If benefits are paid prior to notification to BCBSTX, refunds will be requested.

   Please refer to the **Continuation Privilege** subsection in this Benefit Booklet for additional information.

Allowable Amount

The Allowable Amount is the maximum amount of benefits BCBSTX will pay for Eligible Expenses you incur under the Plan. BCBSTX has established an Allowable Amount for Medically Necessary services, supplies, and procedures provided by Providers that have contracted with BCBSTX or any other Blue Cross and/or Blue Shield Plan, and Providers that have not contracted with BCBSTX or any other Blue Cross and/or Blue Shield Plan. When you choose to receive services, supplies, or care from a Provider that does not contract with BCBSTX, you will be responsible for any difference between the BCBSTX Allowable Amount and the amount charged by the non-contracting Provider. You will also be responsible for charges for services, supplies, and procedures limited or not covered under the Plan, Deductibles, any applicable Coinsurance Amounts, Out-of-Pocket Maximum amounts and Copayment Amounts.

Review the definition of Allowable Amount in the **DEFINITIONS** section of this Benefit Booklet to understand the guidelines used by BCBSTX.

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 certificate 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 deductible and 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 deductible, coinsurance or 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 of the back of your identification card with questions about claims or bills you have received from Providers.**

   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.

Case Management

Under certain circumstances, the Plan allows BCBSTX the flexibility to offer benefits for expenses which are not otherwise Eligible Expenses. BCBSTX, at its sole discretion, may offer such benefits if:

- The Participant, their family, and the Physician agree;
- Benefits are cost effective; and
- BCBSTX anticipates future expenditures for Eligible Expenses which may be reduced by such benefits.

Any decision by BCBSTX to provide such benefits shall be made on a case-by-case basis. The case coordinator for BCBSTX will initiate case management in appropriate situations.

Continuity of Care

In the event a Participant is under the care of a Network Provider at the time such Provider stops participating in the Network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or for fraud), BCBSTX will continue providing coverage for that Provider's services at the In-Network Benefit Level if the participant has special circumstances or one of the following is met:

- Participant is undergoing a course of treatment for a serious and complex condition,
- Participant is undergoing institutional or inpatient care,
- Participant is scheduled to undergo nonelective surgery from the Provider (including receipt of postoperative care from such Provider with respect to such surgery),
- Participant is pregnant or undergoing a course of treatment for the pregnancy, or
- Participant is determined to be terminally ill.

A *serious and complex condition* is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, Participant is 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.

Special circumstances means a condition such that the treating Physician or health care Provider reasonably believes that discontinuing care by the treating Physician or Provider could cause harm to the Participant. *Special circumstances* shall be identified by the treating Physician or health care Provider, who must request that the Participant be permitted to continue treatment under the Physician's or Provider's care and agree not to seek payment from the Participant of any amounts for which the Participant would not be responsible if the Physician or Provider were still a Network Provider.

The continuity of coverage described under this subsection shall continue until the treatment is complete but shall not extend for more than ninety (90) days, or more than nine (9) months if the Participant has been diagnosed with a terminal illness, beyond the date the Provider's termination from the Network takes effect. However, for Participants past the 13th week of pregnancy at the time the Provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery.

You have the right to appeal any decision made for a request for benefits under this subsection as explained in the **CLAIM FILING AND APPEALS PROCEDURES** section of this Benefit Booklet.

Coverage Determinations

Certain services are covered pursuant to BCBSTX medical policies and clinical procedure and coding policies, which are updated throughout the Calendar Year. The medical policies are guides considered by BCBSTX 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 an Eligible Expense or is Experimental/Investigational, cosmetic, or a convenience item. The clinical procedure and coding policies provide information about what services are reimbursable under the Plan. The most up-to-date medical and clinical procedure and coding policies are available at www.bcbstx.com, or contact customer service at the toll-free number on the back of your Identification Card.

Freedom of Choice

Each time you need medical care, you can choose to:		
See a Network Provider	***See an Out-of-Network Provider***	
	***ParPlan* Provider** *(refer to **ParPlan**, below, for more information)*	**Out-of-Network Provider that is not a contracting Provider**
• You receive the higher level of benefits (In-Network Benefits) • You are not required to file claim forms • You are not balance billed; Network Providers will not bill for costs exceeding the BCBSTX Allowable Amount for covered services • Your Provider will Prior Authorize necessary services	• You receive the lower level of benefits (Out-of-Network Benefits) • You are not required to file claim forms in most cases; *ParPlan* Providers will usually file claims for you • You are not balance billed; *ParPlan* Providers will not bill for costs exceeding the BCBSTX Allowable Amount for covered services • In most cases, *ParPlan* Providers will Prior Authorize necessary services	• You receive Out-of-Network Benefits (the lower level of benefits) • You are required to file your own claim forms • You may be billed for charges exceeding the BCBSTX Allowable Amount for covered services • You must obtain Prior Authorization of necessary services

Identification Card

The Identification Card tells Providers that you are entitled to benefits under your Employer's Health Benefit 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 Health Benefit Plan with BCBSTX.
- ***Any Copayment Amounts 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 Participating 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 (refer to the **WHO GETS BENEFITS** section for instructions when changes are made). Upon receipt of the change in information, the Carrier 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;
    b. Use of the Identification Card after your date of termination of coverage under the Plan;
    c. Obtaining prescription drugs or other benefits for persons not covered under the Plan;
    d. Obtaining prescription drugs or other benefits that are not covered under the Plan;
    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 Plan;
    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 Plan;
    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 Participant can result in, but is not limited to, the following sanctions being applied to all Participants covered under your coverage:

   a. Denial of benefits;
   b. Cancellation of coverage under the Plan for **all** Participants 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 Participants receiving benefits under your coverage;
   e. Notice to proper authorities of potential violations of law or professional ethics.

Medical Necessity

All services and supplies for which benefits are available under the Plan must be Medically Necessary as determined by BCBSTX. Charges for services and supplies which BCBSTX determines are not Medically Necessary will not be eligible for benefit consideration and may not be used to satisfy Deductibles or to apply to the Out-of-Pocket Maximum.

ParPlan

When you consult a Physician or Professional Other Provider who does not participate in the Network, you should inquire if they participate in the Carrier's *ParPlan*...a simple direct-payment arrangement. If the Physician or Professional Other Provider participates in *ParPlan,* they agree to:

- File all claims for you;
- Accept the Carrier's Allowable Amount determination as payment for Medically Necessary services; and
- Not bill you for services over the Allowable Amount determination.

You will receive Out-of-Network Benefits and be responsible for:

- Any Deductibles;
- Coinsurance Amounts; and
- Services that are limited or not covered under the Plan.

Note: If you have a question regarding a Physician's or Professional Other Provider's participation in *ParPlan*, please contact the BCBSTX Customer Service Helpline.

Specialty Care Providers

A wide range of Specialty Care Providers is included in the Network. When you need a specialist's care, In-Network Benefits will be available, but only if you use a Network Provider.

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

- If the services you require are not reasonably available from Network Providers, In-Network Benefits will be provided when you use Out-of-Network Providers. Refer to the Allowable Amount Notice in the **NOTICES** section of this Benefit Booklet for additional information.
- If you elect to see an Out-of-Network Provider and if the services could have been provided by a Network Provider, only Out-of-Network Benefits will be available.

Tobacco User

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 BCBSTX 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.

Use of Non-Contracting Providers

When you choose to receive services, supplies, or care from a Provider that does not contract with BCBSTX (a non- contracting Provider), you receive Out-of-Network Benefits (the lower level of benefits). Benefits for covered services will be reimbursed based on the BCBSTX non-contracting Allowable Amount, which in most cases is less than the Allowable Amount applicable for BCBSTX contracted Providers. Please see the definition of non- contracting Allowable Amount in the **DEFINITIONS** section of this Benefit Booklet. **The non-contracted Provider is not required to accept the BCBSTX non-contracting Allowable Amount as payment in full and may balance bill you for the difference between the BCBSTX non-contracting Allowable Amount and the non-contracting Provider's billed charges. You will be responsible for this balance bill amount, which may be considerable.** You will also be responsible for charges for services, supplies and procedures limited or not covered under the Plan and any applicable Deductibles, Coinsurance Amounts, and Copayment Amounts. However, if you

- pay the Provider a rate less than the average discounted rate which would be paid by BCBSTX to a contracting Provider directly for a covered and Medically Necessary service or supply, and;
- the Provider does not submit a claim to BCBSTX for that service or supply;

then you may submit the appropriate documentation with a claim form to BCBSTX, and allowable credit will, as applicable, be applied towards you**r** in-network annual Deductible and Out-of-Pocket Maximums.

If benefits are provided at a participating Hospital, at a participating surgery center or other participating treatment center, and services are provided by a non-participating anesthesiologist (including a certified registered nurse anesthetist), pathologist, radiologist, neonatologist, or emergency room Physician, assistant surgeon (if the primary surgeon is a Network Provider) or other Hospital-based Physician, the Participant will incur no greater out-of-pocket costs than would have been incurred if the benefits were provided by a Network Provider. For services provided by a Texas-licensed non-participating Provider, unless Participant has signed a written notice and disclosure, in the form and following the requirements adopted by the Texas Department of Insurance, allowing the non-participating Provider to bill Participant for amounts above the non-contracting Allowed Amount, the non-participating Provider may not bill the Participant for the difference between payment by the Plan and the Provider charges plus in-network Deductible, Coinsurance and/or Copayment. For services provided by a non-participating Provider not licensed in Texas, the non-participating Provider may bill the Participant for the difference between payment by the Plan and the Provider charges plus in-network Deductible, Coinsurance and/or Copayment. Please call Customer Service if you have been balance billed by the non-participating Provider, or if you have any questions about the benefits described in this section (paragraph) or how your claims have been processed.

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.

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 BCBSTX 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 for a Post-Service Medical Necessity Review. Some services may require a Prior Authorization before the start of services, while other services will be subject to a Post-Service Medical Necessity Review. If requested, services normally subject to a Post-Service Medical Necessity Review may be reviewed for Medical Necessity prior to the service through a Recommended Clinical Review as defined below.

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

If Prior Authorization is required, the review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of this Benefit Booklet. BCBSTX recommends you confirm with your Provider if Prior Authorization has been obtained.

Prior Authorization Responsibility

Network Provider Prior Authorization

Your Network Provider is responsible for obtaining Prior Authorization, in those circumstances where authorization may be required. If Prior Authorization is not obtained and the services are denied as not Medically Necessary, the Participating Provider will be held responsible and will not be able to bill the Member for the services.

For additional information about Prior Authorization for services outside of our service area, refer to the Other Blue Cross and Blue Shield Plans Separate Financial Policies Compliance Disclosure Requirements Notice in the **NOTICES** section of this Benefit Booklet.

Note: Providers that contract with other Blue Cross and Blue Shield Plans are not familiar with the Prior Authorization requirements of BCBSTX. Unless a Provider contracts directly with BCBSTX as a Network Provider, the Provider is not responsible for being aware of this Plan's Prior Authorization requirements.

Out-of-Network Prior Authorization

If any Provider outside Texas (except for those contracting as Network Providers directly with BCBSTX) or any Out-of-Network Provider list recommends an Admission or a service that requires Prior Authorization, the Provider is not obligated to obtain the Prior Authorization for you. In such cases, it is your responsibility to ensure that Prior Authorization is obtained. If authorization is not obtained before services are received, you may be entirely responsible for the charges if the service is determined to not be Medically Necessary. If the service is determined to be Medically Necessary, Out-of-Network Benefits will apply. The Provider may call on your behalf, but it is your responsibility to ensure that BCBSTX is called.

Inpatient Hospital Admissions

In order to receive maximum benefits, you, your authorized representative, or your Provider may need to obtain Prior Authorization from the Plan for inpatient admissions, if inpatient admissions are identified as needing a Prior Authorization. In the case of an elective inpatient admission, if services require an authorization, it is recommended that the call for Prior Authorization should be made at least two working days before you are admitted unless it would delay Emergency Care. In an emergency, it is recommended that Prior Authorization should take place within two working days after admission, or as soon thereafter as reasonably possible.

Your Network Provider is required to obtain Prior Authorization for inpatient admissions that may require Prior Authorization. If Prior Authorization is not obtained for inpatient services and the services are denied as not Medically Necessary, the Network Provider will be held responsible and will not be able to bill the Participant for the services.

If the Physician or Provider of services is not a Network Provider then you, your Physician, Provider of services, or an authorized representative should obtain Prior Authorization by the Plan by calling one of the toll-free numbers shown on the back of your Identification Card. The call should be made between 6:00 a.m. and 6:00 p.m., Central Time, on business days and 9:00 a.m. and 12:00 p.m., Central Time on Saturdays, Sundays and legal holidays. Calls made after these hours will be recorded and returned not later than 24 hours after the call is received. We will follow up with your Provider's office. After working hours or on weekends, please call the **Medical Prior Authorization Helpline** toll-free number listed on the back of your Identification Card. Your call will be recorded and returned the next working day. A benefits management nurse will follow up with your Provider's office. All timelines for Prior Authorization requirements are provided in keeping with applicable state and federal regulations.

In-Network Benefits will be available if you use a Network Provider or Network Specialty Care Provider. If you elect to use Out-of-Network Providers for services and supplies available In-Network, Out-of-Network Benefits will be paid.

However, if care is not reasonably available from Network Providers as defined by applicable law, and BCBSTX authorizes your visit to an Out-of-Network Provider to be covered at the In-Network Benefit level **prior to the visit**, In-Network Benefits will be paid; otherwise, Out-of-Network Benefits will be paid.

When Prior Authorization of an inpatient admission is obtained, a length-of-stay is assigned. Your Provider may seek an extension for the additional days if you require a longer stay. Benefits will not be available for room and board charges for medically unnecessary days. For more information regarding lengths of stay, refer to the ***Length of Stay/Service Review*** section of this Benefit Booklet.

For Behavioral Health Inpatient Hospital Admissions, please see Contacting Behavioral Health section below.

Prior Authorization not Required for Maternity Care and Treatment of Breast Cancer Unless Extension of Minimum Length of Stay Requested

Your Plan is required to provide a minimum length of stay in a Hospital facility for the following:

- Maternity Care
  - 48 hours following an uncomplicated vaginal delivery; or
  - 96 hours following an uncomplicated delivery by caesarean section.
- Treatment of Breast Cancer
  - 48 hours following a mastectomy; or
  - 24 hours following a lymph node dissection.

You or your Provider will not be required to obtain Prior Authorization from BCBSTX for a length of stay less than 48 hours (or 96 hours) for Maternity Care or less than 48 hours (or 24 hours) for Treatment of Breast Cancer. If you require a longer stay, you, your authorized representative, or your Provider must seek an extension for the additional days by obtaining Prior Authorization from BCBSTX.

Outpatient Service Review

If Prior Authorization is required, the review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Benefit Booklet. BCBSTX recommends you confirm with your Provider if Prior Authorization has been obtained.

There may be general categories of covered services that require Prior Authorization.

To determine if a specific service or category requires Prior Authorization, visit our website at www.bcbstx.com/find-care/where-you-go-matters/utilization-management for the required Prior Authorization list, which is updated when new services are added or when services are removed. You can also call BCBSTX Customer Service at the toll-free telephone number on the back of your Identification Card.

For Behavioral Health Outpatient Service review please see **Contacting Behavioral Health** section below.

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 **CLAIM FILING AND APPEALS PROCEDURES** section of this Benefit Booklet.

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 BCBSTX for continued services. If you, your Provider or authorized representative requests to extend care beyond the approved time limit, BCBSTX will make a determination on the request within the timeframes described in the **Review of Claim Determinations** provision of this Booklet.

Recommended Clinical Review Option

There are services that do not require a Prior Authorization that may be subject to a post-service medical necessity review before the claim is paid. There is an option for your Provider to request a Recommended Clinical Review to determine if the service meets approved PPO medical policy and/or level of care review criteria before services are provided to you. Once a decision has been made on the services reviewed as part of the Recommended Clinical Review process, the same services will not be reviewed for Medical Necessity after they have been performed.

To determine if a Recommended Clinical Review is available for a specific service, visit our website at www.bcbstx.com/find-care/where-you-go-matters/utilization-management for the Recommended Clinical Review list, which is updated when new services are added or when services are removed. You can also call BCBSTX Customer Service at the number on the back of your Identification Card. You or your Provider may request a Recommended Clinical Review. This website also includes information on which services require Prior Authorization before services are performed.

In the event a Recommended Clinical Review determines the proposed services are not medically necessary, you have the right to file an appeal as described in the COMPLAINT AND APPEAL PROCEDURES section. All appeal and review requirements related to medical necessity determinations, including independent review, apply to services where your Provider requests a Recommended Clinical Review.

Recommended Clinical Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of this Benefit Booklet. Please coordinate with your Provider to submit a written request for Recommended Clinical Review.

Contacting Behavioral Health

You, your Physician or Provider of services or your authorized representative may contact BCBSTX for a Prior Authorization or Recommended Clinical Review 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 PM, 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.

General Provisions Applicable to All Recommended Clinical Reviews

1. **No Guarantee of Payment**

   A Recommended Clinical Review is a determination of the medical necessity of a proposed service, but it is not a guarantee of benefits or payment of benefits by BCBSTX. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Plan. Even if the service has been approved on Recommended Clinical Review, coverage or payment can be affected for reasons other than medical necessity. For example, you may have become ineligible as of the date of service or the member's benefits may have changed as of the date of service.

2. **Request for Additional Information**

   The Recommended Clinical Review process may require additional documentation from your Provider or pharmacist. In addition to the written request for Recommended Clinical Review, the Provider or pharmacist may be required to include pertinent documentation explaining the proposed services, 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 BCBSTX to make a determination of coverage pursuant to the terms and conditions of this Plan.

Post-Service Medical Necessity Review

A Post-Service Medical Necessity Review, sometimes referred to as a retrospective review or Post-Service Claims request, 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 the service was Medically Necessary. Providers should submit appropriate documentation at the time of a Post-Service Review request. A Post-Service Medical Necessity Review may be performed when a Prior Authorization or Recommended Clinical Review was not obtained prior to services being rendered.

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 benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Plan. Post-Service Medical Necessity Review does not guarantee payment of benefits by BCBSTX, for instance you may become ineligible as of the date of service or your benefits may have changed as of the date of service.

2. **Request for Additional Information**

   The Post-Service Medical Necessity Review process may require additional documentation from your Provider or pharmacist. In addition to the written request for Post-Service Medical Necessity Review, the 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 BCBSTX to make a determination of coverage pursuant to the terms and conditions of this Plan.

Failure to Obtain Prior Authorization

If Prior Authorization for Medical and Behavioral Health inpatient services, medical outpatient and home services, any of the specific outpatient procedures/services listed above, and specified outpatient treatment of Chemical Dependency (SUD), Serious Mental Illness and Mental Health Care is not obtained:

- BCBSTX will review the Medical Necessity of your treatment or service prior to the final benefit determination.
- If BCBSTX determines the treatment or service is not Medically Necessary or is Experimental/Investigational, benefits will be reduced or denied.
- You may be responsible for a penalty in connection with the following Covered Services, if indicated on your Schedule of Coverage:
  - Inpatient admission; and
  - Inpatient treatment of Chemical Dependency (SUD), Serious Mental Illness, or Mental Health Care including treatment received at Residential Treatment Centers.

Network Providers are responsible for satisfying the Prior Authorization requirements for any inpatient admissions. If Prior Authorization is not obtained, the Network Provider will be sanctioned based on the BCBSTX contractual agreement with the Provider, and no penalty charges will be deducted.

Prior Authorization Renewal Process

Renewal of an existing Prior Authorization issued by BCBSTX can be requested by a Physician or health care Provider up to 60 days prior to the expiration of the existing Prior Authorization.

CLAIM FILING 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, the Hospital, or your Physician or Professional Other Provider, the 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

Providers that contract with BCBSTX and some other health care Providers (such as *ParPlan* Providers) will 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 Providers in filing your claims, you should carry your Identification Card with you.

Contracting Providers

When you receive treatment or care from a Provider or Covered Drugs dispensed from a Pharmacy that contracts with BCBSTX, you will generally not be required to file claim forms. The Provider will usually submit the claims directly to BCBSTX for you.

Non-Contracting Providers

When you receive treatment or care from a health care Provider or Covered Drugs dispensed from a Pharmacy that does not contract with BCBSTX, you may be required to file your own claim forms. Some Providers, however, will do this for you. If the Provider does not submit claims for you, refer to the subsection entitled ***Participant-filed claims*** below for instruction on how to file your own claim forms.

Mail-Order Program

When you receive Covered Drugs dispensed through the Mail-Order Program, you must complete and submit the mail service prescription drug claim form to the address on the claim form. Additional information may be obtained from your Employer, from the Carrier, off of the BCBSTX website at www.bcbstx.com/rx-drugs/drug-lists/drug-lists, or by calling the Customer Service Helpline.

Participant-filed claims

- ***Medical Claims***
  If your Provider does not submit your claims, you will need to submit them to BCBSTX using a Subscriber-filed claim form provided by BCBSTX. Your Employer should have a supply of claim forms or you can obtain copies from the BCBSTX website at www.bcbstx.com, or by calling Customer Service at the toll-free number on your Identification Card. 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

health care Providers, labs, etc., printed on their letterhead and showing the services performed, dates of service, charges, and name of the Participant involved.

- ***Prescription Drug Claims***
  When you receive Covered Drugs dispensed from a Participating or non-Participating Pharmacy, a *Prescription Reimbursement Claim Form* must be submitted. This form can be obtained from the Carrier, at www.bcbstx.com, or by calling Customer Service at the toll-free number on your Identification Card, or your Employer. This claim form, accompanied by an itemized bill obtained from the Pharmacy showing the prescription services you received, should be mailed to the address shown below or on the claim form.

  Instructions for completing the claim form are provided on the back of the form. You may need to obtain additional information, which is not on the receipt from the pharmacist, to complete the claim form.

  Bills for Covered Drugs should show the name, address, and telephone number of the pharmacy, a description and quantity of the drug, the prescription number, the date of purchase and most importantly, the name of the Participant using the drug.

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

www.bcbstx.com

Where to Mail Completed Claim Forms

Medical Claims
Blue Cross and Blue Shield of Texas
Claims Division
P. O. Box 660044
Dallas, Texas 75266-0044

Prescription Drug Claims
Blue Cross and Blue Shield of Texas
c/o Prime Therapeutics LLC
P. O. Box 25136
Lehigh Valley, PA 18002-5136

Who Receives Payment

Benefit payments will be made directly to contracting Providers when they bill BCBSTX. Written agreements between BCBSTX and some Providers 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 not 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 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 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 Provider, 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* 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 Provider for the additional information.

REVIEW OF CLAIM DETERMINATIONS

Claim Determinations

When BCBSTX 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 BCBSTX of any determination of a claim, any determination of a request for Prior Authorization, or any other determination made by BCBSTX of your benefits under the Plan.

Note: If BCBSTX 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.

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 BCBSTX 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 BCBSTX'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 BCBSTX;
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on Medical Necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;

- In the case of a denial of an Urgent Care Clinical Claim, a description of the expedited review procedure applicable to such claim. An Urgent Care Clinical Claim decision may be provided orally, so long as a written notice is furnished to the claimant within 3 days of oral notification; and
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

Timing of Required Notices and Extensions

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

- **Urgent Care Clinical Claim** is any Pre-Service Claim that requires Prior Authorization, as described in this Benefit Booklet, 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 BCBSTX 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 BCBSTX may request in connection with services rendered to you.

Urgent Care Clinical Claims*

Type of Notice or Extension	Timing
If your claim is incomplete, BCBSTX must notify you within:	**24 hours**
If you are notified that your claim is incomplete, you must then provide completed claim information to BCBSTX within:	**48 hours** after receiving notice
BCBSTX 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**
if your claim involves post-stabilization treatment subsequent to emergency treatment or a Life-Threatening Condition, BCBSTX will issue and transmit a determination indicating whether proposed services are Prior Authorized within:	**the time appropriate to the circumstances relating to the delivery of the services and your condition, but in no case to exceed one hour from the receipt of the request***

* If the request is received outside the period during which BCBSTX is required to have personnel available to provide determinations, BCBSTX will make the determination within one hour from the beginning of the next time period requiring appropriate personnel to be available. You do not need to submit Urgent Care Clinical Claims in writing. You should call BCBSTX at the toll-free number listed on the back of your Identification Card as soon as possible to submit an Urgent Care Clinical Claim.

Note: If a proposed medical care or health care service requires Prior Authorization by BCBSTX, a determination will be issued no later than the third calendar day after BCBSTX's receipt the request. If you are an inpatient in a healthcare facility at the time the services are proposed, BCBSTX will issue the determination within 24 hours after BCBSTX receives the request.

Pre-Service Claims

Type of Notice or Extension	Timing
If BCBSTX has received all information necessary to complete the review, BCBSTX must notify you within:	**2 working days of or our receipt of the complete claim or 3 calendar days of the request, whichever is sooner, if the claim is approved; and** **3 calendar days of the request, if the claim is denied.**
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**

Note: For claims involving services related to Acquired Brain Injury, BCBSTX will issue the determination no later than 3 calendar days after BCBSTX receives the request.

Post-Service Claims (Retrospective Review)

Type of Notice or Extension	Timing
If your claim is incomplete, BCBSTX must notify you within:	**30 days**
If you are notified that your claim is incomplete, you must then provide completed claim information to BCBSTX within:	**45 days** after receiving notice
BCBSTX 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, if BCBSTX extended the period, less any days already utilized by BCBSTX during the review**

∗ This period may be extended one time by BCBSTX for up to 15 days, provided that BCBSTX 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 BCBSTX expects to render a decision. If the period is extended because BCBSTX require additional information from you or your Provider, the period for BCBSTX making the determination is tolled from the date BCBSTX sends notice of extension to you until the earlier of (1) the date on which BCBSTX receives the information or (2) the date by which the information was to be submitted.

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.

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 in response to a claim, Pre-Service Claim or Urgent Care Clinical Claims, 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 BCBSTX and BCBSTX 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.

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 BCBSTX 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, BCBSTX 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, BCBSTX 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. BCBSTX 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 BCBSTX.

How to Appeal an Adverse Benefit Determination

You have the right to seek and obtain a full and fair review of any determination of a claim, any determination of a request for Prior Authorization, or any other determination made by BCBSTX 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 their 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 BCBSTX at the number on the back of your Identification Card. If you believe BCBSTX incorrectly denied all or part of your benefits, you may have your claim reviewed. BCBSTX 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 BCBSTX to request a claim review. BCBSTX 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

- BCBSTX 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 BCBSTX. 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.

  BCBSTX will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the review of your claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give you a chance to respond. If the initial benefit determination regarding the claim is based in whole or in part on a medical judgment, the appeal determination will be made by a Physician associated

or contracted with BCBSTX and/or by external advisors, but who were not involved in making the initial denial of your claim.

- If you have any questions about the claims procedures or the review procedure, write to BCBSTX's Administrative Office or call the toll-free Customer Service Helpline number shown in this Benefit Booklet or on your Identification Card.
- This appeal process does not prohibit you from pursuing civil action available under the law.
- If you have a claim for benefits which is denied or ignored, in whole or in part, and your Plan is governed by the Employee Retirement Income Security Act (ERISA), you may file suit under 502 (a) of ERISA.

Timing of Appeal Determinations

BCBSTX 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 BCBSTX.

BCBSTX 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 BCBSTX.

If You Need Assistance

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

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

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

Notice of Appeal Determination

BCBSTX 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, by a written notice of the determination.

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

- The reasons for the determination;
- A reference to the benefit Plan provisions on which the determination is based, and the contractual, administrative or protocol basis 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 BCBSTX'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 BCBSTX;
- 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 BCBSTX denies your appeal, in whole or in part, or you do not receive a 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. Your external review rights are described in the ***How to Appeal a Final Internal Adverse Determination to an Independent Review Organization (IRO)*** section below.

How to Appeal a Final Internal Adverse Determination to an Independent Review Organization (IRO)
An "**Adverse Determination**" means a determination by BCBSTX or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service that is a covered service has been reviewed and, based upon the information provided, is determined to be Experimental/Investigational, or does not meet BCBSTX's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated.

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

This procedure (not part of the complaint process) pertains only to appeals of Adverse Determinations. In addition, in life-threatening, urgent care circumstances or if BCBSTX has discontinued coverage of prescription drugs or intravenous infusions for which you were receiving health benefits under the Plan, you are entitled to an immediate appeal to an IRO and are not required to comply with BCBSTX's appeal of an Adverse Determination process.

Any party whose appeal of an Adverse Determination is denied by BCBSTX may seek review of the decision by an IRO. At the time the appeal is denied, BCBSTX will provide you, your designated representative or 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 within four (4) months after your receipt of the Adverse Determination. In life-threatening, urgent care situations, or if BCBSTX has discontinued coverage of prescription drugs or intravenous infusions for which you were receiving health benefits under the Plan, you, your designated representative, or your Provider of record may contact BCBSTX by telephone to request the review and provide the required information.

- BCBSTX will submit medical records, names of Providers and any documentation pertinent to the decision of the IRO;
- BCBSTX will comply with the decision by the IRO;
- BCBSTX will pay for the independent review.

Upon request and free of charge, you or your 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 BCBSTX;
- Medical judgments, including whether a particular service is Experimental/Investigational or not Medically Necessary or appropriate; and
- Expert advice and consultation obtained by BCBSTX 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 Plan is governed by the Employee Retirement Income Security Act (ERISA), you have the right to bring civil action under 502(a) of ERISA.

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 and discretion 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.

Eligible Expenses

The Plan provides coverage for the following categories of Eligible Expenses:

- Inpatient Hospital Expenses,
- Medical-Surgical Expenses,
- Extended Care Expenses, and
- Special provisions expenses, and
- Pharmacy expenses.

Wherever Schedule of Coverage is mentioned, please refer to the Schedule(s) in this Benefit Booklet. 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.

Copayment Amounts

Some of the care and treatment you receive under the Plan will require that a Copayment Amount be paid at the time you receive the services. Refer to your Schedule of Coverage under "Copayment Amounts Required" for your specific Plan information.

A Primary Care Copayment Amount, if shown on your Schedule of Coverage, will be required for each office visit charge you incur when services are rendered by a family practitioner, an obstetrician/gynecologist, a pediatrician, a Behavioral Health Practitioner, an internist, and a Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these listed Physicians.

A Specialty Copayment Amount, if shown on your Schedule of Coverage, will be required for each office visit charge you incur:

- When services are rendered by a Specialty Care Provider (as classified by the American Board of Medical Specialist as a Specialty Care Provider), or
- When services are rendered by any other Professional Other Provider as defined in the **DEFINITIONS** section of this Benefit Booklet; with the exception of services provided by a Physician Assistant or Advanced Practice Nurse as described in the preceding paragraph.

If the services provided by your Physician require a return office visit on a different day, a new Copayment Amount will be required. A Copayment Amount will be required for the initial office visit for Maternity Care, but will not be required for subsequent visits.

The following services are not payable under this Copayment Amount provision but instead are considered Medical-Surgical Expense, subject to the Coinsurance Amounts and may be subject to any Deductible shown on your Schedule of Coverage:

- Lab and x-ray services;
- X-ray or diagnostic imaging;
- Surgery performed in the Physician's office;
- Physical therapy;
- Occupational modalities in conjunction with physical therapy;
- Any services requiring Prior Authorization;
- Certain Diagnostic Procedures, if shown on your Schedule of Coverage;
- Imaging Services, if shown on your Schedule of Coverage.

A Copayment Amount, if shown on your Schedule of Coverage, will be required for each visit to an Urgent Care center. If the services provided require a return visit on a different day, a new Copayment Amount will be required.

A Copayment Amount, if shown on your Schedule of Coverage, will apply to each inpatient Hospital Admission or inpatient Hospice admission of a Participant.

A Copayment Amount, if shown on your Schedule of Coverage, will be required for each visit to a Retail Health Clinic.

A Copayment Amount, if shown on your Schedule of Coverage, will be required for each Virtual Visit.

A Copayment Amount, if shown on your Schedule of Coverage, will be required for facility charges for each Hospital outpatient emergency room visit. If admitted to the Hospital as a direct result of the emergency condition or accident, the Copayment Amount will be waived, and Inpatient Hospital Expenses will apply.

A Copayment Amount, if shown on your Schedule of Coverage, will be required for facility charges for each outpatient surgery.

A Copayment Amount, if shown on your Schedule of Coverage, will be required for each Certain Diagnostic Procedure performed.

A Copayment Amount, if shown on your Schedule of Coverage, will be required for each Imaging Service performed.

A Copayment Amount, if shown on your Schedule of Coverage, will be required for each x-ray or diagnostic imaging performed.

Deductible(s)

The benefits of the Plan will be available after satisfaction of the applicable Deductible(s) as shown on your Schedule of Coverage. The Deductible(s) are explained as follows:

Calendar Year Deductible: The individual Deductible amount shown under "Deductibles" on your Schedule of Coverage must be satisfied by each Participant under your coverage each Calendar Year. This Deductible, unless otherwise indicated, will be applied to all categories of Eligible Expenses, including any eligible dental expenses provided by the dental rider before benefits are available under the Plan.

The following are exceptions to the Deductible(s) described above.

If you have several covered Dependents, all charges used to apply toward an "individual" Deductible amount will be applied toward the "family" Deductible amount shown on your Schedule of Coverage. When that family Deductible amount is reached, no further individual Deductibles will have to be satisfied for the remainder of that Calendar Year. No Participant will contribute more than the individual Deductible amount to the "family" Deductible amount.

Eligible Expenses applied toward satisfying the "individual" and "family" In-Network Deductible will only apply to the In-Network Deductible. Eligible Expenses applied toward satisfying the "individual" and "family" Out-of-Network Deductible will only apply to the Out-of-Network Deductible.

Out-of-Pocket Maximum

Most of your Eligible Expense payment obligations, including any eligible dental expenses provided by a dental rider are applied to the Out-of-Pocket Maximum.

The Out-of-Pocket Maximum will not include:

- Services, supplies, or charges limited or excluded by the Plan;
- Expenses not covered because a benefit maximum has been reached;
- Any Eligible Expense paid by the Primary Plan when BCBSTX is the Secondary Plan for purposes of coordination of benefits;
- Penalties for failing to obtain Prior Authorization;
- Any Coinsurance Amounts paid for Out-of-Network Pharmacy Benefits.

Individual Out-of-Pocket Maximum

When the Out-of-Pocket Maximum amount for the In-Network or Out-of-Network Benefits level for a Participant in a Calendar Year equals the "individual" "Out-of-Pocket Maximum" shown on your Schedule of Coverage for that level, the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by that Participant for the remainder of that Calendar Year for that level.

Family Out-of-Pocket Maximum

When the Out-of-Pocket Maximum amount for the In-Network or Out-of-Network Benefits level for all Participants under your coverage in a Calendar Year equals the "family" "Out-of-Pocket Maximum" shown on your Schedule

of Coverage for that level, the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by all family Participants for the remainder of that Calendar Year for that level. No Participant will be required to contribute more than the individual Out-of-Pocket Maximum to the family Out-of-Pocket Maximum.

Out-of-Pocket Maximum

There is no Out-of-Network Out-of-Pocket Maximum amount for individual or family coverage under this Plan. The Participant will continue to be responsible for any Deductibles, Copayment Amounts and Coinsurance Amounts, if applicable. The benefit amounts shown on your Schedule of Coverage will be used for purposes of determining the benefits available for additional Eligible Expense incurred by the Participant.

The following are exceptions to the Out-of-Pocket Maximum described above:

1. There are separate Out-of-Pocket Maximums for In-Network Benefits and Out-of-Network Benefits.
2. Eligible Expenses applied toward satisfying the "individual" and "family" In-Network Out-of-Pocket Maximum will only apply to the In-Network Out-of-Pocket Maximum. Eligible Expenses applied toward satisfying the "individual" and "family" Out-of-Network Out-of-Pocket Maximum will only apply to the Out-of-Network Out-of-Pocket Maximum.

Changes in Benefits

Changes to covered benefits will apply to all services provided to each Participant under the Plan. Benefits for Eligible Expenses incurred during an admission in a Hospital or Facility Other Provider that begins before the change will be those benefits in effect on the day of admission.

COVERED MEDICAL SERVICES

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; and
- 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.

Inpatient Hospital Expenses

The Plan provides coverage for Inpatient Hospital Expense for you and eligible Dependents. Each inpatient Hospital Admission requires Prior Authorization. Refer to the **UTILIZATION MANAGEMENT** subsection of this Benefit Booklet for additional information.

The benefit percentage of your total eligible Inpatient Hospital Expense, in excess of any Deductible, shown under "Inpatient Hospital Expenses" on the Schedule of Coverage is BCBSTX's obligation under the Plan. The remaining unpaid Inpatient Hospital Expense, in excess of any Deductible, is your obligation to pay.

Services and supplies provided by an Out-of-Network Provider will receive In-Network Benefits when those services and supplies are not available from a Network Provider provided BCBSTX acknowledges your visit to an

Out-of-Network Provider **prior** to the visit. Otherwise, Out-of-Network Benefits will be paid and the claim will have to be resubmitted for review and adjustment, if appropriate.

Refer to the Schedule of Coverage for information regarding Deductibles, coinsurance percentages and penalties for failure to Prior Authorize that may apply to your coverage.

Medical Surgical Expenses

The Plan provides coverage for Medical-Surgical Expense for you and your covered Dependents. Some services require Prior Authorization. Refer to the **UTILIZATION MANAGEMENT** subsection of this Benefit Booklet for more information.

Copayment Amounts, if shown on your Schedule of Coverage, must be paid to your Network Physician or other Network Provider at the time you receive services.

The benefit percentages of your total eligible Medical-Surgical Expense shown under "Medical-Surgical Expenses" on the Schedule of Coverage in excess of any applicable Copayment Amounts and Coinsurance Amounts, and any applicable Deductibles shown are BCBSTX's obligation under the Plan. The remaining unpaid Medical-Surgical Expense in excess of any Copayment Amount and Coinsurance Amounts, and any Deductibles is your obligation to pay.

To calculate your benefits, subtract any applicable Copayment Amounts and Deductibles from your total eligible Medical-Surgical Expense and then multiply the difference by the benefit percentage shown on your Schedule of Coverage under "Medical-Surgical Expenses." Most remaining unpaid Medical-Surgical Expense in excess of the Copayment Amount and Deductible is your Coinsurance Amount.

Medical-Surgical Expense shall include:

1. Services of Physicians and Professional Other Providers.
2. Consultation services of a Physician and Professional Other Provider.
3. Services of a certified registered nurse-anesthetist (CRNA).
4. Diagnostic x-ray and laboratory procedures.
5. Radiation therapy.
6. Rental of durable medical equipment required for therapeutic use unless purchase of such equipment is required by BCBSTX. The term "durable medical equipment (DME)" shall not include:
    a. Equipment primarily designed for alleviation of pain or provision of patient comfort; or
    b. Home air fluidized bed therapy.

    Examples of non-covered equipment include, but are not limited to, air conditioners, air purifiers, humidifiers, home spirometers or telespirometers, physical fitness equipment, and whirlpool bath equipment.
7. Medical or disposable supplies prescribed by a Physician include, but are not limited to:
    a. Urinary catheters;
    b. Wound care or dressing supplies given by a Provider during treatment for covered health services; and
    c. 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.
8. Ostomy supplies include, but are not limited to:
    a. Pouches, face plates and belts;
    b. Irrigation sleeves, bags and ostomy irrigation catheters;
    c. Skin barriers; and
    d. Deodorants, filters, lubricants, tape, appliance cleaners, adhesive and adhesive remover.
9. For Emergency Care, professional local ground ambulance transportation or air ambulance transportation to the nearest Hospital appropriately equipped and staffed for treatment of the Participant's condition. Non-Emergency ground ambulance transportation from one acute care Hospital to another acute care Hospital

for diagnostic or therapeutic services (e.g., MRI, CT scans, acute interventional cardiology, intensive care unit services, etc.) may be considered Medically Necessary when specific criteria are met. The non-emergency ground ambulance transportation to or from a Hospital or medical facility, outside of the acute care Hospital setting, may be considered Medically Necessary when the Participant's condition is such that trained ambulance attendants are required to monitor the Participant's clinical status (e.g., vital signs and oxygenation), or provide treatment such as oxygen, intravenous fluids or medications, in order to safely transport the Participant, or the Participant is confined to bed and cannot be safely transported by any other means. Non-Emergency ground ambulance transportation services provided primarily for the convenience of the Participant, the Participant's family/caregivers or Physician, or the transferring facility are considered not Medically Necessary.

Non-Emergency air ambulance transportation means transportation from a Hospital emergency department, health care facility, or Inpatient setting to an equivalent or higher level of acuity facility may be considered Medically Necessary when the Participant requires acute Inpatient care and services are not available at the originating facility and commercial air transport or safe discharge cannot occur. Such transfer must be to the nearest facility with the capabilities to perform the medically necessary services not available at the originating facility. Non-Emergency air ambulance transportation services provided primarily for the convenience of the Participant, the Participant's family/caregivers or Physician, or the transferring facility are considered not Medically Necessary.

10. Anesthetics and its administration, when performed by someone other than the operating Physician or Professional Other Provider.
11. Oxygen and its administration provided the oxygen is actually used.
12. Blood, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for the Participant.
13. Prosthetic Appliances, including replacements necessitated by growth to maturity of the Participant.
14. Orthopedic braces (i.e., an orthopedic appliance used to support, align, or hold bodily parts in a correct position) and 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, Physician-prescribed, directed, or applied dressings, bandages, trusses, and splints which are custom designed for the purpose of assisting the function of a joint.
15. Home Infusion Therapy.
16. Outpatient Infusion Therapy. Some outpatient infusion services for routine maintenance drugs have been identified as capable of being safely administered outside of an outpatient Hospital setting. The Participants' out of pocket expenses may be lower when Covered Services are provided in an Infusion Suite, a home, or an office instead of a Hospital. Non-maintenance outpatient infusion therapy services will be covered the same as any other illness. The Schedule of Coverage describes payment for Infusion Services. For the purpose of this section, an Infusion Suite is an alternative to Hospital and clinic-based infusion settings where specialty medications can be infused.
17. Teledentistry Dental Services, Telehealth Services and Telemedicine Services.
18. Services or supplies used by the Participant during an outpatient visit to a Hospital, a Therapeutic Center, or a Chemical Dependency (SUD) Treatment Center, or scheduled services in the outpatient treatment room of a Hospital.
19. Certain Diagnostic Procedures, if shown on your Schedule of Coverage.
20. Outpatient Contraceptive Services, prescription contraceptive devices, and prescription contraceptive medications. NOTE: Prescription contraceptive medications are covered under the **PHARMACY BENEFITS** portion of your Plan.
21. Foot care in connection with diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency.
22. Drugs that have not been approved by the FDA for self-administration when injected, ingested or applied in a Physician's or Professional Other Provider's office.

Extended Care Expenses

The Plan also provides benefits for Extended Care Expense for you and your covered Dependents. All Extended Care Expense requires Prior Authorization. Refer to the **UTILIZATION MANAGEMENT** section of this Benefit Booklet for more information.

BCBSTX's benefit obligation as shown on your Schedule of Coverage will be:

1. At the benefit percentage under "Extended Care Expenses," and;
2. Up to the number of days or visits shown for each category of Extended Care Expense on your Schedule of Coverage.

If shown on your Schedule of Coverage, the Calendar Year Deductible will apply. Any unpaid Extended Care Expense will not be applied to any Out-of-Pocket Maximums.

For Hospice Care that is provided in a Hospital the Calendar Year Deductible and Copayment Amount for Inpatient Hospital Expense, if shown on your Schedule of Coverage, will apply.

Any charges incurred as Home Health Care or home Hospice Care for drugs (including antibiotic therapy) and laboratory services will not be Extended Care Expense but will be considered Medical-Surgical Expense.

Services and supplies for Extended Care Expense:

1. For Skilled Nursing Facility:
    a. All usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
    b. Room and board and all routine services, supplies, and equipment provided by the Skilled Nursing Facility;
    c. Physical, occupational, speech, and respiratory therapy services by licensed therapists.
2. For Home Health Care:
    a. Part-time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
    b. Part-time or intermittent home health aide services which consist primarily of caring for the patient;
    c. Physical, occupational, speech, and respiratory therapy services by licensed therapists;
    d. Supplies and equipment routinely provided by the Home Health Agency.

    Benefits will **not** be provided for Home Health Care for the following:

    - Food or home delivered meals;
    - Social case work or homemaker services;
    - Services provided primarily for Custodial Care;
    - Transportation services;
    - Home Infusion Therapy;
    - Durable medical equipment.

3. For Hospice Care:

   For Home Hospice Care:

   a. Part-time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);

   b. Part-time or intermittent home health aide services which consist primarily of caring for the patient;

   c. Physical, speech, and respiratory therapy services by licensed therapists;

   d. Homemaker and counseling services routinely provided by the Hospice agency, including bereavement counseling.

   For Facility Hospice Care:

   a. All usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);

   b. Room and board and all routine services, supplies, and equipment provided by the Hospice facility;

   c. Physical, speech, and respiratory therapy services by licensed therapists.

Special Provisions Expenses

The benefits available under this **Special Provisions Expenses** subsection are generally determined on the same basis as other Inpatient Hospital Expense, Medical-Surgical Expense, and Extended Care Expense, except to the extent described in each item. Benefits for Medically Necessary expenses will be determined as indicated on your Schedule(s) of Coverage. Remember that certain services require Prior Authorization and that any Copayment Amounts, Coinsurance Amounts, Out-of-Pocket Maximums, and Deductibles shown on your Schedule(s) of Coverage will also apply.

Benefits for Treatment of Complications of Pregnancy

Benefits for Eligible Expenses incurred for treatment of Complications of Pregnancy will be determined on the same basis as treatment for any other sickness.

Benefits for Fertility Preservation Services

Benefits are available for Fertility Preservation Services for Participants 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.

Benefits for Maternity Care

Benefits for Eligible Expenses incurred for Maternity Care will be determined on the same basis as for any other treatment of sickness. Dependent children will be eligible for Maternity Care benefits.

Services and supplies incurred by a Participant for delivery of a child shall be considered Maternity Care and are subject to all provisions of the Plan.

The Plan provides coverage for inpatient care for the birthing parent and newborn child in a health care facility for a minimum of:

- 48 hours following an uncomplicated vaginal delivery; and
- 96 hours following an uncomplicated delivery by caesarean section.

If the birthing parent or newborn is discharged before the minimum hours of coverage, the Plan provides coverage for *Postdelivery Care* for the birthing parent and newborn. The *Postdelivery Care* may be provided at the birthing parent's home, a health care Provider's office, or a health care facility.

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

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

Charges for well-baby nursery care, including the initial examination and administration of a newborn screening test (which includes the test kit, required by the state of Texas) during the birthing parent's Hospital Admission for the delivery will be considered Inpatient Hospital Expense of the child and will be subject to the benefit provisions and benefit maximums as described under **Inpatient Hospital Expenses**. Benefits will also be subject to any Deductible amounts shown on your Schedule of Coverage.

Behavioral Health Services

Benefits for Treatment of Chemical Dependency (SUD)

Benefits for Eligible Expenses incurred for the treatment of Chemical Dependency (SUD) will be the same as for treatment of any other sickness. Your specific benefits are shown on your Schedule of Coverage. Refer to the **UTILIZATION MANAGEMENT** subsection to determine what services require Prior Authorization.

The Plan may use state guidelines to administer benefits for treatment of Chemical Dependency (SUD). Inpatient treatment of Chemical Dependency (SUD) must be provided in a Chemical Dependency (SUD) Treatment Center, Residential Treatment Center or Hospital. Benefits for the medical management of acute life-threatening intoxication (toxicity) in a Hospital will be available on the same basis as for sickness generally as described under **Benefits for Inpatient Hospital Expense**.

Mental Health Care provided as part of the Medically Necessary treatment of Chemical Dependency (SUD) will be considered for benefit purposes to be treatment of Chemical Dependency (SUD) until completion of Chemical Dependency (SUD) treatments. (Mental Health Care treatment after completion of Chemical Dependency (SUD) treatments will be considered Mental Health Care.)

Benefits for Serious Mental Illness

Benefits for Eligible Expenses incurred for the treatment of Serious Mental Illness are shown on your Schedule of Coverage. Refer to the **UTILIZATION MANAGEMENT** subsection to determine what services require Prior Authorization.

Medically Necessary services for Serious Mental Illness in a Crisis Stabilization Unit or Facility, a Residential Treatment Center for Children and Adolescents, or a Residential Treatment Center in lieu of hospitalization will be considered Inpatient Hospital Expense. The Inpatient Hospital Expense benefit percentages for this Plan, and any Deductible as shown on your Schedule of Coverage, will apply.

The Medical-Surgical Expense benefit percentages for this Plan, and any Deductible as shown on your Schedule of Coverage, will apply.

Benefits for Mental Health Care

Benefits for Eligible Expenses incurred for the treatment of Mental Health Care are shown on your Schedule of Coverage. Refer to the **UTILIZATION MANAGEMENT** subsection to determine what services require Prior Authorization.

Medically Necessary services for Mental Health Care in a Crisis Stabilization Unit or Facility, a Residential Treatment Center for Children and Adolescents, or a Residential Treatment Center in lieu of hospitalization will be considered Inpatient Hospital Expense. The Inpatient Hospital Expense benefit percentages for this Plan, and any Deductible as shown on your Schedule of Coverage, will apply.

The Medical-Surgical Expense benefit percentages for this Plan, and any Deductible as shown on your Schedule of Coverage, will apply.

Benefits for Emergency Care

The Plan provides coverage for Emergency Care. Services provided in an emergency room, freestanding emergency room, or other comparable facility that are not Emergency Care may be excluded from Emergency Care coverage, although these services may be covered under another benefit if applicable. If you disagree with the BCBSTX's determination in processing your benefits as non-Emergency Care instead of Emergency Care, you may call BCBSTX at the number on the back of your Identification Card. Please review the *Review of Claim Determinations* provision in the **CLAIM FILING AND APPEALS PROCEDURES** section of this Benefit Booklet for specific information on your right to seek and obtain a full and fair review of your claim.

Emergency Care does not require Prior Authorization. However, if reasonably possible, contact your Network Physician or Behavioral Health Practitioner before going to the emergency room. They can help you determine if you need Emergency Care and recommend that care. If not reasonably possible, go to the nearest emergency facility, whether or not the facility is in the Network.

Whether you require hospitalization or not, you should notify your Network Physician or Behavioral Health Practitioner as soon as reasonably possible of any emergency medical treatment so they can recommend the continuation of any necessary medical services.

In-Network and Out-of-Network Benefits for Eligible Expenses for Emergency Care, including Emergency Care for Behavioral Health Services and Accidental Injury, will be determined as shown on your Schedule of Coverage. Copayment Amounts will be required for facility charges for each emergency room visit if shown on your Schedule of Coverage. If admitted for the emergency condition immediately following the visit, the Copayment Amount will be waived. If admitted for the emergency condition immediately following the visit, Prior Authorization of the inpatient Hospital Admission will be required, and Inpatient Hospital Expenses will apply.

If you continue to be treated by an Out-of-Network Provider after you receive Emergency Care and you can safely be transferred to the care of an In-Network Provider, only Out-of-Network Benefits will be available.

Notwithstanding anything in this certificate to the contrary, for Out-of-Network Emergency Care services rendered by non-contracting Providers, the Allowable Amount shall be the Plan usual and customary rate or at a rate agreed to between BCBSTX and the non-contracting Provider, not to exceed billed charges. The Plan's usual and customary rate will be based upon our rate information for the same or similar services. The usual and customary rate shall not be less than the non-contracting Allowable Amount as defined in this Plan.

Benefits for Urgent Care

Benefits for Eligible Expenses for Urgent Care will be determined as shown on your Schedule of Coverage. A Copayment Amount, if shown on your Schedule of Coverage, will be required for each Urgent Care visit. Urgent Care means the delivery of medical care in a facility dedicated to the delivery of scheduled or unscheduled, walk-in care outside of a Hospital emergency room department, freestanding emergency room, comparable facility or Physician's office. The necessary medical care is for a condition that is not life-threatening.

Benefits for Retail Health Clinics

Benefits for Eligible Expenses for Retail Health Clinics will be determined as shown on your Schedule of Coverage. Retail Clinics provide diagnosis and treatment of uncomplicated minor conditions in situations that can be handled without a traditional primary care office visit, Urgent Care visit or Emergency Care visit.

Benefits for Eligible Expenses for Retail Health Clinics will be determined as shown on your Schedule of Coverage. Retail Clinics provide diagnosis and treatment of uncomplicated minor conditions in situations that can be handled without a traditional primary care office visit, Urgent Care visit or Emergency Care visit.

Benefits for Virtual Visits

Benefits for Eligible Expenses for Virtual Visits will be determined as shown on your Schedule of Coverage. BCBSTX provides you with access to Virtual Providers that can provide diagnosis and treatment of non-emergency medical and behavioral health conditions in situations that can be handled without a traditional primary care office visit, behavioral health office visit, urgent care visit or Emergency Care visit. Covered Services may be provided via 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.

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

Preventive Care Services

Preventive care services will be provided for the following covered services:

a. 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");

b. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved;

c. 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; and

d. With respect to women, such additional preventive care and screenings, not described in item a. above, as provided for in comprehensive guidelines supported by the HRSA.

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

For purposes of this benefit provision, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009).

The Preventive Care Services described in items a. through d. may change as USPSTF, CDC and HRSA guidelines are modified and will be implemented by BCBSTX in the quantities and at the times required by applicable law or regulatory guidance. For more information, you may access the website at www.bcbstx.com or contact customer service at the toll-free number on your Identification Card.

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 Amount, Coinsurance Amount, Deductible, or dollar maximum when obtained from a Participating Pharmacy. Drugs on the No-Cost Preventive Drug List that are obtained from a non-Participating Pharmacy, may be subject to Copayment Amount, Coinsurance Amount, Deductibles, or dollar maximums, if applicable.

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

Examples of covered services included are routine annual physicals, immunizations, well-child care, cancer screening mammograms, annual In Home Health Assessment, bone density test, screening for colorectal cancer, smoking cessation counseling services and intervention (including a screening for tobacco use, counseling and FDA-approved tobacco cessation medications) and healthy diet counseling and obesity screening/counseling.

NOTE: Tobacco cessation medications are covered under the **PHARMACY BENEFITS** portion of your Plan, when prescribed by a Health Care Practitioner.

Examples of covered immunizations included are Diphtheria, Haemophilus influenzae type b, Hepatitis B, Measles, Mumps, Pertussis, Polio, Rubella, Tetanus, Varicella and any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision.

Preventive care services included in items a. through d. above provided by an In-Network Provider will not be subject to Coinsurance, Deductible, Copayment or dollar maximums.

Preventive care services included in items a. through d. above provided by an Out-of-Network Provider will be subject to Coinsurance and Deductibles. Deductibles and coinsurance are not applicable to immunizations covered under ***Required Benefits for Childhood Immunizations*** provision.

Covered services not included in items a. through d. above may be subject to Coinsurance, Deductible, Copayment and/or dollar maximums.

If a recommendation or guideline for a particular preventive care service does not specify the frequency, method, treatment or setting in which it must be provided, BCBSTX may use reasonable medical management techniques to apply coverage.

If a covered preventive care service is provided during an office visit and is billed separately from the office visit, you may be responsible for Coinsurance, Deductible and/or Copayments for the office visit only. If an office visit and the preventive care service are not billed separately and the primary purpose of the visit was not the preventive health service, you may be responsible for Coinsurance, Deductible and/or Copayments.

Benefits for Certain Tests for Detection of Human Papillomavirus and Cervical Cancer

Benefits are available for certain tests for detection of Human Papillomavirus and Cervical Cancer for each woman enrolled in the Plan who is 18 years of age or older for an annual medically recognized diagnostic examination for the early detection of cervical cancer. Coverage includes, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods as approved by the United States Food and Drug Administration alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

Benefits for Mammography Screening

Benefits are available for a screening by low-dose mammography for the presence of occult breast cancer for a Participant 35 years of age and older except that benefits will not be available for more than one routine mammography screening each Calendar Year. Low-dose mammography includes digital mammography or breast tomosynthesis.

Benefits for Detection and Prevention of Osteoporosis

If a Participant is a *Qualified Individual*, benefits are available for medically accepted bone mass measurement for the detection of low bone mass and to determine a Participant's risk of osteoporosis and fractures associated with osteoporosis.

Qualified Individual means:

a. A postmenopausal woman not receiving estrogen replacement therapy;

b. An individual with:

- Vertebral abnormalities,
- Primary hyperparathyroidism, or
- A history of bone fractures; or

c. An individual who is:

- Receiving long-term glucocorticoid therapy, or
- Being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

Benefits for Tests for Detection of Colorectal Cancer

Benefits are available for a diagnostic, medically recognized screening examination for the detection of colorectal cancer for Participants who are 45 years of age or older and who are at normal risk for developing colon cancer:

a. All colorectal cancer examinations, preventive services, and laboratory test 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
b. 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.

Benefits provided above by a Network Provider will not be subject to Deductible, Copayment Amounts or Coinsurance Amounts.

Benefits provided above by an Out-of-Network Provider will be subject to Deductible, Copayment Amounts or Coinsurance Amounts.

Benefits for Outpatient Contraceptive Drugs, Devices, and Procedures Not Subject to Coinsurance, Deductible, Copayment, or Benefit Maximum

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, vaginal contraceptive devices, spermicide, and condoms. The contraceptive drugs and devices listed above may change as FDA guidelines, medical management and medical policies are modified. NOTE: Prescription contraceptive medications are covered under the **PHARMACY BENEFITS** portion of your Plan.

Contact Customer Service at the toll-free number on your Identification Card to determine what contraceptive drugs and devices are covered under this benefit provision.

Contraceptive drugs and devices not covered under this benefit provision may be covered under other sections of this certificate, subject to any applicable Coinsurance, Copayments, Deductibles and/or benefit maximum.

Benefits will be provided for female sterilization procedures for women with reproductive capacity and Outpatient Contraceptive Services benefits. Also, benefits will be provided for FDA approved over-the-counter female contraceptives with a written prescription by a Health Care Practitioner. The Participant will be responsible for submitting a claim form with the written prescription and itemized receipt for the female over-the-counter contraceptive. Visit the BCBSTX website at www.bcbstx.com to obtain a claim form.

Benefits for the above listed services received from Out-of-Network Providers or non-Participating Pharmacies may be subject to any applicable Deductible, Coinsurance, Copayment and/or benefit maximum.

Benefits for Breastfeeding Support, Services and Supplies

Benefits will be provided for breastfeeding counseling and support services when rendered by a Provider, during pregnancy and/or in the post-partum period. Benefits include the rental of hospital grade breast pumps (not to exceed the total cost) or purchase of manual or electric breast pumps, breast pump supplies, and breast milk storage supplies, with a written prescription from a Provider, and are not subject to coinsurance, Deductible, copayment, or benefit maximums when received from a Network Provider. Benefits for electric breast pumps are limited to one per Benefit Period. You may be required to pay the full amount and submit a claim form to BCBSTX with a written prescription and the itemized receipt for the manual, electric or Hospital grade breast pump, breast pump supplies, and breast milk storage supplies. Visit the BCBSTX website at www.bcbstx.com to obtain a claim form.

If you use an Out-of-Network Provider, the benefits may be subject to any applicable Deductible, Coinsurance, Copayment and/or benefit maximum.

Contact Customer Service at the toll-free number on the back of your Identification Card for additional information.

Required Benefits for Childhood Immunizations

Benefits are available for:

- Diphtheria,
- Haemophilus influenza type b,
- Hepatitis B,
- Measles,
- Mumps,
- Pertussis,
- Polio,
- Rubella,
- Tetanus,
- Varicella
- COVID-19, and
- Any other immunization that is required by law for the child.

Injections for allergies are not considered immunizations under this benefit provision.

Benefits for Certain Therapies for Children with Developmental Delays

Medical-Surgical Expense benefits are available to a covered Dependent child for the necessary rehabilitative and habilitative therapies in accordance with an Individualized Family Service Plan issued by the Texas Interagency Council on Early Childhood Intervention under Chapter 73, *Texas Human Resources Code.*

Such therapies include:

- Occupational therapy evaluations and services;
- Physical therapy evaluations and services;
- Speech therapy evaluations and services; and
- Dietary or nutritional evaluations.

The *Individualized Family Service Plan* must be submitted to BCBSTX prior to the commencement of services and when the Individualized Family Service Plan is altered.

After the age of 3, when services under the *Individualized Family Service Plan* are completed, Eligible Expenses, as otherwise covered under this Plan, will be available. All contractual provisions of this Plan will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximums.

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

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

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

Required Benefits for Screening Tests for Hearing Impairment

Benefits are available for Eligible Expenses incurred by a covered Dependent child:

- For a screening test for hearing loss from birth through the date the child is 30 days old; and
- Necessary diagnostic follow-up care related to the screening tests from birth through the date the child is 24 months.

Benefits for Early Detection Test for Ovarian Cancer

Benefits are available for:

1. A CA 125 blood test; and
2. Any other test or screenings approved by the United States Food and Drug Administration for the detection of ovarian cancer.

Benefits are available once every twelve months for each woman enrolled in the Plan who is age 18 years of age or older. Benefits are subject to the same Deductibles, Coinsurance Amounts and Copayment Amounts as for services and supplies generally.

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).

Benefits for Certain Tests for Detection of Prostate Cancer

Benefits are available for an annual medically recognized diagnostic, physical examination for the detection of prostate cancer and a prostate-specific antigen test used for the detection of prostate cancer for each individual under the Plan who is at least:

1. 50 years of age and asymptomatic; or
2. 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

Benefits are subject to the same Deductibles, Coinsurance Amounts and Copayment Amounts as for services and supplies generally.

Benefits for Diagnostic Mammography and Other Breast Imaging

Diagnostic Imaging is covered to the same extent as ***Benefits for Mammogram Screenings*** as described in the **Preventive Services** but without Participant age restrictions**.**

In addition to the applicable terms provided in the **DEFINITIONS** section of the Benefit Booklet, 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 and Coinsurance Amounts shown on your Schedule(s) of Coverage for Preventive Services will apply.

Benefits for Biomarker Testing

Benefits are available 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 disruption in care, including limiting the number of biopsies and biospecimen samples.

Benefits for Routine Foot Care

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

Benefits for Cosmetic, Reconstructive, or Plastic Surgery

The following Eligible Expenses described below for Cosmetic, Reconstructive, or Plastic Surgery will be the same as for treatment of any other sickness as shown on your Schedule of Coverage:

- Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Participant; or
- Treatment provided for reconstructive surgery following cancer surgery; or
- Surgery performed on a newborn child for the treatment or correction of a congenital defect; or
- Surgery for the treatment or correction of a congenital defect (other than conditions of the breast); or
- Reconstruction of the breast on which mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy.

Benefits for Dental Services

Benefits for Eligible Expenses incurred by a Participant will be provided on the same basis as for treatment of any other sickness as shown on the Schedule of Coverage only for the following:

- Covered Oral Surgery;
- Services provided which are necessary for treatment or correction of a congenital defect; or
- The correction of damage caused solely by Accidental Injury and such injury resulting from domestic violence or a medical condition, to healthy, un-restored natural teeth and supporting tissues. An injury sustained as a result of biting or chewing shall not be considered an Accidental Injury.

This Plan provides coverage for Medically Necessary general anesthesia in connection with dental services.
If a Participant is unable to undergo dental treatment in a dental office or under local anesthesia due to a documented physical, mental or medical reason, as determined by the Participant's Physician or by the dentist providing the dental care, a Participant shall have coverage for Medically Necessary, non-dental related services to the dental treatment.

Any other dental services, except as excluded in the **MEDICAL LIMITATIONS AND EXCLUSIONS** section of this Benefit Booklet, for which a Participant incurs Inpatient Hospital Expense for a Medically Necessary inpatient Hospital Admission, will be determined as described in **Benefits for Inpatient Hospital Expenses**.

Benefits for Organ and Tissue Transplants

1. Subject to the conditions described below, benefits for covered services and supplies provided to a Participant by a Hospital, Physician, or Other Provider related to an organ or tissue transplant will be determined as follows, but only if all the following conditions are met:

    - The transplant procedure is not Experimental/Investigational in nature;
    - Donated human organs or tissue or an FDA-approved artificial device are used;
    - The recipient is a Participant under the Plan;
    - The transplant procedure is Prior Authorized as required under the Plan;
    - The Participant meets all of the criteria established by BCBSTX in pertinent written medical policies; and
    - The Participant 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.

2. Benefits are available and 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:

    - A recipient who is covered under this Plan; and
    - A donor who is a Participant under this Plan; or
    - A donor who is not a Participant under this Plan.

3. Covered services and supplies include services and supplies provided for the:

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

4. No benefits are available for a Participant for the following services or supplies:

    - Living and/or travel expenses of the recipient or a live donor;
    - Expenses related to maintenance of life of a donor for purposes of organ or tissue donation;
    - Purchase of the organ or tissue; or
    - Organs or tissue (xenograft) obtained from another species.
    - If the transplant operation or post-transplant care is performed in China or another country known to have participated in forced organ harvesting; or
    - 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.

5. Prior Authorization is required for any organ or tissue transplant. Review the **UTILIZATION MANAGEMENT** section in this Benefit Booklet for more specific information about Prior Authorization.

    - Such specific Prior Authorization is required even if the patient is already a patient in a Hospital under another Prior Authorization.
    - At the time of Prior Authorization, BCBSTX will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if BCBSTX determines that an extension is Medically Necessary.

6. No benefits are available for any organ or tissue transplant procedure (or the services performed in preparation for, or in conjunction with, such a procedure) which BCBSTX considers to be Experimental/ Investigational.

Benefits for Treatment of Acquired Brain Injury

Benefits for Eligible Expenses incurred for Medically Necessary treatment of an Acquired Brain Injury will be determined on the same basis as treatment for any other physical condition. Cognitive Rehabilitation Therapy, Cognitive Communication Therapy, Neurocognitive Therapy and Rehabilitation; Neurobehavioral, Neuropsychological, Neurophysiological and Psychophysiological Testing and Treatment; Neurofeedback Therapy, Remediation, Post-Acute Transition Services and Community Reintegration Services, including Outpatient Day Treatment Services, or any other Post-Acute Care Treatment Services are covered, if such services are necessary as a result of and related to an Acquired Brain Injury.

Treatment for an Acquired Brain Injury may be provided at a Hospital, an acute or post-acute rehabilitation Hospital, an assisted living facility or any other facility at which appropriate *services* or *therapies* may be provided.

Service means the work of testing, treatment, and providing therapies to an individual with an Acquired Brain Injury.

Therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an Acquired Brain Injury.

To ensure that appropriate post-acute care treatment is provided, this Plan includes coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered who:

- Has incurred an Acquired Brain Injury;
- Has been unresponsive to treatment; and
- Becomes responsive to treatment at a later date.

Treatment goals for services may include the maintenance of functioning or the prevention of or slowing of further deterioration.

Benefits for Acquired Brain Injury will not be subject to any visit limit indicated on your Schedule of Coverage.

Benefits for Autism Spectrum Disorder

Generally recognized services prescribed in relation to Autism Spectrum Disorder by the Participant's Physician or Behavioral Health Practitioner in a treatment plan recommended by that Physician or Behavioral Health Practitioner are covered.

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; or
2. An individual acting under the supervision of a Health Care Practitioner described in 1 above.

    For purposes of this section, generally recognized services 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.

Benefits for Autism Spectrum Disorder will not apply towards any maximum indicated on your Schedule of Coverage. Please review the *Benefits for Habilitation Services, Benefits for Rehabilitation Services* and *Benefits for Speech and Hearing Services* provisions of this Benefit Booklet.

All contractual provisions of this Plan will apply, including but not limited to, defined terms, limitations and exclusions and Prior Authorization.

Prior Authorization will assess whether services meet coverage requirements. Review the **UTILIZATION MANAGEMENT** section in this Benefit Booklet for more specific information about Prior Authorization.

Please see the definition of "Qualified ABA Provider" in the **DEFINITIONS** section of this Benefit Booklet for more information.

Benefits for Treatment of Diabetes

Benefits are available and will be determined on the same basis as any other sickness for those Medically Necessary items for *Diabetes Equipment* and *Diabetes Supplies* (for which a Physician or Professional Other Provider has written an order) and *Diabetic Management Services/Diabetes Self-Management Training*. Such items, when obtained for a *Qualified Participant,* shall include but not be limited to the following:

Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Participant. Covered diabetes equipment is specifically defined as:

a) Blood Glucose monitors, including monitors designed to be used by blind individuals;

b) Insulin infusion devices;

c) Insulin pumps and associated appurtenances;

d) Infusion sets;

e) Insulin cartridges;

f) Alcohol wipes;

g) Adhesive supplies;

h) Durable and disposable devices to assist in the injection of insulin;

i) Batteries; and

j) Podiatric appliances (shoes, shoe inserts and foot orthotics) for prevention of complications associated with diabetes.

Insulin pumps are subject to all the conditions of coverage stated under Durable Medical Equipment.

Diabetic supplies covered under **PHARMACY BENEFITS** are specifically defined as:

a) Glucagon emergency kits;

b) Injection aids;

c) Lancets and lancet devices;

d) Syringes;

e) Test strips for blood glucose monitors;

f) Visual reading and urine test strips and tablets which test for glucose, ketone, and protein; and

g) Biohazard disposable container.

NOTE: Insulin, prescriptive and non-prescriptive oral agents for controlling blood sugar levels, insulin pens and syringes/pen needles are covered under the **PHARMACY BENEFITS**.

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.

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 Professional Other Provider who issues the written order for the supplies or equipment.

Medical-Surgical Expense provided for the nutritional, educational, and psychosocial treatment of the *Qualified Participant*. Such *Diabetic Management Services/Diabetes Self-Management Training* for which a Physician or Professional Other Provider has written an order to the Participant or caretaker of the Participant is limited to the following when rendered by or under the direction of a Physician.

Initial and follow-up instruction concerning:

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

Diabetes Self-Management Training for the *Qualified Participant* will include the development of an individualized management plan that is created for and in collaboration with the *Qualified Participant* (and/or their family) to understand the care and management of diabetes, including nutritional counseling and proper use of *Diabetes Equipment* and *Diabetes Supplies.*

A *Qualified Participant* means an individual eligible for coverage under this Contract who has been diagnosed with (a) insulin dependent or non-insulin dependent diabetes, (b) elevated blood glucose levels induced by pregnancy, or (c) another medical condition associated with elevated blood glucose levels.

Benefits for Habilitation Services

Benefits for Medical-Surgical Expense incurred for Habilitation Services are available as shown on your Schedule of Coverage.

All benefit payments made by BCBSTX for Habilitation Services, whether under the In-Network or Out-of-Network Benefits level, will apply toward the benefit maximum under each level of benefits.

Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any Habilitation Services visits maximum indicated on your Schedule of Coverage.

Benefits for Rehabilitation Services

Benefits for Medical-Surgical Expense incurred for Rehabilitation Services are available as shown on your Schedule of Coverage.

All benefit payments made by BCBSTX for Rehabilitation Services, whether under the In-Network or Out-of-Network Benefits level, will apply toward the benefit maximum under each level of benefits.

Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any Rehabilitation Services visits maximum indicated on your Schedule of Coverage.

Benefits for Foot Orthotics

Medically Necessary foot orthotics that are consistent with the Medicare Benefits Policy Manual are covered subject to the same Deductibles, Coinsurance Amounts and Copayment Amounts as for services and supplies generally. There is no Calendar Year maximum. This is in addition to, and does not affect, the coverage for Podiatric appliances as shown in ***Treatment of Diabetes.***

Benefits for Speech and Hearing Services

Benefits as shown on your Schedule of Coverage are available for the services of a Physician or Professional Other Provider to restore loss of or correct an impaired speech or hearing function. 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.

Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any speech services visits maximum indicated on your Schedule of Coverage.

If a "Hearing Aids maximum" is indicated on your Schedule of Coverage, any benefit payments made by BCBSTX for hearing aids, whether under the In-Network Benefits or Out-of-Network Benefits level, will apply toward the benefit maximum amount.

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.

Benefits for Gender Transition Procedure or Treatment

Benefits for Gender Transition Procedure or Treatment includes coverage for related adverse consequences and side effects, necessary annual testing and screening. Coverage also includes procedures to manage, reverse, reconstruct from, or recover from the Gender Transition.

Benefits for Routine Patient Costs for Participants in Approved Clinical Trials

Benefits for Eligible Expenses for Routine Patient Care Costs are provided in connection with a phase I, phase II, phase III, or phase IV clinical trial if the clinical trial 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.

Benefits for Early Detection Tests 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 individual 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 individual 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 your Schedule of Coverage.

Benefits for Medical Therapeutic Alternatives

Certain prescription drugs administered by a health care professional have therapeutic equivalents or therapeutic alternatives that are used to treat the same condition. Benefits may be limited to only certain therapeutic equivalents or therapeutic alternatives. However, benefits may be provided for the therapeutic equivalents or therapeutic alternatives that are not otherwise covered under your benefit, if an exception is granted.

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

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

MEDICAL LIMITATIONS AND EXCLUSIONS

The benefits as described in this Benefit Booklet are not available for:

1. Any services or supplies which are not Medically Necessary and essential to the diagnosis or direct care and treatment of a sickness, injury, condition, disease, or bodily malfunction.
2. Any Experimental/Investigational services and supplies. You may contact Customer Service at the toll-free telephone number on the back of your Identification Card for more information about what Experimental/Investigational services or supplies may be excluded.
3. 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.
4. Any portion of a charge for a service or supply that is in excess of the Allowable Amount as determined by BCBSTX.
5. 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.
6. Any services or supplies for which benefits are, or could upon proper claim be (except in the case of Medicare), provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical assistance (Medicaid); provided, however, that this exclusion shall not be applicable to any coverage held by the Participant for hospitalization and/or Medical-Surgical Expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
7. Any services or supplies for which a Participant is not required to make payment or for which a Participant would have no legal obligation to pay in the absence of this or any similar coverage, except services or supplies for treatment of mental illness or mental retardation provided by a tax supported institution of the State of Texas.
8. Any services or supplies provided by a person who is related to the Participant by blood or marriage.
9. Any services or supplies provided for injuries sustained:
    - As a result of war, declared or undeclared, or any act of war; or
    - While on active or reserve duty in the armed forces of any country or international authority.
10. Any charges:
    - Resulting from the failure to keep a scheduled visit with a Physician or Professional Other Provider; or
    - For completion of any insurance forms; or
    - For acquisition of medical records.
11. Room and board charges incurred during a Hospital Admission for diagnostic or evaluation procedures unless the tests could not have been performed on an outpatient basis without adversely affecting the Participant's physical condition or the quality of medical care provided.
12. Any services or supplies provided before the patient is covered as a Participant hereunder or any services or supplies provided after the termination of the Participant's coverage, except as provided in ***Extension Of Benefits***.
13. Any services or supplies provided for Dietary and Nutritional Services, except as may be provided under the Plan for:
    - An inpatient nutritional assessment program provided in and by a Hospital and approved by BCBSTX; or
    - ***Benefits for Treatment of Diabetes*** as described in **Special Provisions Expenses**; or

- ***Benefits for Certain Therapies for Children with Developmental Delays*** as described in **Special Provisions Expenses**; or
- ***Benefits for Autism Spectrum Disorder*** as described in **Special Provisions Expenses.**

14. Any services or supplies provided for long term or Custodial Care.
15. Any non-surgical (dental restorations, orthodontics, or physical therapy) or non-diagnostic services or supplies (oral appliances, oral splints, oral orthotics, devices, or prosthetics) provided for the treatment of the temporomandibular joint and all adjacent or related muscles and nerves.
16. Any items of Medical-Surgical Expense incurred for dental care and treatments, Covered Oral Surgery, or dental appliances, except as provided for in the ***Benefits for Dental Services*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet.
17. Any services or supplies provided for Cosmetic, Reconstructive, or Plastic Surgery, except as provided for in the ***Benefits for Cosmetic, Reconstructive, or Plastic Surgery*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet.
18. Any services or supplies provided for:
    - Treatment of myopia and other errors of refraction, including refractive surgery; or
    - Orthoptics or visual training; or
    - Eyeglasses or contact lenses, provided that intraocular lenses shall be specific exceptions to this exclusion; or
    - Examinations for the prescription or fitting of eyeglasses or contact lenses, except as may be provided under the **Special Provisions Expenses** portion of this Benefit Booklet; or
    - Restoration of loss or correction to an impaired speech or hearing function, including hearing aids, except as may be provided under the ***Benefits for Speech and Hearing Services*** and ***Benefits for Autism Spectrum Disorder*** provisions in the **Special Provisions Expenses** portion of this Benefit Booklet.
19. Any occupational therapy services which do not consist of traditional physical therapy modalities and which are not part of an active multi-disciplinary physical rehabilitation program designed to restore lost or impaired body function, except as may be provided under the ***Benefits for Rehabilitation Services, Benefits for Habilitation Services*** and ***Benefits for Autism Spectrum Disorder*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet.
20. Travel or ambulance services because it is more convenient for the patient than other modes of transportation whether or not recommended by a Physician or Professional Other Provider.
21. Services or supplies provided for reduction of obesity or weight, even if the Participant has other health conditions which might be helped by a reduction of obesity or weight, except for healthy diet counseling and obesity screening/counseling as may be provided under **Preventive Services.**
22. Any services or supplies provided primarily for:
    - Environmental Sensitivity;
    - Management and treatment of Idiopathic Environmental Intolerance (IEI), including laboratory or other diagnostic tests to affirm the diagnosis of IEI.
    - Clinical Ecology or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists; or
    - Inpatient allergy testing or treatment; or
    - Allergen specific IgG measurement.
23. Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.

24. Any services or supplies provided for, in preparation for, or in conjunction with:
    - Sterilization reversal;
    - Sexual dysfunctions;
    - In vitro fertilization; and
    - Promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct intra-peritoneal insemination, trans-uterine tubal insemination, gamete intra-fallopian transfer, pronuclear oocyte stage transfer, zygote intra-fallopian transfer, and tubal embryo transfer.
25. Treatment of decreased blood flow to the legs with pneumatic compression device high pressure rapid inflation deflation cycle.
26. Treatment of tissue damage or disease in any location with platelet-rich plasma.
27. Any services or supplies in connection with foot care for flat feet, fallen arches, or chronic foot strain.
28. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
29. Any services or supplies provided for the following treatment modalities:
    - acupuncture (dry needling, or trigger-point acupuncture);
    - intersegmental traction;
    - all types of home traction devices and equipment;
    - vertebral axial decompression sessions;
    - surface EMGs;
    - spinal manipulation under anesthesia;
    - muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron; and
    - balance testing through computerized dynamic posturography sensory organization test.
30. 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.
31. Benefits for any covered services or supplies furnished by a Contracting Facility for which such facility has not been specifically approved to furnish under a written contract or agreement with BCBSTX will be paid at the Out-of-Network benefit level.
32. Any items that include, but are not limited to, an orthodontic or other dental appliance; splints or bandages provided by a Physician in a non-Hospital setting or purchased "over the counter" for support of strains and sprains; orthopedic shoes which are a separable part of a covered brace, specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or affect changes in the foot or foot alignment, arch supports, elastic stockings and garter belts.

    NOTE: This exclusion does not apply to podiatric appliances when provided as Diabetic Equipment.
33. Testing of:
    - blood measurements of the following to detect cardiovascular disease: Lipoprotein a, small dense LDL; subclass high resolution lipoprotein; subclass particle numbers; and associated phospholipase A2;
    - urine for measurement of collagen cross links, which is a substance that might be ordered in people with suspected bone loss;
    - breath for hydrogen or methane, which might be ordered in people with suspected intestinal issues;

- cervicovaginal fluid for amniotic fluid protein during pregnancy, which might be ordered in people suspected to have fluid leaking from around the baby.

34. Any benefits in excess of any specified dollar, day/visit, Calendar Year maximums.
35. Any services, supplies or drugs received by a Participant outside the United States, except for Emergency Care.
36. Donor expenses for a Participant in connection with an organ and tissue transplant if the recipient is not covered under this Plan.
37. Replacement Prosthetic Appliances when necessitated by misuse or loss by the Participant.
38. Private duty nursing services, except for Extended Care Expenses.
39. Any Covered Drug that is provided under the Pharmacy Benefits portion of the Plan.
40. Biofeedback except for an Acquired Brain Injury diagnosis or other behavior modification services.
41. Abortion (except for a pregnancy that, as certified by a physician, places the Participant in danger of death.)
42. Self-administered drugs dispensed or administered by a Physician in their office.
43. Select medications may be excluded from the medical benefit when a self-administered formulation of the product is available.
44. Any services or supplies from more than one Provider on the same day(s) to the extent benefits were duplicated.
45. Behavioral health services provided at behavioral modification facilities, boot camps, emotional group academies, military schools, therapeutic boarding schools, wilderness programs, halfway houses and group homes, except for Covered Services provided by appropriate Providers as described in this Benefit Booklet.
46. Any of the following applied behavior analysis (ABA) services:
    - Services with a primary diagnosis that is not Autism Spectrum Disorder;
    - Services that are facilitated by a Provider that is not properly credentialed. Please see the definition of Qualified ABA Provider in the **DEFINITIONS** section of this Benefit Booklet.
    - Activities primarily of an educational nature;
    - Respite, shadow, or companion services; or
    - Any other services not provided by an appropriately licensed Provider in accordance with nationally accepted treatment standards.
47. Any related services to a non-covered service except for routine patient care for Participants in an Approved Clinical Trial. Related services are:
    - Services in preparation for the non-covered service;
    - Services in connection with providing the non-covered service;
    - Hospitalization required to perform the non-covered service; or
    - Services that are usually provided following the non-covered service, such as follow-up care or therapy after surgery.
48. Medical 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:

    - Ostomy bags and related supplies for which benefits are provided as described under Ostomy Supplies section.
    - Disposable supplies necessary for the effective use of Durable Medical Equipment for which benefits are provided as described under Medical Surgical Expenses section.

- Urinary catheters, wound care or dressing supplies given by a Provider during treatment for covered services.
- Medical grade compression stockings when considered medically necessary. The stockings must be prescribed by a Physician, individually measured and fitted to the patient.
- Diabetic supplies for which benefits are provided as described under Diabetes Services section.
- Batteries, tubing, nasal cannulas, connectors and masks except when used with Durable Medical Equipment.

Not all Medical Supplies are covered services and all are subject to medical review.

49. Any services or supplies not specifically defined as Eligible Expenses in this Plan.

50. 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; or

    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;
        - Your plan does not cover both qualitative (type of drug) testing and presumptive (to verify presence of drugs) testing on the same specimen.

    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 in 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 are 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
- 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

51. 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.

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

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

The definitions used in this Benefit Booklet apply to all coverage unless otherwise indicated.

Accidental Injury means accidental bodily injury resulting, directly and independently of all other causes, in initial necessary care provided by a Physician or Professional Other Provider.

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.

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

- ***For Hospitals and Facility Other Providers, Physicians, and Professional Other Providers contracting with BCBSTX in Texas or any other Blue Cross and Blue Shield Plan*** – The Allowable Amount is based on the terms of the Provider contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis-related groups (DRG), fee schedule, package pricing, global pricing, per diems, case-rates, discounts, or other payment methodologies.
- ***For Hospitals and Facility Other Providers, Physicians, Professional Other Providers, and any Other Provider not contracting with BCBSTX in Texas or any other Blue Cross and Blue Shield Plan outside of Texas (non-contracting Allowable Amount)*** **–** The Allowable Amount will be the lesser of: (i) the Provider's billed charges, or; (ii) the BCBSTX non-contracting Allowable Amount. Except as otherwise provided in this section, the non-contracting Allowable Amount is developed from base Medicare Participating reimbursements adjusted by a predetermined factor established by BCBSTX. Such factor shall be not less than 75% and will exclude any Medicare adjustment(s) which is/are based on information on the claim.

  Notwithstanding the preceding sentence, the non-contracting Allowable Amount for Home Health Care is developed from base Medicare national per visit amounts for low utilization payment adjustment, or LUPA, episodes by Home Health discipline type adjusted for duration and adjusted by a predetermined factor established by BCBSTX. Such factor shall be not less than 75% and shall be updated on a periodic basis.

  When a Medicare reimbursement rate is not available or is unable to be determined based on the information submitted on the claim, the Allowable Amount for non-contracting Providers will represent an average contract rate in aggregate for Network Providers adjusted by a predetermined factor established by BCBSTX. Such factor shall be not less than 75% and shall be updated not less than every two years.

  BCBSTX will utilize the same claim processing rules and/or edits that it utilizes in processing Network Provider claims for processing claims submitted by non-contracted Providers which may also alter the Allowable Amount for a particular service. In the event BCBSTX does not have any claim edits or rules, BCBSTX may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The Allowable Amount will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including, but not limited to, disproportionate share and graduate medical education payments.

  Any change to the Medicare reimbursement amount will be implemented by BCBSTX within ninety (90) days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

  The non-contracting Allowable Amount does not equate to the Provider’s billed charges and Participants receiving services from a non-contracted Provider will be responsible for the difference between the non-contracting Allowable Amount and the non-contracted Provider’s billed charge, and this difference may be considerable. To find out the BCBSTX non-contracting Allowable Amount for a particular service, Participants may call customer service at the number on the back of your BCBSTX Identification Card.

Notwithstanding the above, where applicable state or federal law requires another standard for a non-contracting claim, the Allowable Amount shall be the lessor of billed charge or the amount prescribed by law.

- ***For multiple surgeries*** – The Allowable Amount for all surgical procedures performed on the same patient on the *same* day will be the amount for the single procedure with the highest Allowable Amount *plus* a determined percentage of the Allowable Amount ***for each*** of the other covered procedures performed.
- ***For procedures, services, or supplies provided to Medicare recipients*** – The Allowable Amount will not exceed Medicare's limiting charge.
- ***For Covered Drugs as applied to Participating and non-Participating Pharmacies*** – The Allowable Amount for Participating Pharmacies and the Mail-Order Program will be based on the provisions of the contract between BCBSTX and the Participating Pharmacy or Pharmacy for the Mail-Order Program in effect on the date of service. The Allowable Amount for non-Participating Pharmacies will be based on the Participating Pharmacy contract rate.
- ***For non-Emergency Care provided by an Out-of-Network Provider when a contracting Provider is not reasonably available as defined by applicable law or when services are pre-approved or Prior Authorized based upon the unavailability of a Preferred Provider and balance billing is not prohibited by Texas or Federal law –*** The Allowable Amount will be the Plan usual and customary charge as defined by Texas law or as prescribed under applicable law and regulations, or at a rate agreed to between BCBSTX and the Out-of-Network Provider, not to exceed billed charges.
- ***For Out-of-Network Emergency Care, care provided by an Out-of-Network facility-based Provider in a Network Hospital, ambulatory surgery center or birthing center, or services provided by an Out-of-Network Laboratory or Diagnostic Imaging Service in connection with care delivered by a Network Provider –*** the Allowable Amount will be the Plan usual and customary rate or at a rate agreed to between BCBSTX and the Out-of-Network Provider as prescribed by the Texas Insurance Code, not to exceed billed charges. The Plan's usual and customary rate will be based upon our rate information for the same or similar services. The usual and customary rate shall not be less that the non-contracting Allowable Amount as defined in this Plan.

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:

1. Conducted under an investigational new drug application reviewed by the United States Food and Drug Administration;
2. Exempt from obtaining an investigational new drug application; or
3. Approved or funded by:
    a. 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;
    b. A cooperative group or center of the United States Department of Defense or the United States Department of Veterans Affairs;
    c. A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes for Health for center support groups; or
    d. 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:
        i. Be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
        ii. Provide unbiased scientific review by individuals who have no interest in the outcome of the review.
4. Conducted and approved by 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 (ASD) means a *neurobiological disorder* that includes autism, Asperger's syndrome, or pervasive developmental disorder--not otherwise specified. A *neurobiological disorder* means an illness of the nervous system caused by genetic, metabolic, or other biological factors.

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

Behavioral Health Practitioner means a Physician or Professional Other Provider who renders services for Mental Health Care, Serious Mental Illness or Chemical Dependency.

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 commencing on a January 1 and ending on the next succeeding December 31, inclusive.

Certain Diagnostic Procedures means:

- Bone Scan;
- Cardiac Stress Test;
- CT Scan (with or without contrast);
- MRI (Magnetic Resonance Imaging);
- Myelogram; or
- PET Scan (Positron Emission Tomography).

Chemical Dependency means the abuse of or psychological or physical dependence on or addiction to alcohol or a Controlled Substance. Also referred to in this Benefit Booklet as substance use disorder (SUD).

Chemical Dependency Treatment Center means a facility which provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved and monitored by a Behavioral Health Practitioner and which facility is also:

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral; or
2. Accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations; or
3. Licensed as a chemical dependency treatment program by an agency of the state of Texas having legal authority to so license, certify or approve; or
4. 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.

Clinical Ecology means the inpatient or outpatient diagnosis or treatment of allergic symptoms by:

1. Cytotoxicity testing (testing the result of food or inhalant by whether or not it reduces or kills white blood cells);
2. Urine auto injection (injecting one's own urine into the tissue of the body);
3. Skin irritation by Rinkel method;
4. Subcutaneous provocative and neutralization testing (injecting the patient with allergen); or
5. Sublingual provocative testing (droplets of allergenic extracts are placed in mouth).

Cognitive Communication Therapy means services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.

Cognitive Rehabilitation Therapy means services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.

Coinsurance Amount means the dollar amount expressed as a percentage of Eligible Expenses incurred by a Participant during a Calendar Year that exceeds benefits provided under the Plan.

Community Reintegration Services means services that facilitate the continuum of care as an affected individual transitions into the community.

Complications of Pregnancy means:

1. 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
2. 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 Anniversary Date means the corresponding date in each year after the Contract Date for as long as the Contract is in force.

Contract Date means the date on which coverage for the Employer's Contract with BCBSTX commences.

Contract Month means each succeeding monthly period, beginning on the Contract Date.

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

Copayment Amount means the payment, as expressed in dollars, that must be made by or on behalf of a Participant for certain services at the time they are provided.

Cosmetic, Reconstructive, or Plastic Surgery means surgery that:

1. Can be expected or is intended to improve the physical appearance of a Participant; or
2. Is performed for psychological purposes; or
3. Restores form but does not correct or materially restore a bodily function.

Covered Oral Surgery means maxillofacial surgical procedures limited to:

1. Excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths;
2. Incision and drainage of facial abscess;
3. Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses; and
4. Reduction of a dislocation of, excision of, and injection of the temporomandibular joint, except as excluded under the Plan; and
5. Removal of complete bony impacted teeth.

Crisis Stabilization Unit or Facility means an institution which is appropriately licensed and accredited as a Crisis Stabilization Unit or Facility for the provision of Mental Health Care and Serious Mental Illness services to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

Custodial Care means any service primarily for personal comfort for convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care Services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g., simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g., bathing, eating, dressing, etc.).

Deductible means the dollar amount of Eligible Expenses that must be incurred by a Participant before benefits under the Plan will be available.

Dependent means your spouse or Domestic Partner (provided your Employer covers Domestic Partners) or any *child* covered under the Plan.

Child means a natural child, a stepchild, an eligible foster child, an adopted child (including a child for whom you or your spouse is a party in a suit in which the adoption of the child is sought), under twenty-six (26) 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. A child of your child must be dependent on you for federal income tax purposes at the time of application of coverage for the child of your child is made under the Plan. A child not listed above whose primary residence is your household and to whom you are legal guardian or related by blood or marriage and who is dependent upon you for more than one-half of their support as defined by the Internal Revenue Code of the United States, is also considered a Dependent *child* under the Plan.

For purposes of this Plan, the term *Dependent* will also include those individuals who no longer meet the definition of a Dependent, but are beneficiaries under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or continued under the appropriate provisions of the *Texas Insurance Code*.

Dietary and Nutritional Services means the education, counseling, or training of a Participant (including printed material) regarding:

1. Diet;
2. Regulation or management of diet; or
3. The assessment or management of nutrition.

Domestic Partner means a person with whom you have entered into a domestic partnership in accordance with the Employer's Plan guidelines and who has been determined eligible by the Exchange, as appropriate. *Note:* Domestic Partner coverage is available at your Employer's discretion. Contact your Employer for information on whether Domestic Partner coverage is available under your Plan.

Durable Medical Equipment Provider means a Provider that provides therapeutic supplies and rehabilitative equipment and is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Eligible Expenses mean either, Inpatient Hospital Expenses, Medical-Surgical Expenses, Extended Care Expenses, or Special Provisions Expenses, or pharmacy expenses as described in this Benefit Booklet.

Emergency Care means health care services provided in a Hospital emergency facility (emergency room), 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 the person's condition, sickness, or injury is of such a nature that failure to get immediate care could result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment of bodily functions;
3. Serious dysfunction of any bodily organ or part;
4. Serious disfigurement; or
5. In the case of a pregnant individual, serious jeopardy to the health of the fetus.

Employee means an individual employed by a Small Employer.

For purposes of this plan, the term *Employee* may also include those individuals who are no longer an Employee of the Small Employer, but who are Participants covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or continued under the appropriate provisions of the *Texas Insurance Code*.

Environmental Sensitivity means the inpatient or outpatient treatment of allergic symptoms by:

1. Controlled environment; or
2. Sanitizing the surroundings, removal of toxic materials; or
3. Use of special non-organic, non-repetitive diet techniques.

Exchange means a governmental agency or non-profit entity that meets the applicable Exchange standards, and other related standards established under applicable law, and makes Qualified Health Plans (QHPs) available to Qualified Employees and Qualified Employers (as these terms are defined by applicable law).

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

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

Standard Medical Treatment means the services or supplies that are in general use in the medical community in the United States; and:

- Have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- Are appropriate for the Hospital or Facility Other Provider in which they were performed; and
- The Physician or Professional Other Provider has had the appropriate training and experience to provide the treatment or procedure.

The medical staff of BCBSTX 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 Physician or Professional Other Provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, BCBSTX still may determine such services or supplies to be Experimental/Investigational within this definition. Treatment provided as part of a clinical search study is Experimental/Investigational.

Extended Care Expenses means the Allowable Amount of charges incurred for those Medically Necessary services and supplies provided by a Skilled Nursing Facility, a Home Health Agency, or a Hospice as described in the **Extended Care Expenses** portion of this Benefit Booklet**.**

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.

Fixed-Wing Air Ambulance means a specially equipped airplane used for ambulance transport.

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.

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 may 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. The term does not include:

1. Accident only or disability income insurance, or a combination of accident-only and disability income insurance;
2. Credit-only insurance;

3. Disability insurance coverage;
4. Coverage for a specified disease or illness;
5. Medicare services under a federal contract;
6. Medicare supplement and Medicare Select policies regulated in accordance with federal law;
7. Long-term care coverage or benefits, Home Health Care coverage or benefits, nursing home care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits;
8. Coverage that provides limited-scope dental or vision benefits;
9. Coverage provided by a single service health maintenance organization;
10. Coverage issued as a supplement to liability insurance;
11. Workers' compensation or similar insurance;
12. Automobile medical payment insurance coverage;
13. Jointly managed trusts authorized under 29 U.S.C. Section 141, et seq., that:
    - Contain a plan of benefits for Employees,
    - Is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the Employees, and
    - Is authorized under 29 U.S.C. Section 157;
14. Hospital indemnity or other fixed indemnity insurance;
15. Reinsurance contracts issued on a stop-loss, quota-share, or similar basis;
16. Short-term major medical contracts;
17. Liability insurance, including general liability insurance and automobile liability insurance;
18. Other coverage that is:
    - Similar to the coverage described by this subdivision under which benefits for medical care are secondary or incidental to other insurance benefits; and
    - Specified in federal regulations;
19. Coverage for onsite medical clinics; or
20. Coverage that provides other limited benefits specified by federal regulations.

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.

Health Status Related Factor means:

1. Health status;
2. Medical condition, including both physical and mental illness;
3. Claims experience;
4. Receipt of health care;
5. Medical history;
6. Genetic information;
7. Evidence of insurability, including conditions arising out of acts of family violence; and
8. Disability.

Home Health Agency means a business that provides Home Health Care and is licensed, approved, or certified by the appropriate agency of the state in which it is located or is certified by Medicare as a supplier of Home Health Care.

Home Health Care means the health care services for which benefits are provided under the Plan when such services are provided during a visit by a Home Health Agency to patients confined at home due to a sickness or injury requiring skilled health services on an intermittent, part-time basis.

Home Infusion Therapy means the administration of fluids, nutrition, or medication (including all additives and chemotherapy) by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting. Home Infusion Therapy shall include:

1. Drugs and IV solutions;
2. Pharmacy compounding and dispensing services;
3. All equipment and ancillary supplies necessitated by the defined therapy;
4. Delivery services;
5. Patient and family education; and
6. Nursing services.

Over-the-counter products which do not require a Physician's or Professional Other Provider's prescription, including but not limited to standard nutritional formulations used for enteral nutrition therapy, are not included within this definition.

Home Infusion Therapy Provider means an entity that is duly licensed by the appropriate state agency to provide Home Infusion Therapy.

Hospice means a facility or agency primarily engaged in providing skilled nursing services and other therapeutic services for terminally ill patients and which is:

1. Licensed in accordance with state law (where the state law provides for such licensing); or
2. Certified by Medicare as a supplier of Hospice Care.

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

Hospital means a short-term acute care facility which:

1. Is duly licensed as a Hospital by the state in which it is located and meets the standards established for such licensing, and is either accredited by the Joint Commission on Accreditation of Healthcare Organizations or is certified as a Hospital Provider under Medicare;
2. Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians or Behavioral Health Practitioner for compensation from its patients;
3. Has organized departments of medicine and major surgery, either on its premises or in facilities available to the Hospital on a contractual prearranged basis, and maintains clinical records on all patients;
4. Provides 24-hour nursing services by or under the supervision of a Registered Nurse; and
5. Has in effect a Hospital Utilization Review Plan.

Hospital Admission means the period between the time of a Participant's entry into a Hospital or a Chemical Dependency Treatment Center as a *Bed patient* and the time of discontinuance of bed-patient care or discharge by the admitting Physician, Behavioral Health Practitioner or Professional Other Provider, whichever first occurs. The day of entry, but not the day of discharge or departure, shall be considered in determining the length of a Hospital Admission.

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

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

Identification Card means the card issued to the Employee by the Carrier indicating pertinent information applicable to their coverage.

Imaging Center means a Provider that can furnish technical or total services with respect to diagnostic Imaging Services and is licensed by an agency of the state of Texas having legal authority to so license, certify or approve.

Imaging Services means:

- CT Scan (with or without contrast)
- MRI (Magnetic Resonance Imaging)
- PET Scan (Positron Emission Tomography)

Independent Laboratory means a Medicare certified laboratory that provides technical and professional anatomical and/or clinical laboratory services.

Infusion Therapy means the administration of medication through a needle or catheter. It is prescribed when a patient's condition is so severe that it cannot be treated effectively by oral medications. Typically, "infusion therapy" means that a drug is administered intravenously, but the term also may refer to situations where drugs are

provided through other non-oral routes, such as intramuscular injections and epidural routes (into the membranes surrounding the spinal cord). Infusion therapy in most cases requires health care professional services for the safe and effective administration of the medication.

In Home Health Assessment means covered services which may include, but are 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.

In-Network Benefits means the benefits available under the Plan for services and supplies that are provided by a Network Provider or an Out-of-Network Provider when acknowledged by BCBSTX.

Inpatient Hospital Expense means the Allowable Amount incurred for the Medically Necessary items of service or supply listed below for the care of a Participant, provided that such items are:

1. Furnished at the direction or prescription of a Physician, Behavioral Health Practitioner or Professional Other Provider; and
2. Provided by a Hospital or a Chemical Dependency Treatment Center; and
3. Furnished to and used by the Participant during an inpatient Hospital Admission.

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

Inpatient Hospital Expense shall include:

1. Room accommodation charges. If the Participant is in a private room, the amount of the room charge in excess of the Hospital's average semiprivate room charge *is not* an Eligible Expense.
2. All other usual Hospital services, including drugs and medications, which are Medically Necessary and consistent with the condition of the Participant. Personal items *are not* an Eligible Expense.

Medically Necessary Mental Health Care or treatment of Serious Mental Illness in a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, a Residential Treatment Center, or a Residential Treatment Center for Children and Adolescents, in lieu of hospitalization, shall be Inpatient Hospital Expense.

Intensive Outpatient Program means a freestanding or Hospital-based program that provides services for at least three hours per day, two or more days per week, to treat mental illness, drug addiction, substance abuse or alcoholism, or specializes in the treatment of co-occurring mental illness with drug addiction, substance abuse or alcoholism. These programs offer integrated and aligned assessment, treatment and discharge planning services for treatment of severe or complex co-occurring conditions which make it unlikely that the Participants will benefit from programs that focus solely on mental illness conditions.

Late Enrollee means any Employee or Dependent eligible for enrollment who requests enrollment in an Employer's Health Benefit Plan (1) after the expiration of the initial enrollment period established under the terms of the first plan for which that Participant was eligible through the Employer, (2) after the expiration of an Open Enrollment Period, or (3) after the expiration of a special enrollment period.

An Employee or a Dependent is *not* a Late Enrollee if:

1. The individual:
    a. Was covered under another Health Benefit Plan or self-funded Health Benefit Plan at the time the individual was eligible to enroll; and
    b. Declines in writing, at the time of initial eligibility, stating that coverage under another Health Benefit Plan or self-funded Health Benefit Plan was the reason for declining enrollment; and
    c. Has lost coverage under another Health Benefit Plan or self-funded Health Benefit Plan as a result of:
        (1) Termination of employment;
        (2) Reduction in the number of hours of employment;
        (3) Termination of the other plan's coverage;
        (4) Termination of contributions toward the premium made by the Employer;
        (5) The death of a spouse;
        (6) Divorce or terminate a domestic partnership;

(7) COBRA coverage or State continuation benefits have been exhausted;
(8) cessation of Dependent status;
(9) The Plan no longer offers any benefits to the class of similarly situated individuals that include the individual; or
(10) In the case of coverage offered through an HMO, the individual no longer resides, lives, or works in the service area of the HMO and no other benefit option is available; and

d. Requests enrollment not later than the 31st day after the date on which coverage under the other Health Benefit Plan or self-funded Health Benefit Plan terminates.

2. The request for enrollment is made by the individual within the 60th day after the date on which coverage under Medicaid or CHIP terminates.
3. The individual is employed by an Employer who offers multiple Health Benefit Plans and the individual elects a different Health Benefit Plan during an Open Enrollment Period.
4. A court has ordered coverage to be provided for a spouse under a covered Employee's plan and the request for enrollment is made not later than the 31st day after the date on which the court order is issued.
5. A court has ordered coverage to be provided for a child under a covered Employee's plan and the request for enrollment is made not later than the 31st day after the date on which the Employer receives the court order or notice of the court order.
6. A Dependent child is not a Late Enrollee if the child:

    a. Was covered under Medicaid or the Children's Health Insurance Program (CHIP) at the time the child was eligible to enroll;
    b. The Employee declined coverage for the child in writing, stating that coverage under Medicaid or CHIP was the reason for declining coverage;
    c. The child has lost coverage under Medicaid or CHIP;
    d. The request for enrollment is made within the 60th day after the date on which coverage under Medicaid or CHIP terminates.

7. The individual has a change in family composition due to marriage or establishment of a domestic partnership; birth of a newborn child, placement as a foster child, adoption of a child, or because a Participant becomes a party in a suite for the adoption of a child, provided the request for enrollment is made no later than the 31st day after the date of the marriage or establishment of a domestic partnership, birth, adoption or date an insured becomes a party in a suite for the adoption.The individual becomes a Dependent due to marriage or establishment of a domestic partnership, birth of a newborn child, placement as a foster child, adoption of a child, or because an insured becomes a party in a suit for the adoption of a child provided the request for enrollment is made no later than the 31st day after the date of the marriage or establishment of a domestic partnership, birth, adoption or date an insured becomes a party in a suite for the adoption.

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.

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

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

1. Social and emotional factors related to the Participant's sickness, need for care, response to treatment, and adjustment to care; and
2. Relationship of the Participant's medical and nursing requirements to the home situation, financial resources, and available community resources.

Medical-Surgical Expenses means the Allowable Amount for those charges incurred for the Medically Necessary items of service or supply listed below for the care of a Participant, provided such items are:

1. Furnished by or at the direction or prescription of a Physician, Behavioral Health Practitioner or Professional Other Provider; and
2. Not included as an item of Inpatient Hospital Expense or Extended Care Expense in the Plan.

A service or supply is furnished at the direction of a Physician, Behavioral Health Practitioner or Professional Other Provider if the listed service or supply is:

1. Provided by a person employed by the directing Physician, Behavioral Health Practitioner or Professional Other Provider; and
2. Provided at the usual place of business of the directing Physician, Behavioral Health Practitioner or Professional Other Provider; and
3. Billed to the patient by the directing Physician, Behavioral Health Practitioner or Professional Other Provider.

An expense shall have been incurred on the date of provision of the service for which the charge is made.

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

1. Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, or bodily malfunction; and
2. Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States; and
3. Not primarily for the convenience of the Participant, their Physician, Behavioral Health Practitioner, the Hospital, or the Other Provider; and
4. The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the Participant.
5. If more than one health intervention meets the requirements listed above, Medically Necessary means the most cost effective in terms of type, frequency, extent, site, duration, which is safe and effective for the patient's illness, injury, or disease.

When applied to hospitalization, this further means that the Participant requires acute care as a bed patient due to the nature of the services provided or the Participant's condition, and the Participant cannot receive safe or adequate care as an outpatient.

The medical staff of BCBSTX shall determine whether a service or supply is Medically Necessary under the Plan and will consider the views of the state and national medical communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a Physician, Behavioral Health Practitioner or Professional Other Provider may have prescribed treatment, such treatment may not be Medically Necessary within this definition. BCBSTX does not determine course of treatment or whether particular health care services are received. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between the Participant, his Physician, Behavioral Health Practitioner, the Hospital, or the Other Provider.

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 the Carrier, 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 Physician, Behavioral Health Practitioner or Professional Other Provider (or by any person working under the direction or supervision of a Physician, Behavioral Health Practitioner or Professional Other Provider) when the Eligible Expense is:
    a. Individual, group, family, or conjoint psychotherapy,
    b. Counseling,
    c. Psychoanalysis,
    d. Psychological testing and assessment,
    e. The administration or monitoring of psychotropic drugs, or

f. Hospital visits or consultations in a facility listed in subsection 5, below;

3. Electroconvulsive treatment;
4. Psychotropic drugs;
5. Any of the services listed in subsections 1 through 4, above, performed in or by a Hospital, Facility Other Provider, or other licensed facility or unit providing such care.

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 number on the back of your ID card or visit www.cms.gov.

Network means identified Physicians, Behavioral Health Practitioners, Professional Other Providers, Hospitals, and other facilities that have entered into agreements with BCBSTX (and in some instances with other participating Blue Cross and/or Blue Shield Plans) for participation in a managed care arrangement.

Network Provider means a Hospital, Physician, Behavioral Health Practitioner, or Other Provider who has entered into an agreement with BCBSTX (and in some instances with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care Provider.

Neurobehavioral Testing means an evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family or others.

Neurobehavioral Treatment means interventions that focus on behavior and the variables that control behavior.

Neurocognitive Rehabilitation means services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

Neurocognitive Therapy means services designed to address neurological deficits in informational processing and to facilitate the development of higher-level cognitive abilities.

Neurofeedback Therapy means services that utilize operant conditioning learning procedures based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior and stabilized mood.

Neurophysiological Testing means an evaluation of the functions of the nervous system.

Neurophysiological Treatment means interventions that focus on the functions of the nervous system.

Neuropsychological Testing means the administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

Neuropsychological Treatment means interventions designed to improve or minimize deficits in behavioral and cognitive processes.

Non-Contracting Facility means a Hospital, a Facility Other Provider, or any other facility or institution which has not executed a written contract with BCBSTX for the provision of care, services, or supplies for which benefits are provided by the Plan. Any Hospital, Facility Other Provider, facility, or institution with a written contract with BCBSTX which has expired or has been canceled is a Non-Contracting Facility.

Open Enrollment Period means the 31-day period preceding the next Contract Anniversary Date during which Employees and Dependents may enroll for coverage.

Other Provider means a person or entity, other than a Hospital or Physician, that is licensed where required to furnish to a Participant an item of service or supply described herein as Eligible Expenses. Other Provider shall include:

Facility Other Provider - an institution or entity, only as listed:

1. Chemical Dependency Treatment Center
2. Crisis Stabilization Unit or Facility

3. Durable Medical Equipment Provider
4. Home Health Agency
5. Home Infusion Therapy Provider
6. Hospice
7. Imaging Center
8. Independent Laboratory
9. Prosthetics/Orthotics Provider
10. Psychiatric Day Treatment Facility
11. Renal Dialysis Center
12. Residential Treatment Center for Children and Adolescents
13. Skilled Nursing Facility
14. Therapeutic Center

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

1. Advanced Practice Nurse
2. Doctor of Chiropractic
3. Doctor of Dentistry
4. Doctor of Optometry
5. Doctor of Podiatry
6. Doctor in Psychology
7. Licensed Acupuncturist
8. Licensed Audiologist
9. Licensed Chemical Dependency Counselor
10. Licensed Dietitian
11. Licensed Hearing Instrument Fitter and Dispenser
12. Licensed Marriage and Family Therapist
13. Licensed Clinical Social Worker
14. Licensed Occupational Therapist
15. Licensed Physical Therapist
16. Licensed Professional Counselor
17. Licensed Speech-Language Pathologist
18. Licensed Surgical Assistant
19. Nurse First Assistant
20. Physician Assistant
21. Psychological Associates who work under the supervision of a Doctor in Psychology

The listings shown, above, in 1. and 2., unless otherwise defined in the Plan, shall have the meaning assigned to them by the *Texas Insurance Code*. In states where there is a licensure requirement, Other Providers must be licensed by the appropriate state administrative agency.

Out-of-Network Benefits means the benefits available under the Plan for services and supplies that are provided by an Out-of-Network Provider.

Out-of-Network Provider means a Hospital, Physician, Behavioral Health Practitioner, or Other Provider who has not entered into an agreement with BCBSTX (or other participating Blue Cross and/or Blue Shield Plan) as a managed care Provider.

Out-of-Pocket Maximum means the cumulative dollar amount of Eligible Expenses, including the Calendar Year Deductible, incurred by a Participant during a Calendar Year.

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

Outpatient Day Treatment Services means structured services provided to address deficits in physiological, behavioral, and/or cognitive functions. Such services may be delivered in settings that include transitional residential, community integration, or non-residential treatment settings.

Participant means an Employee or Dependent whose coverage has become effective under this Contract.

Physician means a person, when acting within the scope of their license, who is a Doctor of Medicine or Doctor of Osteopathy. The terms Doctor of Medicine or Doctor of Osteopathy shall have the meaning assigned to them by the *Texas Insurance Code*.

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

Post-Acute Care Treatment Services means services provided after acute care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral, or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.

Post-Acute Transition Services means services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

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

Primary Care Copayment Amount means the payment, as expressed in dollars, that must be made by or on behalf of a Participant for each office visit charge you incur when services are rendered by a family practitioner, an obstetrician/gynecologist, a pediatrician, Behavioral Health Practitioner, an internist, and a Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these listed Physicians.

Prior Authorization means the process that determines in advance the Medical Necessity or Experimental/Investigational nature of certain care and services under this Plan.

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.

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

Prosthetics/Orthotics Provider means a certified prosthetist that supplies both standard and customized prostheses and orthotic supplies.

Provider means a Hospital, Physician, Behavioral Health Practitioner, Other Provider, or any other person, company, or institution furnishing to a Participant an item of service or supply listed as Eligible Expenses.

Psychiatric Day Treatment Facility means an institution which is appropriately licensed and is accredited by the Joint Commission on Accreditation of Healthcare Organizations as a Psychiatric Day Treatment Facility for the provision of Mental Health Care and Serious Mental Illness services to Participants for periods of time not to exceed eight hours in any 24-hour period. Any treatment in a Psychiatric Day Treatment Facility must be certified in writing by the attending Physician or Behavioral Health Practitioner to be in lieu of hospitalization.

Psychophysiological Testing means an evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

Psychophysiological Treatment means interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

Qualified ABA Provider means a Provider operating within the scope of their license or certification that has met the following requirements:

For the treatment supervisor / case manager / facilitator:

1. Health Care Practitioner who is licensed, certified, or registered by an appropriate agency in the state where services are being provided; or
2. Health Care Practitioner whose professional credential is recognized and accepted by an appropriate agency of the United States, (i.e., Board-Certified Behavior Analyst (BCBA) or Board-Certified Behavior Analyst –Doctoral (BCBA-D)); or
3. Health Care Practitioner who is certified as a Provider under the TRICARE military health system.

For the para-professional / line therapist:

1. Two years of college educated staff person with a Board-Certified Assistant Behavior Analyst (BCaBA) for the para-professional/therapist, or
2. A staff person with a Registered Behavior Tech (RBT) certification for the direct line therapist effective as of January 1, 2019.

Qualified Health Plan or **QHP** means a health plan that has in effect a certification that it meets the applicable government standards issued or recognized by each Exchange through which such plan is offered.

Recommended Clinical Review means an optional voluntary review of Provider's recommended medical procedure, treatment or test, that does not require Prior Authorization, to make sure it meets approved Blue Cross and Blue Shield medical policy guidelines and Medical Necessity requirements.

Rehabilitation Services means services, including devices, on the other hand, 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.

Remediation means the process(es) of restoring or improving a specific function.

Renal Dialysis Center means a facility which is Medicare certified as an end-stage renal disease facility providing staff assisted dialysis and training for home and self-dialysis.

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 for treatment of Chemical Dependency. BCBSTX requires that any facility providing Mental Health Care and/or a Chemical Dependency Treatment Center must be licensed in the state where it is located, or accredited by a national organization that is recognized by BCBSTX 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 child-care institution which is appropriately licensed and accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Association of Psychiatric Services for Children as a residential treatment center for the provisions of Mental Health Care and Serious Mental Illness services for emotionally disturbed children and adolescents.

Retail Health Clinic means a Provider that provides treatment of uncomplicated minor illnesses. Retail Health Clinics are typically located in retail stores and are typically staffed by Advanced Practice Nurses or Physician Assistants.

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

Routine patient care costs do not include:

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

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

1. Bipolar disorders (hypomanic, manic, depressive, and mixed);
2. Depression in childhood and adolescence;
3. Major depressive disorders (single episode or recurrent);
4. Obsessive-compulsive disorders;
5. Paranoid and other psychotic disorders;
6. Schizo-affective disorders (bipolar or depressive); and
7. Schizophrenia.

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

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

Small Employer (Employer) means an employer (individual, corporation, partnership, or other legal entity) whose total Employee count would meet the definition of a Small Employer group consistent with applicable state and federal law.

Specialty Care Provider means a Physician or Professional Other Provider who has entered into an agreement with BCBSTX (and in some instances with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care Provider of specialty services with the exception of a family practitioner, obstetrician/gynecologist, pediatrician, Behavioral Health Practitioner, an internist or a Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these.

Specialty Copayment Amount means the payment, as expressed in dollars, that must be made by or on behalf of a Participant for each office visit charge you incur when services are rendered by a Specialty Care Provider.

Teledentistry Dental Service 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 Service means a health service, other than a Telemedicine Medical Service or a Teledentistry Dental Service, delivered by a health professional licensed, certified, or otherwise entitled to practice in Texas and acting within the scope of the health professional’s license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.

Telemedicine Medical Service means a health care service delivered by a Physician or Behavioral Health Practitioner licensed in Texas, or a health professional acting under the delegation and supervision of a Physician or Behavioral Health Practitioner 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 telecommunications or information technology.

Therapeutic Center means an institution which is appropriately licensed, certified, or approved by the state in which it is located and which is:

1. An ambulatory (day) surgery facility;
2. A freestanding radiation therapy center; or
3. A freestanding birthing center.

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 our website at www.bcbstx.com.

Virtual Provider means a licensed Provider that has entered into a contractual agreement with BCBSTX 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 ***Benefits for Virtual Visits*** provision.

Waiting Period means a period established by an Employer that must pass before an individual who is a potential enrollee in a Health Benefit Plan is eligible to be covered for benefits. 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 we reserve the right to begin your coverage on a date that we believe is within the required period. Regardless of whether we exercise that right, your group is responsible for your Waiting Period. If you have questions about your Waiting Period, please contact your Employer.

Covered Drugs

Benefits for Medically Necessary Covered Drugs prescribed to treat a Participant for a chronic, disabling, or life-threatening illness are available under the Plan if the drug:

1. Is included on the applicable Drug List;
2. Has been approved by the United States Food and Drug Administration (FDA) for at least one indication; and
3. Is recognized by the following for treatment of the indication for which the drug is prescribed:
    a. A prescription drug reference compendium approved by the Department of Insurance, or
    b. Substantially accepted peer-reviewed medical literature.

For a list of Covered Drugs, you can access the website at https://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.

Injectable Drugs

Injectable drugs approved by the FDA for self-administration are covered under the Plan. Benefits will not be provided under **PHARMACY BENEFITS** for any self-administered drugs dispensed by a Physician. You are responsible for any Deductibles, Copayment Amounts, Coinsurance Amounts, and pricing differences that may apply to the Covered Drug dispensed.

Diabetes Supplies for Treatment of Diabetes

Benefits are available for Medically Necessary items of Diabetes Supplies for which an authorized Health Care Practitioner has written an order. Such Diabetes Supplies, when obtained for a Qualified Participant (for more information regarding Qualified Participant, refer to the ***Benefits for Treatment of Diabetes*** section of the medical portion of this Benefit Booklet), shall include but not be limited to the following:

- Test strips specified for use with a corresponding blood glucose monitor;
- Lancets and lancet devices;
- Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein;
- Insulin and insulin analog preparations;
- Injection aids, including devices used to assist with insulin injection and needleless systems;
- Insulin syringes;
- Prescriptive and non-prescriptive oral agents for controlling blood sugar levels; and
- Glucagon emergency kits

You are responsible for any Deductibles, Copayment Amounts, Coinsurance Amounts and any pricing differences that may apply to the items dispensed.

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

Emergency Refills of Insulin or Insulin-Related Equipment and Supplies

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 Benefit Booklet, 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 Deductibles, Copayment Amounts, Coinsurance Amounts 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 Coverage, 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 Amount, Coinsurance Amount, Deductibles or dollar maximums, if applicable.

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

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, Coinsurance, Deductible or dollar maximums when obtained from a Participating Pharmacy. Covered Drugs purchased form a non-Participating Pharmacy, may be subject to Copayment Amount, Coinsurance Amount, Deductibles or dollar maximums, if applicable.

Select Vaccinations obtained through select Participating Pharmacies

Benefits for select vaccinations, as shown on your Schedule of Coverage, are available through certain Participating Pharmacies that have contracted with BCBSTX to provide this service. To locate one of these contracting Participating Pharmacies in the Pharmacy Vaccine Network in your area, and to determine which vaccinations are covered under this benefit, you may access our website at www.bcbstx.com or call our Customer Service Helpline number shown in this booklet or on your Identification Card. At the time you receive services, present your BCBSTX Identification Card to the pharmacist. This will identify you as a Participant in the BCBSTX health care plan provided by your employer. You are responsible for paying any Deductibles, Copayment Amounts, Coinsurance Amounts and any pricing differences, when applicable.

Each Participating Pharmacy that has contracted with BCBSTX to provide this service may have age, scheduling, or other requirements that will apply, so you are encouraged to contact them in advance.

Formulas for the Treatment of Phenylketonuria or Other Heritable Diseases

Benefits are available for dietary formulas necessary for the treatment of phenylketonuria or other heritable diseases to the same extent as any other Covered Drug available only on the orders of a Health Care Practitioner.

Amino Acid-Based Elemental Formulas

Benefits are available for 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.

Benefits for 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. No Deductible, Coinsurance or Copayment Amount will apply to certain orally administered anticancer medications when received from a Participating Provider. Coverage of prescribed orally administered anticancer medication when received from a non-Preferred Specialty Pharmacy or Non-Participating Pharmacy will be provided on a basis no less favorable the intravenously administered or injected cancer medications. To determine if a specific drug is included in this benefit contact Customer Service at the toll-free number on your Identification Card.

Specialty Drugs

Benefits are available for Specialty Drugs as described under ***Specialty Pharmacy Program***.

Member Rewards Rx

Member Rewards Rx is a free, voluntary program in which eligible Participants can earn a cash reward for choosing a cost-effective prescription alternative. Participants can use the Medication Finder feature located within the Provider Finder tool on our website at https://www.bcbstx.com/find-a-doctor-or-hospital to search for eligible opportunities on prescribed drugs.

When you choose a reward eligible opportunity on a prescribed drug, you will earn a reward in the form of a check mailed to you, usually within 60 days. This reward is separate from, and does not affect, your claim for a qualified prescription. To earn a reward, you must:

1. Have active coverage on the date you shop for a rewards-eligible prescribed drug opportunity; and
2. Have active coverage on the date the prescription is filled.

Reward eligibility is limited to the first fill of each eligible prescription after shopping. The reward amount you may earn on any medication is $100. Any reward amounts received may be taxable.

Your Provider may prescribe you a drug that is not eligible for a reward. However, you must use an eligible opportunity on prescribed drugs to receive a reward. Remember, all decisions on prescribed drug use are between you and your Provider.

Member Rewards Rx is not a discount program and will not impact benefits or claims processing. The Plan may discontinue or change this program upon 180 days' notice. To maintain eligibility for a reward, you must complete shopping for a rewards-eligible opportunity prior to the program termination following such notice. Rewards may be paid out up to 90 days after program termination. All rewards earned under this program will be funded by BCBSTX, and subject to the provided provisions of this program and all other applicable articles of coverage including payment of benefits, termination of coverage, and review of claim determinations.

If you have questions about this program, call customer service or visit our website at www.bcbstx.com.

Selecting a Pharmacy

Participating Pharmacy

When you go to a Participating Pharmacy:

- Present your Identification Card to the pharmacist along with your Prescription Order,
- Provide the pharmacist with the birth date and relationship of the patient,
- Sign the insurance claim log.

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

- The billed charges, or
- The Allowable Amount as determined by BCBSTX, or
- Other contractually determined payment amounts.

You are responsible for paying any Deductibles, Copayment Amounts, Coinsurance Amounts, and any pricing differences, when applicable. You may be required to pay for limited or non-covered services. No claim forms are required.

Although you can go to the Pharmacy of your choice, your benefits for drugs and other items covered under this provision will be greater when you obtain them from a Preferred Participating Pharmacy. Preferred Participating Pharmacies will charge less than Participating Pharmacies. Refer to your Schedule of Coverage for applicable payment levels. However, if you

- pay Pharmacy a rate less than the average discounted rate which would be paid by BCBSTX to a Participating Pharmacy directly for a covered and Medically Necessary service or supply, and
- the Pharmacy does not submit a claim to BCBSTX for that service or supply;

then you may submit the appropriate documentation with a claim form to BCBSTX, and allowable credit will, as applicable, be applied towards your in-network annual Deductible and Out-of-Pocket Maximums.

If you are unsure whether a Pharmacy is a Participating Pharmacy, you may access our website at https://www.bcbstx.com/onlinedirectory/important_info_rx.htm or contact the Customer Service toll-free number shown on your Identification Card.

Non-Participating Pharmacy

If you have a Prescription Order filled or obtain a covered vaccination at a non-Participating Pharmacy, you must pay the Pharmacy the full amount of its bill and submit a claim form to the Carrier with itemized receipts verifying that the Prescription Order was filled or a covered vaccination was provided. The Plan will reimburse you for Covered Drugs and covered vaccinations less:

- The appropriate Copayment/Coinsurance/Deductible Amount, if any, and
- Any pricing differences that may apply to the Covered Drug or covered vaccination you receive.

You will not be reimbursed for any charges over the Allowable Amount of the Covered Drugs. However, if you

- pay Pharmacy a rate less than the average discounted rate which would be paid by BCBSTX to a Participating Pharmacy directly for a covered and Medically Necessary service or supply, and
- the Pharmacy does not submit a claim to BCBSTX for that service or supply;

then you may submit the appropriate documentation with a claim form to BCBSTX, and allowable credit will, as applicable, be applied towards your in-network annual Deductible and Out-of-Pocket Maximums.

Please refer to the provision entitled “Prescription Drug Claims” in the **WHO FILES CLAIM** section of this Benefit Booklet.

Extended Prescription Drug Supply Program

Your coverage includes benefits for up to a 90-day supply of covered maintenance type drugs and diabetic supplies purchased from a Participating Pharmacy (which may only include retail or mail order Pharmacies). Each prescription or refill is subject to the Copayment Amount, Coinsurance Amount and any Deductible shown in your Schedule of Coverage and any applicable pricing differences.

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

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

Day Supply

Benefits for Covered Drugs are provided up to the maximum day supply limit as indicated on your Schedule of Coverage. The Copayment Amounts applicable for the designated day supply of dispensed drugs are also indicated on your Schedule of Coverage. The Carrier has the right to determine the day supply. Payment for benefits covered under this Plan may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum day supply limitation.

Mail-Order Program

The mail-order program provides delivery of Covered Drugs directly to your home address. If you and your covered Dependents elect to use the mail-order service, refer to your Schedule of Coverage for applicable payment levels.

Some drugs may not be available through the mail-order program. If you have any questions about this mail-order program, need assistance in determining the amount of your payment, or need to obtain the mail-order prescription form, you may access the website at www.bcbstx.com or contact Customer Service 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.

If you send an incorrect payment amount for the Covered Drug dispensed, you will: (a) receive a credit if the payment is too much; or (b) be billed for the appropriate amount if it is not enough.

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

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, benefits for Eligible Expenses will be determined as shown on your Schedule of Coverage of this Certificate.

A list identifying these Specialty Drugs is available by accessing the website at https://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 appropriate Specialty Drug Copayment indicated on the Schedule of Coverage and 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.

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 Deductible and out-of-pocket maximum. Available select Covered Drugs and drug discount card pricing through MedsYourWay may change occasionally. Certain restrictions may apply and certain Covered Drugs or drug discount cards may not be available for the MedsYourWay program. You may experience a different out-of-pocket amount for select Covered Drugs

depending upon which retail pharmacy is utilized. For additional information regarding MedsYourWay, please contact a Customer Service Representative at the toll-free telephone number on the back of your Identification Card. 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.

Your Cost

Copayment Amounts

Copayment Amounts for a Participating Pharmacy or non-Participating Pharmacy are shown on your Schedule of Coverage. The amount you pay depends on the Covered Drug dispensed.

If the Allowable Amount of the Covered Drug is less than the Copayment Amount, the Participant will pay the lower cost. When that lower cost is more than the amount you would pay if you purchased the drug without using your BCBSTX pharmacy benefits or any other source of drug benefits or discounts, you pay such purchase price.

Out-of-Pocket Maximum

There is no Out-of-Network Out-of-Pocket Maximum amount for individual or family coverage under this Plan. The Participant will continue to be responsible for any Deductibles, Copayment Amounts and Coinsurance Amounts, if applicable. The benefit amounts shown on your Schedule of Coverage will be used for purposes of determining the benefits available for additional Eligible Expense incurred by the Participant.

Member Pay the Difference

If you obtain a Brand Name Drug when a Generic Drug is available, you will pay the applicable Copayment Amount and/or Coinsurance Amount based on the current tier of Brand Name Drug **plus** the difference between the Allowable Amount of the Brand Name Drug and the Allowable Amount of the Generic Drug. 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 Provider 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 Provider 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 Physician 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 and/or Coinsurance Amounts after Deductible will still apply. For additional information, contact the customer service number on the back of your Identification Card or visit www.bcbstx.com.

Copayment Amounts paid at Non-Participating Pharmacy will only apply to the Out-of-Network Out-of-Pocket Maximum. Any additional charge for using a Non-Participating Pharmacy will not apply to your Out-of-Pocket Maximums.

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

Any Deductible, Copayment Amount or Coinsurance Amount for Covered Drugs on each drug tier is shown on your Schedule of Coverage. You can also contact customer service at the toll-free number on your Identification Card.

If a Covered Drug was paid for using any third-party payments, financial assistance, discount, product voucher, or other reduction in out-of-pocket expenses made by You or on Your behalf, that amount will be applied to your cost-sharing requirements (including Deductible, Copayment, or Out-of-Pocket Maximum).

About Your Benefits

Covered Drug List

Drugs listed on the Drug List are selected by BCBSTX 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 affiliated with BCBSTX. 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 financial impact to you (e.g., drug exclusion, drug moving to a higher payment tier, or drugs requiring step therapy or prior authorization) occur quarterly or annually consistent with Texas Insurance Code, 1369.0541. However, when there has been a pharmaceutical manufacturer's recall or other safety concern, changes to the Drug List may occur more frequently.

The Drug List and any modifications will be made available to you. By accessing the BCBSTX website at https://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.

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 Physician or 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 exemption, you, your prescribing Physician or other Health Care Practitioner, can call the number on the back of your ID 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, 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. You and your prescribing Physician or other Health Care Practitioner will be notified of the IRO's decision within 24 hours for 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 request is granted, coverage will be provided for the duration of the prescription, including refills.

Prescription Refills
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, BCBSTX will prorate the Copayment Amount or Coinsurance Amount due for Covered Drugs based on the proportion of days the reduced Prescription Order covers to the regular day supply outlined in your Schedule of Coverage.

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 Participants within a certain age range, or coverage only for Participants 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 https://www.bcbstx.com/member/prescription-drug-plan-information/drug-lists 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 BCBSTX, 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. 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. BCBSTX has the right to determine dispensing limits. Payment for benefits covered under this Plan may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or 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 you have not filled one of these medications within 120 days, you may only be able to receive a partial fill (14 – 15 day supply) of the medication for up to the first 3 months of therapy. This is to help see how the medication is working for you. If you receive a partial fill, your Copayments and/or Coinsurance after your deductible will be adjusted to align with the quantity of medication dispensed. If the medication is working for you and your Health Care Practitioner 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 https://www.bcbstx.com/rx-drugs/pharmacy/pharmacy-programs website.

GLP-1 30-Day Supply Maximum
Coverage is limited to a 30-day supply, per fill, for GLP-1 medications.

Step Therapy
Coverage for certain designated prescription drugs may be 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 the Plan.

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 medication and possible alternatives are available to you and your Health Care Practitioner on our website at www.bcbstx.com.

Non-Participating Pharmacies do not file your claims electronically and, therefore, will not have this online messaging. Should you elect to have your Prescription Order filled at a non-Participating Pharmacy, it is important that you access our website at https://www.bcbstx.com/member/prescription-drug-plan-information/drug-lists or contact the Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card prior to using one of these Pharmacies since Prescription Orders obtained through a non-Participating Pharmacy may be denied for reimbursement based upon this criteria.

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:

- **Stage-Four Advanced, Metastatic Cancer** means a cancer that has spread from the primary or original site of the cancer to nearby tissues, lymph nodes, or other areas or parts of the body.
- **Associated Conditions** means the symptoms or side effects associated with Stage-Four Advanced, Metastatic Cancer or its treatment and which, in the judgment of the Health Care Practitioner, further jeopardize the health of a patient if left untreated.

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 believes that denial of the Step Therapy Exception Request could cause you serious harm or death, the request is considered approved if We do not deny 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 Review of Claim Determinations section of this Benefit Booklet.

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

- 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
- 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:

- Once in a plan year; and
- If the generic or equivalent drug is added to the plan's Drug List.

Prior Authorizations
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. A list of the medications which require prior authorization is available to you and your Health Care Practitioner 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 medication which requires 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. The requested medication may be approved or denied for coverage under the Plan based upon its accordance with established clinical criteria.

Non-Participating Pharmacies do not file your claims electronically and, therefore, will not have this online messaging. Should you elect to have your Prescription Order filled at a non-Participating Pharmacy, it is important that you access our website at www.bcbstx.com or contact the Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card prior to using one of these Pharmacies since Prescription Orders obtained through a non-Participating Pharmacy may be denied for reimbursement based upon these 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.

Controlled Substances Limitations
In the event that BCBSTX determines that a Participant 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 be limited to services provided by a certain Provider and/or Pharmacy of the Participant's choice for the prescribing and dispensing of the Controlled Substance and/or limiting coverage to certain quantities. If the member does not choose such Provider and/or Pharmacy within a reasonable time, BCBSTX will make the choice. Additional Copayment Amounts, and Coinsurance Amounts and any Deductibles may apply.

Right of Appeal
You have the right to appeal as indicated under the **Review of Claim Determinations** section of this Benefit Booklet.

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 this Plan and/or such coverage is required in accordance with applicable law or regulatory guidance.
2. Non-FDA approved drugs.
3. Drugs which do not by law require a Prescription Order, except as indicated under ***Preventive Care*** in **PHARMACY BENEFITS**, from a Provider or authorized Health Care Practitioner (**except** insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and select vaccinations administered through certain Participating Pharmacies as shown on your Schedule of Coverage); and Legend Drugs or covered devices for which no valid Prescription Order is obtained.
4. Devices, Technologies, and/or durable medical equipment of any type (even though such devices may require a Prescription Order,) such as, but not limited to, contraceptive devices, therapeutic devices, including support garments and other non-medicinal substances, artificial appliances, digital health technologies and/or applications, or similar devices (except disposable hypodermic needles and syringes for self-administered injections and those devices listed as Diabetes Supplies). NOTE: Coverage for female contraceptive devices and the rental or purchase of manual or electric breast pumps is provided under the medical portion of this Plan.
5. 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.
6. Administration or injection of any drugs.
7. 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**).
8. Drugs injected, ingested or applied in a Physician's or authorized Health Care Practitioner's office or during confinement while a patient is in a Hospital, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.
9. Covered Drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
10. Covered Drugs, devices, or other Pharmacy services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or the laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical assistance (Medicaid), or any prescription drug which may be properly obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law; provided, however, that the exclusions of this section shall not be applicable to any coverage held by the Participant for prescription drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
11. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery. Select vaccinations shown on your Schedule of Coverage, administered through certain Participating Pharmacies are an exception to this exclusion.
12. Covered Drugs for which the Pharmacy's usual retail price to the general public is less than or equal to the Participant's cost share determined under this Plan.
13. Oral and injectable infertility and fertility medications.
14. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
15. Fluoride supplements except as required by law.
16. 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.

17. Drugs dispensed in quantities in excess of the day supply amounts stipulated in your Schedule of Coverage or as shown under the Day Supply section of this Benefit Booklet, or refills of any prescriptions in excess of the number of refills specified by the Physician or authorized Health Care Practitioner or by law, or any drugs or medicines dispensed more than one year following the Prescription Order date.

18. Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous intramuscular (in the muscle), unless approved by the FDA for self-administration, intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting. NOTE: This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases. This exception also does not apply to amino-acid based elemental formulas, regardless of the formula delivery method, used for the diagnosis and treatment of immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins, severe food protein-induced enterocolitis syndromes, eosinophilic disorders, as evidenced by the results of biopsy and disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract. A Prescription Order from your Health Care Practitioner is required.

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

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

21. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Identification Card.

22. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under your Employer's group health care plan, or for which benefits have been exhausted.

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. 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.)

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

26. Prescription Orders for which there is an over-the-counter product available with the same active ingredient(s) in the same strength, unless otherwise determined by the Plan.

27. Certain drug classes where there are over-the-counter alternatives available.

28. Athletic performance enhancement drugs.

29. Drugs to treat sexual dysfunction, including, but not limited to, sildenafil citrate (Viagra), phentolamine (Regitine), alprostadil (Prostin, Edex, Caverject), and apomorphine in oral and topical form.

30. Allergy serum and allergy testing material.

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

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

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

34. Some drugs have therapeutic equivalents/therapeutic alternatives. In some cases, Blue Cross and Blue Shield of Texas 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.

35. Replacement of drugs or other items that have been lost, stolen, destroyed or misplaced.
36. Shipping, handling or delivery charges.
37. Institutional packs and drugs that are repackaged by anyone other than the original manufacturer.
38. Bulk powders.
39. Diagnostic agents (except for diabetic testing supplies or test strips as described in this Benefit Booklet).
40. Prescription Orders written by a member of your immediate family, or a self-prescribed Prescription Order.
41. Drugs determined by the Plan to have inferior efficacy or significant safety issues.
42. Self-administered drugs dispensed or administered by a Physician in their office.
43. Drugs that are not considered Medically Necessary or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines.
44. New-to-market FDA-approved drugs which are subject to review by Prime Therapeutics Pharmacy and Therapeutic (P&T) Committee prior to coverage of the drug.

Definitions

(In addition to the applicable terms provided in the **DEFINITIONS** *Section of the Benefit Booklet, the following terms will apply specifically to this* **PHARMACY BENEFITS** *section.)*

Allowable Amount means the maximum amount determined by BCBSTX to be eligible for consideration of payment for a particular Covered Drug.

1. As applied to Participating Pharmacies the Allowable Amount is based on the provisions of the contract between BCBSTX and the Participating Pharmacy in effect on the date of service.
2. As applied to non-Participating Pharmacies, 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.

Coinsurance Amount means the percentage amount of Covered Drugs incurred by a Participant during a Calendar Year that exceeds benefits provided under the Plan.

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

Copayment Amount means the dollar amount paid by the Participant for each Prescription Order filled or refilled through a Participating Pharmacy or non-Participating Pharmacy.

Covered Drugs 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 Participant 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 Pharmacy and is received by the Participant while covered under the Plan, **except when** received from a Provider's office, or during confinement while a patient in a Hospital or other acute care institution or facility (refer to **Limitations and Exclusions**).

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

Drug List means a list of all drugs that may be covered under the **PHARMACY BENEFITS** portion of the Plan. This list is available by accessing the website at https://www.bcbstx.com/member/prescription-drug-plan-information/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 a Brand Name Drug and is allowed to be produced after the Brand Name Drug's patent has expired. In determining the brand or generic classification for Covered Drugs BCBSTX utilizes the generic/brand status assigned by a nationally recognized Provider of drug product database information. You should know that not all drugs identified as a "generic" by the drug product database, manufacturer, Pharmacy, or your Health Care Practitioner will adjudicate as generic by BCBSTX. Generic Drugs are shown on the Drug List which is available by accessing the website at https://www.bcbstx.com/member/prescription-drug-plan-information/drug-lists or you may also 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 Drugs mean drugs, biologicals, or compounded prescriptions which are required by law to have a label stating "Caution - Federal Law Prohibits Dispensing Without a Prescription," and which are approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose.

Non-Preferred Brand Name Drug means a Brand Name Drug which appears on the applicable *Drug List* as a Non-Preferred Brand Name Drug. This *Drug List* is available by accessing the website at https://www.bcbstx.com/member/prescription-drug-plan-information/drug-lists.

Non-Preferred Generic Drug means a Generic Drug which appears on the applicable Drug List as a Non-Preferred Generic Drug. The Drug List is available by accessing the website at https://www.bcbstx.com/member/prescription-drug-plan-information/drug-lists.

Non-Preferred Specialty Drug means a Specialty Drug which appears on the applicable Drug List as a Non-Preferred Specialty Drug. The Drug List is available by accessing the website at https://www.bcbstx.com/member/prescription-drug-plan-information/drug-lists.

Participating Pharmacy means an independent retail Pharmacy, chain of retail Pharmacies, mail-order Pharmacy or Specialty Drug Pharmacy which has entered into a written agreement with BCBSTX to provide pharmaceutical services to Participants under the Plan.

Pharmacy means a state and federally licensed establishment that is physically separate and apart from any Provider's office, and where Legend Drugs and devices are dispensed under Prescription Orders to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which they practice.

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

Preferred Brand Name Drug means a Brand Name Drug which appears on the applicable *Drug List* as a Preferred Brand Name Drug. The Drug List is available by accessing the website at https://www.bcbstx.com/member/prescription-drug-plan-information/drug-lists.

Preferred Generic Drug means a Generic Drug which appears on the applicable Drug List as a Preferred Generic Drug. The Drug List is available by accessing the website at https://www.bcbstx.com/member/prescription-drug-plan-information/drug-lists.

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

Preferred Specialty Drug means a Specialty Drug which appears on the applicable Drug List as a Preferred Specialty Drug. Drug. List is available by accessing the website at https://www.bcbstx.com/member/prescription-drug-plan-information/drug-lists.

Prescription Order means a written or verbal order from an authorized Health Care Practitioner to a pharmacist for a drug or device to be dispensed. Orders written by an authorized Health Care Practitioner located outside the United States to be dispensed in the United States are not covered under the Plan**.**

Specialty Drug 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,
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 https://www.bcbstx.com/member/prescription-drug-plan-information/drug-lists.

Specialty Pharmacy Provider means a Participating Pharmacy from which Specialty Drugs can be obtained.

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.

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. If BCBSTX makes any material modification (as defined under section 102 of ERISA) in any of the terms of the plan or coverage that would affect the content of the Summary of Benefits and Coverage (SBC) (a document that summarizes plan benefits, cost-sharing, and limitations, as required under the Affordable Care Act), that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage, BCBSTX must provide notice of the modification to Participants not later than 60 days prior to the date on which the modification will become effective.

Assignment and Payment of Benefits

If a written assignment of benefits is made by a Participant to a Provider and the written assignment is delivered to the Carrier with the claim for benefits, the Carrier will make any payment directly to the Provider. Payment to the Provider discharges the Carrier's responsibility to Participant for any benefits available under the Plan.

Conformity with State Statutes

Laws in some states require that certain benefits or provisions be provided to you if you are a resident of that state when the contract that insured you is not issued in your state. Any provision of this Benefit Booklet which, on its effective date, is in conflict with applicable statutes of the state in which the Employee resides on such date, is hereby amended to conform to: (a) the minimum requirements of such statutes, or (b) the benefits or provisions of this Benefit Booklet to the extent they exceed such minimum requirements.

Disclosure Authorization

If you file a claim for benefits, it will be necessary that you authorize any health care Provider, insurance carrier, or other entity to furnish 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.

Identity Theft Protection

As a Participant, BCBSTX makes available at no additional cost to you, identity theft protection services, including credit monitoring, fraud detection, credit/identity repair and insurance to help protect your information. These identity theft protection services are currently provided by BCBSTX's designated outside vendor and acceptance or declination of these services is optional to the Participant. Participants who wish to accept such identity theft protection services will need to individually enroll in the program online at www.bcbstx.com/ or telephonically by calling 1-800-521-2227. Services may automatically end when the person is no longer an eligible Participant. Services may change or be discontinued at any time with reasonable notice. BCBSTX does not guarantee that a particular vendor or service will be available at any given time.

Incontestability

Except as to issues concerning nonpayment of Premiums due:

- The validity of the Plan may not be contested after the Plan has been in force for two years after its date of issue.
- In the absence of fraud, no statement made by any individual covered under the Plan relating to the individual's insurability may be used in contesting the validity of the coverage with respect to which the statement was made:
    - After the coverage has been in force before the contest for two years; and
    - Unless the statement is contained in written instrument signed by the individual making the statement.

Medicare

Special rules apply when you are covered by this Plan and by Medicare. Generally, the Plan is a Primary Plan if you are an active Employee, and Medicare is a Primary Plan if you are a retired Employee.

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 BCBSTX, or, if you do not reside in the Plan Service Area, by the Blue Cross and/or Blue Shield Plan 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 BCBSTX offers you, if you do not reside in the Plan Service Area, BCBSTX may facilitate your right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Blue Cross and/or Blue Shield Plan available in the service area in which you reside. To do this we may (1) communicate directly with you and/or (2) provide the Blue Cross and/or Blue Shield Plan whose service area covers the geographic area in which you reside, with your personal information and other general information relating to your coverage under this Plan to the extent reasonably necessary to enable the appropriate Blue Cross and/or Blue Shield Plan to offer you coverage continuity through replacement coverage.

Member Rewards Medical

Member Rewards is a free, voluntary program in which eligible Participants can earn a percentage of the claim savings in the form of a cash reward by selecting quality, low-cost Network facilities for qualified elective, nonemergency medical services. Participants can use the Provider Finder tool on our website at www.bcbstx.com/find-a-doctor-or-hospital to find a list of all eligible services and facility options. Shopping can also be conducted by calling customer service, who will shop for services and facilities on your behalf.

When you choose a rewards eligible service, you will earn a portion of the savings in the form of a check mailed to you, usually within 60 days. This reward is separate from and does not affect your claim for a qualified service. To earn a reward, you must:

1. Have active coverage on the date you shop for a rewards-eligible service;
2. Have active coverage on the date the medical service is rendered; and
3. Complete the rewards-eligible service within thirteen months of shopping.

Incentive amounts and eligible services are subject to change; however, the maximum reward amount you may earn on any single procedure is $500. Any reward amounts received may be taxable.

Your provider may refer you to a facility or location to complete your medical service or procedure that is not eligible for a reward. However, you must use a facility that is eligible for the program to receive a reward. If your provider refers you to a facility that is not eligible for a reward under the program, customer service may be able to

coordinate with your provider to find an eligible facility or location, if one is available. Remember, all decisions on where to receive care are between you and your provider.

Member Rewards is not a discount program and will not impact benefits or claims processing. The Plan may discontinue or change this program upon 180 days' notice. To maintain eligibility for a reward, you must complete shopping for a rewards-eligible service prior to the program termination following such notice. Rewards may be paid out up to 90 days after program termination. All rewards earned under this program will be funded by BCBSTX, and subject to the provided provisions of this program and all other applicable articles of coverage including payment of benefits, termination of coverage, and review of claim determinations. A Referral or Prior Authorization may be required for your procedure or service.

If you have questions about this program, call customer service or visit our website at www.bcbstx.com

New Medical Technology

Blue Cross and Blue Shield of Texas 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.

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 in the DEFINITIONS section of this Benefit Booklet, 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.

Participant/Provider Relationship

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

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

Refund of Benefit Payments

If your group's benefit plan or BCBSTX pays benefits for Eligible Expenses incurred by you or your Dependents and it is found that the payment was more than it should have been, or was made in error ("Overpayment"), your group's Plan and BCBSTX have the right to obtain a refund of the Overpayment from: (1) the person to, or for whom, such benefits were paid, or (2) any insurance company or plan, or (3) any other persons, entities or organizations, including, but not limited to, Network Providers or Out-of-Network Providers.

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

- Any future benefit payment made to any person or entity under this Benefit Booklet, whether for the same or a different Participant; or,
- 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,
- Any future benefit payment made to any person or entity under another BCBSTX-insured group benefit plan or individual policy; or,
- Any future benefit payment, or other payment, made to any person or entity; or,
- Any future payment owed to one or more Participating Providers or Out-of-Network 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.

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, except as limited by and subject to Chapter 140 of the Texas Civil Practice and Remedies Code. 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.

Rescission of Coverage

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 cancellation or non-renewal of coverage due to failure to timely pay required premiums or contributions toward the cost of coverage (including COBRA premiums), a cancellation 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 Benefit Booklet, BCBSTX may at its option make an offer to reform the Benefit Booklet already in force and/or change the rating category/level. In the event of reformation, the Benefit Booklet 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.

State Government Programs

1. If a Participant under the Plan is also a Medicaid recipient, any benefits for services or supplies under the Plan will not be excluded solely because benefits are paid or payable for such services or supplies under Medicaid. Any benefits available under the Plan will be payable to the Texas Health and Human Services Commission to the extent required by the *Texas Insurance Code*; and

2. All benefits paid on behalf of a child or children under the Plan must be paid to the Texas Health and Human Services Commission where;

    a. The Texas Health and Human Services Commission 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 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 Health and Human Services Commission.

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 deductible, copayment, or coinsurance amounts 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.

BCBSTX 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 Plan and any other Health Care Plan covering you on whose behalf a claim is made are as follows:

1. The benefits of a Health Care Plan that does not have a coordination of benefits provision shall in all cases be determined before the benefits of this Plan 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 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:
        (i) The Health Care Plan of the parent whose birthday falls earlier in the Calendar Year is the primary plan; or
        (ii) If both parents have the same birthday, the Health Care Plan that has covered the parent the longest is the primary plan.
    b. For a Dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:
        (i) if a court order states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Health Care Plan of that parent has actual knowledge of those terms, that Health Care Plan is primary. This rule applies to plan years commencing after the Health Care Plan is given notice of the court decree.
        (ii) if a court order states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 2.a. must determine the order of benefits.
        (iii) if a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 2.a. must determine the order of benefits.

(iv) if there is no court order allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
(I) the Health Care Plan covering the Custodial Parent;
(II) the Health Care Plan covering the spouse of the Custodial Parent;
(III) the Health Care Plan covering the non-Custodial Parent; then
(IV) the Health Care Plan covering the spouse of the non-Custodial Parent.

c. For a Dependent child covered under more than one Health Care Plan of individuals who are not the parents of the child, the provisions of 2.a or 2.b. must determine the order of benefits as if those individuals were the parents of the child.

d. For a Dependent child who has coverage under either or both parents' Health Care Plans and has 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.

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

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

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

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, BCBSTX 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. BCBSTX 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.

Termination of Coverage

Termination of Individual Coverage

Coverage under the Plan for you and/or your Dependents will automatically terminate when:

1. Your portion of the group premium is not received timely by BCBSTX; or
2. You no longer satisfy the definition of an Employee as defined in this Benefit Booklet, including termination of employment; or
3. The Plan is terminated; or
4. A Dependent ceases to be a Dependent as defined in the Plan.

However, when any of these events occur, you and/or your Dependents may be eligible for continued coverage. See **Continuation Privilege** in the **GENERAL PROVISIONS** section of this Benefit Booklet.

The Carrier may refuse to renew the coverage of an eligible Employee or Dependent for fraud or intentional misrepresentation of a material fact by that individual.

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

1. *Disabled,* and
2. Dependent upon you for more than one-half of their support as defined by the Internal Revenue Code of the United States.

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

Termination of the Group

The coverage of all Participants will terminate if the group is terminated in accordance with the terms of the Plan.

Extension of Benefits

If this Contract terminates (as described in the Employer's Contract), any Participant who is *Totally Disabled* on the effective date of the termination of the Contract shall be entitled to receive benefits as described in this Benefit Booklet, subject to the benefit limitations and maximums, for the continued treatment of the condition causing the *Total Disability*. Benefits will be available for the period of the *Total Disability* or for 90 days following the termination date of the Contract, whichever is less.

However, if your coverage under the Plan is replaced with coverage issued by a *Succeeding Carrier* which provides substantially equivalent or greater benefits than those provided by this Contract, this extension of benefits for *Total Disability* is not applicable.

Succeeding Carrier means an insurer that has replaced the coverage of BCBSTX with its coverage.

Total Disability or ***Totally Disabled*** means as applied to:

1. An Employee, the complete inability of the Employee to perform all of the substantial and material duties and functions of their occupation and any other gainful occupation in which the Employee earns substantially the same compensation earned prior to disability; and
2. A Dependent, confinement as a bed patient in a Hospital.

Continuation Privilege

Any Participant whose insurance under the Contract has been terminated for any reason except involuntary termination for cause, including discontinuance of the Contract in its entirety or with respect to an insured class, and, who has been continuously insured under the Contract or any group policy providing similar benefits which it replaces for at least three consecutive months immediately prior to termination shall be entitled to such privilege as outlined below:

Continuation of group coverage must be requested in writing and provided to either the Employer or Contractholder within 60 days following the later of:

1. The date the group coverage would otherwise terminate; or
2. The date the Participant is given notice of the right of continuation by either the Employer or the group Contractholder.

A Participant electing continuation must pay the amount of contribution required to the Employer or Contractholder, plus two percent of the group rate for the insurance being continued under the contract. The first payment must be made within 45 days after the initial election of coverage. All subsequent payments must be made no later than 30 days after the payment due date.

Continuation may not terminate until the earliest of:

1. The date on which the maximum continuation period is exhausted, which is:
    a. For covered persons not eligible for COBRA continuation coverage, nine months after the date of state continuation coverage; or
    b. For covered persons covered under COBRA continuation coverage, six additional months following any period of COBRA continuation coverage;
2. The date on which failure to make timely payments would terminate coverage;
3. The date on which the group coverage terminates in its entirety;
4. The date on which the covered person is or could be covered under Medicare;
5. The date on which the covered person is covered for similar benefits by another Hospital, surgical, medical, or major medical expense insurance policy or Hospital or medical subscriber contract or medical practice or other prepayment plan or any other plan or program;
6. The date the covered person is eligible for similar benefits whether or not covered therefor under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or
7. Similar benefits are provided or available to such person, pursuant to or in accordance with the requirements of any state or federal law, other than COBRA continuation coverage.

Additional Continuation for Certain Dependents - State
If coverage terminates as the result of an Employee's death, retirement, or divorce, a Dependent's coverage can continue. The Dependent must have been covered under the Contract for at least one year, except in the case of a Dependent who is an infant under one year of age. Continuation does not require evidence of insurability.

Continuation under this provision will not apply if continuation is required under the Consolidated Omnibus Budget Reconciliation Act of 1985. In addition, continuation is not available when coverage terminates due to any of these circumstances:

1. The Contract is canceled; or
2. The Dependent fails to make any timely premium payments.

Continuation ends after the earliest of the following:

1. The third anniversary of the severance of the family relationship or the retirement or death of the Subscriber;
2. The insured fails to make premium payments within the time required to make the payments;

3. The insured becomes eligible for substantially similar coverage under another plan or program, including a group health insurance policy or contract, Hospital, or medical service subscriber contract, or medical practice or other prepayment plan; or
4. The Contract is canceled.

Notification Requirements
The Dependent must notify the Carrier within 15 days of the Employee's death, retirement, or divorce. The Carrier will immediately provide written notice to the Dependent of the right to continue coverage and will send the election form and instructions for premium payment.

Within 60 days of the Employee's death, retirement, or divorce, the Dependent must give written notice to the Carrier of the desire to exercise the right of continuation or the option expires. Coverage remains in effect during the 60-day period provided premium is paid.

COBRA Continuation – Federal
Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Participants may have the right to continue coverage, after the date coverage ends. Participants will not be eligible for COBRA continuation if the Contractholder is exempt from the provisions of COBRA; however, the Participant may be eligible for State Continuation as addressed under **Additional Continuation for Certain Dependents – State.**

Please check with your Employer or Human Resources Department to determine if Domestic Partners are eligible for COBRA-like benefits in your Plan. Coverage shall be available under the state continuation provisions. For specific criteria or necessary forms required to establish eligibility for benefit coverage under this Plan, contact your Employer or Human Resources Department.

Minimum Size of Group
The Group must have normally employed more than twenty (20) Employees on a typical business day during the preceding Calendar Year. This refers to the number of full-time and part-time Employees employed, not the number of Employees covered by a Health Benefit Plan.

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

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

1. divorce from the covered Employee,
2. death of the covered Employee,
3. the covered Employee becomes eligible for Medicare, or
4. a covered Dependent child no longer meets the Dependent eligibility requirements.

COBRA continuation under the contract ends at the earliest of the following events:

1. The last day of the eighteen (18) month period for events which have a maximum continuation period of eighteen (18) months.
2. The last day of the thirty-six (36) month period for events which have a maximum continuation period of thirty-six (36) months.
3. The first day for which timely payment of premium is not made to the Plan with respect to the qualified beneficiary.
4. The date upon which the Employer ceases to provide any group health plan to any Employee.
5. The date, after the date of the election, upon which the qualified beneficiary first becomes covered under any other employer group Health Benefit Plan.
6. The date, after the date of the election, upon which the qualified beneficiary first becomes entitled to Medicare benefits.

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

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

Notice of COBRA Continuation Rights
The Employer is responsible for providing the necessary notification to Participants as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986.

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

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

If the Health Benefit Plan is part of an "employee welfare benefits plan" and "welfare plan" as those terms are defined in ERISA:

1. The Employer will furnish summary plan descriptions, annual reports, and summary annual reports to you and other plan Participants and to the government as required by ERISA and its regulations.
2. BCBSTX will furnish the Employer with this Benefit Booklet as a description of benefits available under this Health Benefit Plan. Upon written request by the Employer, BCBSTX will send any information which BCBSTX has that will aid the Employer in making its annual reports.
3. Claims for benefits must be made in writing on a timely basis in accordance with the provisions of this Health Benefit Plan. Claim filing and claim review health procedures are found in the **CLAIM FILING AND APPEALS PROCEDURES** section of this Benefit Booklet.
4. BCBSTX is not the ERISA "Plan Administrator" for benefits or activities pertaining to the Health Benefit Plan.
5. This Benefit Booklet is a Certificate of Coverage and not a Summary Plan Description.
6. The Employer has given BCBSTX the authority and discretion to interpret the Health Benefit Plan provisions and to make eligibility and benefit determinations.

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 Blue Cross and Blue Shield of Texas (BCBSTX) Benefit Booklet. Coverage for the routine vision 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 this *Pediatric Vision Care Benefit*.) All provisions in your Benefit Booklet apply to this *Pediatric Vision Care Benefit* unless specifically indicated otherwise below.

Definitions

Eye Care Expenses – 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 ophthalmologist, therapeutic optometrist or 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 this Plan, up to age 19, are eligible for coverage under this *Pediatric Vision Care Benefit.* NOTE: Once coverage is lost under the Plan, 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 we may list a specific service as a benefit, we 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 or 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

How the vision benefits work

You may visit any vision care Provider and receive benefits for a vision examination. In order to maximize benefits for most covered Vision Materials, however, you must purchase them from a Network Provider.

Before you go to a Network vision care 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 Participant in the BCBSTX vision care plan so that your eligibility can be verified.

To locate a Network Provider, visit our website at **www.bcbstx.com**, or contact the Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card to obtain a list of the Network Providers nearest you.

If you obtain glasses or contacts from an Out-of-Network Provider, you must pay the Provider in full and submit a claim for reimbursement (see **CLAIM FILING PROCEDURES** for more information).

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 Provider. Continuity of care will best be maintained when all available services are obtained at one time from one Network Provider and there may be additional professional charges if you seek contact lenses from a 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 Network. 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 Benefit Booklet, 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 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.

Schedule of Pediatric Vision Coverage

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

comprehensive low vision evaluation every 5 years; 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.
Note: Additional discounts on materials may be available.

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

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

RIDERS

In Vitro Fertilization Services Rider

The provisions contained in this rider are added to and shall become a part of the Benefit Booklet. Any Deductibles, Copayment Amounts, terms, conditions, limitations and exclusions of the Benefit Booklet apply to this rider, except as modified herein.

The PRIOR AUTHORIZATION section of your benefit booklet is amended by adding the following type of services require Prior Authorization:

- In Vitro fertilization services

Benefits for In Vitro Fertilization Services

Benefits for Medical-Surgical Expense incurred for in vitro fertilization services will be the same as for Maternity Care provided **all** of the following requirements are met:

a. The patient for the in vitro fertilization procedure is a covered Participant under this Plan;

b. The Participant has a history of infertility of at least five continuous years duration or the infertility is associated with one or more of the following conditions:

   - Endometriosis;
   - Exposure in utero diethylstilbestrol (DES);
   - Blockage or surgical removal of one or both fallopian tubes; or
   - Oligospermia;

c. The Participant has been unable to obtain a successful pregnancy through any less costly applicable infertility treatment which is covered under the Plan; and

d. The in vitro fertilization procedures are performed in a facility licensed and approved to provide in vitro fertilization services under the appropriate state authority, if any.

No benefits for in vitro fertilization services are available if:

- Any condition contained in items (a) through (e) indicated above, is not complied with;
- The Employer has not applied for Maternity Care benefits;
- The services or supplies are for Inpatient Hospital Expense.

The LIMITATIONS AND EXCLUSIONS section of your benefit booklet is amended by replacing exclusion # 24 with the below exclusion.

24. Any services or supplies provided for, in preparation for, or in conjunction with:

- Sterilization reversal
- Sexual dysfunctions; and
- Promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct intra-peritoneal insemination, trans-uterine tubal insemination, gamete intra fallopian transfer, pronuclear oocyte stage transfer, zygote intra-fallopian transfer, and tubal embryo transfer.

PEDIATRIC DENTAL CARE BENEFITS

This is a rider to your Blue Cross and Blue Shield of Texas, A Division of Health Care Service Corporation, Benefit Booklet. It is to be attached to and becomes part of the Benefit Booklet.

Pediatric Dental Care is made part of, and is in addition to any information you may have in your Blue Cross and Blue Shield of Texas (BCBSTX) Benefit Booklet. 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* Benefit). All provisions in your Benefit Booklet apply to the *Pediatric Dental Care* Benefit unless specifically indicated otherwise below.

Eligibility

Participants who are covered under this Plan, up to age 19, are eligible for coverage under the *Pediatric Dental Care Benefit*. NOTE: Once coverage is lost under the Plan, all benefits cease under this *Pediatric Dental Care Benefit.*

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 Benefit Booklet, 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.

PEDIATRIC DENTAL CARE BENEFITS

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	• 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

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.

PEDIATRIC DENTAL CARE BENEFITS

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.

Prior Authorization of Benefits

Prior Authorization 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 prior authorization estimate is provided.

Participant/Dentist Benefit Website

Information concerning covered Dental services is available to you and your Dentist on our website www.bcbstx.com.

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

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 Benefit Booklet. 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 COVERAGE**. Eligible Dental Expenses will apply to the In-Network Deductible amount for an individual and family shown on the **SCHEDULE OF COVERAGE**.

PEDIATRIC DENTAL CARE BENEFITS

Out-of-Pocket Maximum

Your Eligible Dental Expenses payment obligation is applied to the Out-of-Pocket Maximum as shown on your **SCHEDULE OF COVERAGE**. Eligible Dental Expenses will apply to the In-Network Out-of- Pocket Maximum amount for an individual and family shown on the **SCHEDULE OF COVERAGE**. 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.

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 Benefit Booklet.

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.

PEDIATRIC DENTAL CARE BENEFITS

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 Medically Necessary for documented Participants with a disability or for a justifiable medical or dental condition. A person's apprehension does not constitute Medical Necessity.
- Therapeutic parenteral drugs – Therapeutic parenteral drugs will be covered for a Participant under age 19.

PEDIATRIC DENTAL CARE BENEFITS

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 Medically 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.

PEDIATRIC DENTAL CARE BENEFITS

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:

PEDIATRIC DENTAL CARE BENEFITS

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 by the Plan 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 **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 Benefit Booklet or if resulting from accidental injury. Dental services or appliances to increase vertical dimension, unless specifically mentioned in this Benefit Booklet.
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 member.
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 telephone consultations, email or other electronic consultations, 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.

PEDIATRIC DENTAL CARE BENEFITS

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.

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.

Pediatric Orthodontic Services means coverage limited to children under age 19 with an orthodontic condition meeting Dental Necessity criteria (e.g., severe, dysfunctional malocclusion).

PEDIATRIC DENTAL CARE BENEFITS

DENTAL SCHEDULE OF COVERAGE

The Coinsurance and Annual Maximum below are subject to change as permitted by applicable law.

Covered Dental Services	Pediatric Dental Benefits
Diagnostic Evaluations	70% of Allowable Amount after Deductible
Preventive Services Periodic Oral Evaluation and Fluoride treatment covered at 100% - deductible waived	70% of Allowable Amount after Deductible
Diagnostic Radiographs	70% of Allowable Amount after Deductible
Miscellaneous Preventive Services	70% of Allowable Amount after Deductible
Basic Restorative Services	70% of Allowable Amount after Deductible
Non-Surgical Extractions	70% of Allowable Amount after Deductible
Non-Surgical Periodontal Services	70% of Allowable Amount after Deductible
Adjunctive Services	70% of Allowable Amount after Deductible
Endodontic Services	70% of Allowable Amount after Deductible
Oral Surgery Services	70% of Allowable Amount after Deductible
Surgical Periodontal Services	70% of Allowable Amount after Deductible
Major Restorative Services	70% of Allowable Amount after Deductible
Prosthodontic Services	70% of Allowable Amount after Deductible
Miscellaneous Restorative and Prosthodontic Services	70% of Allowable Amount after Deductible
Implants	70% of Allowable Amount after Deductible
Orthodontia	
Pediatric Orthodontic Services	70% of Allowable Amount after Deductible
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.

The health plan Deductible shown on the **SCHEDULE OF COVERAGE** must be met first, and then the cost sharing Coinsurance is applied to the remainder of the Allowable Amount. Eligible Dental Expenses will apply to the In-Network Deductible amount for an individual and family shown on the **SCHEDULE OF COVERAGE**.

Eligible Dental Expenses will apply to the In-Network Out-of-Pocket Maximum amount for an individual and family shown on the **SCHEDULE OF COVERAGE**. Eligible Dental Expenses applied toward satisfying the In-Network Out-of-Pocket Maximum will only apply to the In-Network Out-of-Pocket Maximum.

PEDIATRIC DENTAL CARE BENEFITS

Except as changed by this rider, all terms, conditions, limitations and exclusions of the Benefit Booklet 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

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.
العربية 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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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

BlueCross BlueShield of Texas

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.
فارسی Farsi	توجه: اگر فارسی 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.

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

ALLOWABLE AMOUNT NOTICE

IMPORTANT TO YOUR COVERAGE

To pay less out-of-pocket expenses for your health care costs and to receive a higher level of benefits, it is to your advantage to use In-Network Providers. If you use contracting Providers, you will not be responsible for any charges over the Allowable Amount as determined by BCBSTX. What follows is an example of how much you would pay if you use an In-Network Provider and how much you would pay if you use a non-contracting Out-of-Network Provider. To make the example easier to follow, assume the Allowable Amount is the same (Note: In most cases, however, the non-contracting Allowable Amount will be less than the contracting Allowable Amount, meaning your total payment responsibility will be even greater):

EXAMPLE ONLY

	In-Network 90% of eligible charges $250 Deductible	**Out-of-Network** 80% of eligible charges $500 Deductible
Amount Billed	$20,000	$20,000
Allowable Amount	$5,000	$5,000
Deductible Amount	$250	$500
Plan's Coinsurance Amount	$4,275	$3,600
Your Coinsurance Amount	$475	$900
Non-Contracting Provider's additional charge to you	None	$15,000
YOUR TOTAL PAYMENT	$725 **to a Network Provider**	$16,400 **to a Non-Contracting Out-of-Network Provider**

Even when you consult an In-Network Provider, ask questions about the Providers rendering care to you "behind the scenes." If you are scheduled for surgery, for example, ensure that your Network surgeon will be using a Network facility for your procedure and a Network Provider for your anesthesia services.

If you choose to receive services from an Out-of-Network Provider, inquire if the Provider participates in a contractual arrangement with BCBSTX or any other Blue Cross and/or Blue Shield Plan. Providers who do not contract with BCBSTX may bill the patient for expenses over the Allowable Amount. [1]Refer to PARPLAN in the **HOW THE PLAN WORKS** portion of your booklet for more information.

NOTICE

Other Blue Cross and Blue Shield Plans Separate Financial Policies Compliance Disclosure Requirements

Out-of-Area Services

Blue Cross and Blue Shield of Texas, a division of Health Care Service Corporation, herein called BCBSTX has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever you access healthcare services outside of BCBSTX service area, the claims for these services may be processed through one of these Inter-Plan Arrangements, which includes the BlueCard Program, and may include Negotiated Arrangements available between BCBSTX and other Blue Cross and Blue Shield Licensees.

When you receive care outside our 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 ("non-participating healthcare Providers") don't contract with the Host Blue. We explain how we pay both types of Providers below.

A. BlueCard® Program

Under the BlueCard Program, when you receive covered healthcare services within the geographic area served by a Host Blue, we will remain responsible for what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare Providers.

For inpatient facility services received in a Hospital, the Host Blue's Participating Provider is required to obtain Prior Authorization. If Prior Authorization is not obtained, the Participating Provider will be sanctioned based on the Host Blue's contractual agreement with the Provider, and the member will be held harmless for the Provider sanction.

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

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

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims, as noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied after a claim has already been paid.

B. Negotiated (non-BlueCard Program) Arrangements

As an alternative to the BlueCard Program, your claims for covered healthcare services may be processed through a Negotiated Arrangement with a Host Blue.

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

C. Non-Participating Healthcare Providers Outside BCBSTX Service Area

1) In General

When Covered Services are provided outside of the Plan's service area by Non-Participating Providers, the amount(s) you pay for such services will be calculated using the methodology described in the Certificate for Non-Participating Providers located inside our service area. You may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

2) Exceptions

In some exception cases, the Plan may, but is not required to, in its sole and absolute discretion negotiate a payment with such Non-Participating Provider on an exception basis. If a negotiated payment is not available, then the Plan may make a payment based on the lesser of:

A. the amount calculated using the methodology described in the Certificate for Non-Participating Providers located inside your service area (and described in Section C(a)(1) above); or

B. the following:

(i) for Professional Providers, an amount equal to the greater of the minimum amount required in the methodology described in the Certificate for Non-Participating Providers located inside your service area; or an amount based on publicly available Provider reimbursement data for the same or similar professional services, adjusted for geographical differences where applicable, or

(ii) for Hospital or facility Providers, an amount equal to the greater of the minimum amount required in the methodology described in the Certificate for Non-Participating Providers located inside your service area; or an amount based on publicly available data reflecting the approximate costs that Hospitals or facilities have incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the Hospital or facility.

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

D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, the Plan will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

E. Special Cases: Value-Based Programs

BlueCard® Program

If you receive covered healthcare services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to us through average pricing or fee schedule adjustments.

Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If BCBSTX has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Employer on your behalf, we will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

F. Blue Cross Blue Shield Global Core ®

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global Core when accessing covered healthcare services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard 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 BlueCard service area, you will typically have to pay the Providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or Hospital) outside the BlueCard service area, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a Physician appointment or hospitalization, if necessary.

- **Emergency Care Services**

  This Contract covers only limited health care services received outside of the United States. As used in this section, "Out-of-Area Covered Services" include Emergency Care and Urgent Care obtained outside of the United States. Follow-up care following an emergency is also available, provided the services are Prior Authorized by BCBSTX. Any other services will not be eligible for benefits unless authorized by BCBSTX.

- **Inpatient Services**

  In most cases, if you contact the service center for assistance, Hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts/deductibles, coinsurance, etc. In such cases, the Hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for covered healthcare services.

- **Outpatient Services**

  Outpatient Services are available for the treatment of Emergency Care and Urgent Care.

  Physicians, urgent care centers and other outpatient Providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered healthcare services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**

  When you pay for covered healthcare services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the Provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from 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

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

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your 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 the 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, and

(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 Coverage.

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 participant 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 available for a diagnostic, medically recognized screening examination for the detection of colorectal cancer for Participants who are 45 years of age or older and who are at normal risk for developing colon cancer:

(a) 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

(b) 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.

Benefits provided above by an In-Network Provider will not be subject to a Deductible, Copayment Amounts, or Coinsurance Amounts.

Benefits provided above by an Out-of-Network Provider will be subject to any applicable Deductible, Copayment Amounts, or Coinsurance Amounts.

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 1-800-521-2227 or write us at P.O. Box 660044, Dallas, Texas 75266-0044.

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, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start.

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.

YOUR RIGHTS WITH A PREFERRED PROVIDER BENEFIT PLAN (PPO)

Notice from the Texas Department of Insurance

Your plan

Your health plan contracts with doctors, facilities, and other health care providers to treat its members at discounted rates. Providers that contract with your health plan are called "preferred providers" (also known as "in-network providers"). Preferred providers make up a plan's network. You can go to any doctor or facility you choose, but your costs will be lower if you use one in the plan's network.

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.

Health care costs

You can ask health care providers how much they charge for health care services and procedures. You can also ask your health plan how much of the cost they'll pay.

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 or by calling 1-800-521-2227. 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.

Health care bills

If you want to see a doctor or facility that isn't in your plan's network, you can still do so. You'll probably get a bill and have to pay the amount your health plan doesn't pay. If you received 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 received 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 www.tdi.texas.gov.

BlueCross BlueShield of Texas

MEMBER RIGHTS AND RESPONSIBILITIES STATEMENT

Rights	Responsibilities
Membership	**Membership**
You have the right to:	**You have the responsibility to:**
Receive information about the organization, its services, its practitioners and Providers and member's rights and responsibilities.	Provide, to the extent possible, information that your Health Benefit Plan and practitioner/Provider need, in order to provide care.
Make recommendations regarding the organization's member rights and responsibilities policy.	

Rights	Responsibilities
Communication	**Communication**
You have the right to:	**You have the responsibility to:**
Participate with practitioners in making decisions about your health care.	Follow the plans and instruction for care you have agreed to with your practitioner.
Be treated with respect and recognition of your dignity and your right to privacy.	Understand your health problems and participate in the development of mutually agreed upon treatment goals, to the degree possible.
A candid discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.	
Voice complaints or appeals about the organization or the care it provides.	

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