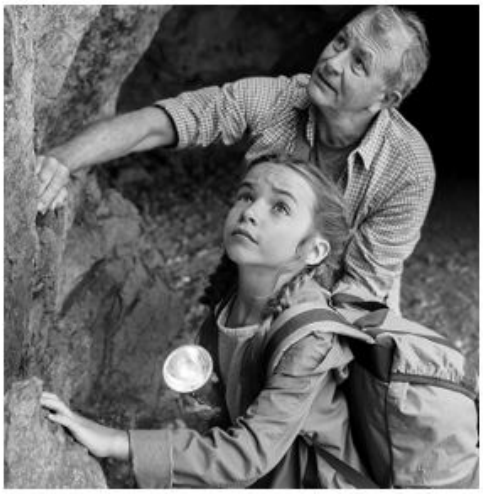
BlueCross BlueShield of Texas






Your Health Care Benefits Program

Managed Health Care
Pharmacy Benefits

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", "we" or "us")

Hereby certifies that it has issued a group preferred provider organization (PPO) benefits and pharmacy benefits contract (herein called the "plan"). Subject to the provisions of the plan, each employee 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 us. 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

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 contact 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 WORKER'S 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: PO 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: 1-800-521-2227
Correo electrónico: BCBSTXComplaints@bcbstx.com
Dirección postal: PO 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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Quick Reference

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

CUSTOMER SERVICE

Medical Benefits	Call	Website
Customer Service Helpline	See telephone number on the back of your identification card	www.bcbstx.com BCBSTX Provider Directory Wellness Other Online Services and Information
Prior authorization for Behavioral Health and for Non-Behavioral Health	See telephone number on the back of your identification card	
INPATIENT ADMISSIONS for Behavioral Health and for Non-Behavioral Health	See telephone number on the back of your identification card	

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

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

BLUECARD® NATIONWIDE/WORLDWIDE COVERAGE PROGRAM

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

MDLIVE®

1-888-684-4233

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

Where to Mail Completed Claim Forms:

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

SUMMARY OF BENEFITS

Blue Choice PPO HSA/013H
Blue Choice PPO℠ Network

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

How cost sharing works:

- The **deductible** amounts and **copayment** amounts listed in the charts below show the amounts you pay for **covered services**.
- **Coinsurance** amounts, if any, listed in the charts below are the percentage of the **allowable amount** you pay. You may have to satisfy **deductible** amount(s), **copayment** amount(s) and/or **coinsurance** amount(s) before you receive services.
- All **copayment** and **coinsurance** costs shown in the charts below are after your **deductible** has been met, if a **deductible** applies.
- Your **benefit period** is a period of one year beginning on January 1 of each year. When you first enroll under this **plan**, your coverage begins on the date shown above and ends on the first of the first day of the month the following year. For example 01-01-2025 to 12-31-2025.

Benefit Period	Calendar year

Deductible	**In-Network Providers**	**Out-of-Network Providers**
Individual	$6,900	$13,800
Family	$13,800	$27,600

Out-of-Pocket Maximum	**In-Network Providers**	**Out-of-Network Providers**
Individual	$6,900	Unlimited
Family	$13,800	Unlimited

All limits are combined for **in-network** and **out-of-network benefits** unless stated otherwise.

Ambulance Services

Description	In-network You pay	Out-of-network You pay
Air ambulance	no charge	
Ground ambulance	no charge	

Behavioral Health Services (Mental Health/Substance Use Disorder)

Description	In-network You pay	Out-of-network You pay
Inpatient facility services	no charge	30% coinsurance
Inpatient physican services	no charge	30% coinsurance
Outpatient facility services	no charge	30% coinsurance
Outpatient physician services	no charge	30% coinsurance
Office visit	no charge	30% coinsurance

Chiropractic Care

Description	In-network You pay	Out-of-network You pay
Office visit	no charge	30% coinsurance
Chiropractic care in the office	no charge	30% coinsurance
Chiropractic care in an outpatient setting	no charge	30% coinsurance
Limits	35 visits each benefit period	
• Visit limit applied to a combination of physical therapy, occupational therapy and chiropractic care.		

Durable Medical Equipment (DME)

Description	In-network You pay	Out-of-network You pay
DME	no charge	30% coinsurance

Emergency & Non-Emergency Services

Description	In-network You pay	Out-of-network You pay
Emergency care facility charges	no charge	
Emergency care physician charges	no charge	
Non-Emergency care facility charges	no charge	30% coinsurance
Non-Emergency care physician charges	no charge	30% coinsurance
• Excluding certain diagnostic procedures		

Hearing Aids

Description	In-network You pay	Out-of-network You pay
Hearing aids	no charge	30% coinsurance
Limits	Limited to one hearing aid per ear each 36-month period	

Home Health Care

Description	In-network You pay	Out-of-network You pay
Home health care	no charge	30% coinsurance
Limits	60 days each benefit period	

Hospice Care

Description	In-network You pay	Out-of-network You pay
Hospice services	no charge	30% coinsurance
Limits	Unlimited	

Infusion Therapy

Description	In-network You pay	Out-of-network You pay
Home infusion therapy	no charge	30% coinsurance

Inpatient Hospital Services

Description	In-network You pay	Out-of-network You pay
Inpatient facility services	no charge	30% coinsurance
Inpatient physician services	no charge	30% coinsurance
Penalty for failure to obtain prior authorization for inpatient services	None	$250

- Certain services will require prior authorization
- All usual hospital services and supplies, including semiprivate room, intensive care, and coronary care units
- Includes treatment of behavioral health services

Maternity Services

Description	In-network You pay	Out-of-network You pay
Maternity care	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Maternity related newborn care	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Prior authorization	Inpatient prior authorization not required for the following length of stays: 48 hours following an uncomplicated vaginal delivery 96 hours following an uncomplicated delivery by caesarean section	Inpatient prior authorization not required for the following length of stays: 48 hours following an uncomplicated vaginal delivery 96 hours following an uncomplicated delivery by caesarean section

Maternity care is globally billed meaning:

- Physician and Specialist Services office visit or consultation benefit located in this SUMMARY OF BENEFITS applies to initial prenatal visit (per pregnancy) to an in-network provider.
- Benefit period deductible and coinsurance apply to subsequent visits and to all out-of-network provider services.

Occupational Therapy Services

Description	In-network You pay	Out-of-network You pay
Office visit	no charge	30% coinsurance
Occupational therapy in the office	no charge	30% coinsurance
Occupational therapy in an outpatient setting	no charge	30% coinsurance
Limits	35 visits each benefit period	

- Benefits for autism spectrum disorder will not apply towards and are not subject to any occupational therapy services visits maximum.
- Visit limit applied to a combination of physical therapy, occupational therapy and chiropractic care.

Outpatient Hospital Services

Description	In-network You pay	Out-of-network You pay
Outpatient facility services	no charge	30% coinsurance
Outpatient physician services	no charge	30% coinsurance
Penalty for failure to obtain prior authorization for outpatient services	None	50% coinsurance not to exceed $500

Pharmacy Services

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

Physical Therapy Services

Description	In-network You pay	Out-of-network You pay
Office visit	no charge	30% coinsurance
Physical therapy in the office	no charge	30% coinsurance
Physical therapy in an outpatient setting	no charge	30% coinsurance
Limits	35 visits each benefit period	

- Benefits for autism spectrum disorder will not apply towards and are not subject to any physical therapy services visits maximum.
- Visit limit applied to a combination of physical therapy, occupational therapy and chiropractic care.

Physician and Specialist Services

Description	In-network You pay	Out-of-network You pay
Primary care office visit or consultation	no charge	30% coinsurance
Retail health clinic visit	no charge	30% coinsurance
Specialty (Specialist) office visit or consultation	no charge	30% coinsurance

Telehealth, Teledentistry & Telemedicine Services Primary care consultation	no charge	30% coinsurance
Telehealth, Teledentistry & Telemedicine Services Primary care consultation for treatment of Behavioral Health	no charge	30% coinsurance
Telehealth, Teledentistry & Telemedicine Services Specialty consultation	no charge	30% coinsurance
Virtual Visits	no charge	Not covered
Diagnostic Services performed in a physician's office	no charge	30% coinsurance
Lab & X-ray services Performed in a physician's office	no charge	30% coinsurance
Surgical procedures performed in a physician's office	no charge	30% coinsurance
All other covered services not otherwise noted	no charge	30% coinsurance
• Includes treatment of behavioral health services		

Preventive Care Services

Description	In-network You pay	Out-of-network You pay
Preventive care services	No charge	30%coinsurance

Skilled Nursing Facility

Description	In-network You pay	Out-of-network You pay
Skilled nursing facility	no charge	30% coinsurance
Limits	25 days each benefit period	

Speech Therapy

Description	In-network You pay	Out-of-network You pay
Speech therapy in the office	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Speech therapy in an outpatient setting	Covered based on type of service and where it is received	Covered based on type of service and where it is received
• Benefits for autism spectrum disorder will not apply towards and are not subject to any speech therapy services visits maximum.		

Surgery

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

Transplant Services (Organ and Tissue Transplants)

Description	In-network You pay	Out-of-network You pay
Organ and Tissue Transplant	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Urgent Care

Description	In-network You pay	Out-of-network You pay
Urgent care center visit	no charge	30% coinsurance

Prior Authorization Penalty

Description	In-network You pay	Out-of-network You pay
Inpatient Admissions	None	$250
Outpatient Services	None	50% coinsurance not to exceed $500

SUMMARY OF BENEFITS
for
PHARMACY BENEFITS

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

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

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

Retail Pharmacy Cost Share

Retail Pharmacy Program	Preferred Participating Pharmacy You Pay	Participating Pharmacy You pay	Non-Participating Retail Pharmacy You Pay
Tier 1	No charge	No charge	No charge plus 50% coinsurance
Tier 2	No charge	No charge	No charge plus 50% coinsurance
Tier 3	No charge	No charge	No charge plus 50% coinsurance
Tier 4	No charge	No charge	No charge plus 50% coinsurance

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

Extended Prescription Drug Supply Program

Extended Prescription Drug Supply Program	Quantity Dispensed	Participating Extended Supply Pharmacy You pay	Non-Participating Extended Supply Pharmacy You pay
Tier 1	1 to 90 days	No charge	Not covered
Tier 2	1 to 90 days	No charge	Not covered
Tier 3	1 to 90 days	No charge	Not covered
Tier 4	1 to 90 days	No charge	Not covered

- In addition to any copayments and/or coinsurance amounts, you are also responsible for any charges which exceed the allowable amounts

- If you receive a brand name drug when a generic drug is available, you may incur additional costs. Refer to the **PHARMACY BENEFITS** section of your benefit booklet for details.
- Up to 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

Mail-Order Pharmacy Program

Mail-Order Pharmacy Program	Quantity Dispensed	Participating Mail-Order Pharmacy You pay	Any Pharmacy other than the Participating Mail-Order Pharmacy You pay
Tier 1	1 to 90 days	No charge	Not covered
Tier 2	1 to 90 days	No charge	Not covered
Tier 3	1 to 90 days	No charge	Not covered
Tier 4	1 to 90 days	No charge	Not covered

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

Specialty Pharmacy Program

Specialty Pharmacy Program (30-Day Supply)	Specialty Network Pharmacy You pay	Any Pharmacy other than a Specialty Network Pharmacy You pay
Tier 5	No charge	No charge plus 50% coinsurance
Tier 6	No charge	No charge plus 50% coinsurance

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

Vaccines

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

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

Diabetes supplies are available under the **Pharmacy Benefits** portion of this plan.

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

Certain covered drugs may be available at no cost through a **participating pharmacy** for the following categories of medication: severe allergic reactions, hypoglycemia, opioid overdoses and nitrates. For further information, call the number on the back of your identification card.

INTRODUCTION

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

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

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

In-Network Benefits

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

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

Out-of-Network Benefits

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

If you are not able to receive reasonable care from an **in-network provider** as defined by applicable law, and we authorize your visit to an **out-of-network provider** to be covered as **in-network** level prior to your visit, benefits will be paid as **in-network**. If not, the benefits will be paid as **out-of-network**.

Your Insurance Identification Card

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

About Your SUMMARY OF BENEFITS

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

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

Your **SUMMARY OF BENEFITS** will also show any total maximum out-of-pocket limit(s) that may apply. You are responsible for paying your part of the cost sharing. You are also responsible for costs not covered by us.

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

What Medical Necessity/Medically Necessary Means

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

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

- The service is **medically necessary** and/or meets **medical necessity** requirements
- For **in-network benefits**, you get the service from an **in-network provider**
- Your **provider** or you get **prior authorization** on services when required

WHO GETS BENEFITS

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

Eligibility Requirements

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

Employee Eligibility

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

- Meet the definition of an **eligible person** as specified by your **employer**
- Have applied for this coverage
- Have received a Blue Cross and Blue Shield of Texas insurance **identification card**
- You must reside or work in the geographic area "network service area" designated by the **plan**

Dependent Eligibility

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

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

Applying For Coverage

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

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

Note: Some **employers** may only offer coverage to their **employees** and not to their **employee's dependents.**

Open Enrollment Period

Your group will designate an **open enrollment period** during which you may apply for or change coverage for you and your eligible **dependents**.

Special Enrollment Period

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

- You or your **dependen**t lose other health insurance coverage or COBRA continuation coverage.
- You lose a **dependent**
- You gain a **dependent** through marriage, establishment of a **domestic partnership** or court ordered coverage
- You gain a **dependent** through birth, adoption or placement for adoption, legal guardianship or placement of a foster **child**
- You or your **dependent** lose eligibility for coverage under a Medicaid plan or a state **child** health plan under Title XXI of the Social Security Act
- You or your **dependent** become eligible for assistance under a Medicaid plan or a state **child** health plan.

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 notification date. If **benefits** are paid to you prior to notification to us, refunds will be requested.

Please refer to the **Continuation Privilege** subsection in this benefit booklet for additional information.

Other Special Enrollment Periods

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

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

Employee Application / Change Form

You can obtain an **employee** application / change form from your **employer**, by calling the number on your **identification card** or by accessing your self-service member portal, Blue Access for Members℠ (BAM) for the qualifying events listed above in addition to:

- Updating you and your **dependents'** name
- Updating you and your **dependents'** address
- Cancel all or a portion of your coverage

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

Late Enrollment

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

When Coverage Begins

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

Dependent Special Enrollment Coverage

Coverage begins from the date of event if you apply for this change within 31 days of any of the following qualifying events:

- You gain a **dependent** through marriage, establishment of a **domestic partnership** or court ordered coverage.

However, if a court has ordered you to provide coverage, coverage begins on the first day of the month following the date the application for coverage is received.

Coverage is automatic for the first 31 days for the following qualifying events. For coverage to continue beyond this time, you must apply for this change within the 31 day period:

- You gain a **dependent** through birth, adoption or placement for adoption, legal guardianship or placement of a foster **child**

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 Late Enrollment provision.

In no event will your **dependent's** coverage become effective prior to your **effective date**.

Medicaid or Child Health Plan Special Enrollment Coverage

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

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

Loss of Other Health Insurance Special Enrollment Coverage

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

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

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

- You and your **dependent** were covered under other health insurance coverage or COBRA continuation coverage when you were first eligible to enroll for this coverage

- You and your **dependent** lost the other health insurance coverage due to:
  - Legal separation
  - Divorce or the end of a domestic partnership
  - Death of a spouse or domestic partner
  - Termination of employment or reduction of hours
  - COBRA continuation coverage is terminated as explained in the **Continuation Privilege** section of this benefit booklet
- You and your **dependent** did not lose coverage due to failure to pay premiums or fraud
- If it was required, you stated in writing that you and your **dependent** were covered by other health insurance or COBRA continuation coverage as reason for declining enrollment in this coverage.

If all conditions described above are not met, you will be considered a late enrollee.

Health Insurance Premium Payment (HIPP) Reimbursement Program

You will be eligible to enroll if you:

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

The **effective date** of coverage is on the first day of the month after we receive the following:

- Written notice from the Texas Health and Human Services Commission
- Enrollment forms and applicable premium payments within 60 days after the date the individual becomes eligible to participate

In addition to the **GLOSSARY** section of this benefit booklet, the following definitions apply to enrollment due to participation in HIPP program:

Late Enrollee means any employee or **dependent** eligible for enrollment who requests enrollment in an **employer's health benefit plan**:

- After the expiration of the initial enrollment period established under the terms of the first plan for which that **participant** was eligible through the **employer**
- At the expiration of an **open enrollment period**
- After the expiration of a special enrollment period

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

HOW THE PLAN WORKS

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

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

Allowable Amount

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

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

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

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

Deductible(s)

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

How individual deductibles work:

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

How family deductibles work:

- If a single-family member reaches the individual **deductible** shown under your **SUMMARY OF BENEFITS,** they will be eligible for **benefits** and do not have to wait for other family members to meet their **deductible**. This is known as an embedded family **deductible.**
- A family member may not apply more than the individual **deductible** amount toward the family **deductible** amount.

Should the federal government adjust the **deductible** amount(s) applicable to this type of coverage, the **deductible** amount(s) will be adjusted accordingly.

Until the **benefit period deductible** is satisfied, **benefits** will be available only for those services or supplies subject to a **copayment**, such as **physician** office visits, and emergency room facility charges, and **covered drugs** under **pharmacy benefits**.

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

If "three-month deductible carryover applies", this means that any expenses incurred during the last three months of a **benefit period** can be applied towards the **benefit period deductible** for that **benefit period** and may be applied toward satisfaction of that **deductible** for the following **benefit period**.

Out-of-Pocket Maximum

The **out-of-pocket maximum** is the total amount of **deductibles**, **copayments** and/or **coinsurance** which must be satisfied during your **benefit period** for all **covered services** received from **in-network providers** before we (your **plan**) will begin to cover all charges up to the allowable amount at 100% for the remainder of the **benefit period**.

How Individual Out-of-Pocket Maximums Work

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

How Family Out-of-Pocket Maximums Work

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

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

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

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

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

ParPlan

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

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

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

- Any **deductibles**

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

Specialty Care Providers

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

- If the services you need are not available from **in-network providers**, **in-network benefits** will be provided when you use **out-of-network providers**.
- If you choose to see an **out-of-network provider** when the services could have been provided by an **in-network provider**, only **out-of-network benefits** will be available.

Use of Non-Contracting Providers

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

Note: Non-contracted **providers** are not required to accept our non-contracting **allowable amount** as payment in full. They may balance bill you for the difference between our non-contracting **allowable amount** and the non-contracting **provider's** billed charges. You will be responsible for this balance bill amount, which may be very large.

However, if you:

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

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

You will also be responsible for charges for services, supplies and procedures limited or not covered under this plan and any applicable cost share.

Federal Balance Billing and Other Protections

This section is based upon the No Surprises Act, a federal law enacted 2020. 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.

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 **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 we have negotiated with **participating providers** for similar services in the area:

- Emergency care from facilities or **providers** who do not participate in your network
- Care furnished by **out-of-network providers** during your visit to an **in-network** facility
- Air ambulance services from **out-of-network providers** if the services would be covered by an **in-network providers**

Out-of-network or non-**participating providers** may not bill you for more than your **deductible**, **coinsurance amount** or **copayments** for the service types referenced above. There are limited instances when an **out-of-network** or **non-participating provider** may send you a bill (for the care services referenced above) 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 us at the number on 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.

Continuity of Care

In the event you are under the care of an **in-network provider** and the **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), we will continue providing coverage for you at the **in-network benefit** level if you have one of the following special circumstances:

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

The continuity of coverage under this subsection shall continue until the treatment is complete but shall not extend for more than ninety (90) days, or more than nine (9) months if you have been diagnosed with a terminal illness, beyond the date the **provider's** termination from the **network** takes effect. If you are pregnant and you are in your second or third trimester 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.

Coverage Determinations

Please note that we must determine services are **medically necessar**y in order to be covered under this **plan**.

Coverage of items and services provided to you is subject to our policies and guidelines, including, but not limited to:

- Medical
- Medical management
- Utilization or clinical review
- Utilization management
- Clinical payment and coding policies

The items and services will be updated throughout the plan year.

These policies are resources we use when making coverage determinations and lay out the procedure and/or criteria to determine if the following is **medically necessary**, eligible as a **covered service**, or is **experimental/investigational**, cosmetic, or a convenience item:

- Procedure
- Treatment
- Facility
- Equipment
- Drug
- Device

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

- Uniform Billing (UB) Editor
- American Medical Association (AMA)
- Current Procedural Terminology (CPT®)
- CPT® Assistant
- Healthcare Common Procedure Coding System (HCPCS)
- ICD-10 CM and PCS
- National Drug Codes (NDC)
- Diagnosis Related Group (DRG) guidelines
- Centers for Medicare and Medicaid Services (CMS)
- National Correct Coding Initiative (NCCI) Policy Manual
- CCI table edits
- 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
- Utilization management policies
- Clinical payment and coding policies
- Coding software logic, including but not limited to lab management or other coding logic or edits

Any line of 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** rendered 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 to Blue Access for Members℠ (BAM) or by contacting customer service.

COVERED SERVICES

This section describes **covered services** for which your **plan** pays **benefits** for you and your eligible **dependents. Covered services** must also meet the criteria for **medically necessary**. Some services may require **prior authorization.** It is your responsibility to ensure that **prior authorization** is obtained, or those services may carry a cost share penalty or a denial of payment. Refer to the **UTILIZATION MANAGEMENT** section or contact Customer Service by calling the number on the back of your **identification card** or visiting the Blue Access for Members℠ (BAM) website for additional information including which services may require **prior authorization**.

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

Covered services appear alphabetically.

Acquired Brain Injury

Covered services include:

- Cognitive rehabilitation therapy
- Cognitive communication therapy
- Neurocognitive therapy and rehabilitation
- Neurobehavioral testing
- Neurobehavioral treatment
- Neuropsychological testing
- Neuropsychological treatment
- Neurophysiological testing
- Neurophysiological treatment
- Psychophysiological testing
- Psychophysiological treatment
- Neurofeedback therapy
- Remediation
- Post-acute transition services and community reintegration services (if necessary as a result of and related to an acquired brain injury), including:
    - Outpatient day treatment services, or
    - Any other post-acute care treatment services

Treatment may be provided at:

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

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

- Has incurred an **acquired brain injury**
- Has been unresponsive to treatment
- Becomes responsive to treatment at a later date

Treatment goals for services may include:

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

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

- Hereditary
- Congenital, or
- Degenerative

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

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

Ambulances Services

Covered services include:

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

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

Air ambulance emergency transportation is covered when:

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

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

The following are **not covered services**:

- Non-emergency ground or air ambulance transportation services provided primarily for the convenience of you, your family/caregivers, **physician**, or the transferring facility.

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

Autism Spectrum Disorder

Covered services include:

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

Screenings at 18 and 24 months

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

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

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

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

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

The following are **not covered services**:

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

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

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

Behavioral Health

Mental Health Treatment

Covered services include:

- The treatment of mental health conditions provided by:
  - A **hospital**

    - **Crisis stabilization unit or facility**
    - Psychiatric **hospital**
    - **Residential treatment center**
    - **Residential treatment center** for children and adolescents
- Office visits with a **physician**, **behavioral health provider**, psychiatrist, psychologist, social worker, or licensed professional counselor
- Individual, group, family or conjoint psychotherapy
- **Partial hospitalization treatment**
- **Intensive outpatient program**
- Electro-convulsive therapy (ECT)
- Transcranial magnetic stimulation (TMS)
- Psychological testing

The following are **not covered services**:

- Behavioral health services provided at behavioral modification facilities, boot camps, emotional group academies, military schools, therapeutic boarding schools, wilderness programs, halfway houses or group homes.

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 treatment services to persons who are displaying a moderate to severe acute demonstrable psychiatric crisis.

Mental Health and Substance Use Disorder Services

Covered services include:

- Treatment of a mental health and/or substance use disorders
- Inpatient **benefits** will also be provided for the diagnosis and/or treatment of mental health and/or substance use disorder in a **residential treatment center**.

Behavioral Health Note: We will not impose quantitative or nonquantitative treatment limitations for the treatment of mental health or substance use disorders that are generally more restrictive than quantitative or nonquantitative treatment limitations imposed on coverage of benefits for medical or surgical expenses.

Biomarker Testing

Covered services includes **biomarker testing** for the purpose of any of the following:

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

Biomarker testing will only be covered when its use provides clinical utility because use of the test for the condition is:

- Evidence based
- Scientifically valid based on medical and scientific evidence
- Informs the members outcome and provider's clinical decision
- Predominantly addresses the acute or chronic issue for which the test is ordered

Coverage of **biomarker testing** will be provided in a manner that limits disruption in care, including limiting the number of biopsies and biospecimen samples.

Biomarker means a characteristic this 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 texts and whole genome sequencing.

Cardiovascular Disease Early Detection Tests

Covered services include:

- One of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five years when performed by a laboratory that is certified by a recognized national organization:
  - Computed tomography (CT) scanning measuring coronary artery calcifications
  - Ultrasonography measuring carotid intima-media thickness and plaque

Tests are available to you, if you are:

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

You must have either:

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

Clinical Trials

Covered services include:

- **Routine patient costs** and related services you have from a provider in connection with participation in an **approved clinical trial**.

Related services are:

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

The following are **not covered services**:

- The investigational item, device, or service itself
- Items or services that are provided solely for data collection or analysis
- A service that is inconsistent with established standards of care for a give diagnosis

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

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

Clinician-Administered Drugs

Covered services for you, if you have a chronic, complex, rare, or life-threatening medical condition include:

- Covered drugs that will be administered by a **provider** in a physician's office. Your provider may obtain the covered drugs from a **non-participating pharmacy**, if they determine that:
    - disease progression
    - patient harm, or
    - death is probable, or
    - where your **provider** has concerns about your adherence or timely delivery

These services are covered under the medical benefit and the cost-sharing requirements will be the same as if they were obtained from a **participating pharmacy**.

Contraceptive/Birth Control Services

Covered services include contraceptive services such as:

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

Covered services may also include female sterilization procedures for women with reproductive capacity and contraceptive service **benefits**.

The following are not **covered services**:

- Any outpatient contraceptive services, contraceptive drugs, and devices
- Any outpatient contraceptive services, contraceptive drugs, and devices, unless the prescription contraceptive coverage is necessary to preserve the life or health of the member. In the event outpatient contraceptive services are covered under the **plan**, contraceptive prescription drugs may be covered under your **PHARMACY BENEFITS**.
- Any non-prescription contraceptive drugs or devices for male use.

Cosmetic, Reconstructive, or Plastic Surgery

Covered services may include only those that are **medically necessary** for any of the following circumstances:

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

The following are **not covered services**:

- Any services, surgery, procedures or supplies solely for cosmetic enhancement reasons
- Breast implant solely for cosmetic reasons, breast implant removal of breast implants that were solely for cosmetic reasons

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

Dental Services and Anesthesia in a Hospital or Surgery Center

Covered services include:

- Anesthesia and facility costs for dental care
- Oral surgery
- Services for treatment or correction of a congenital defect
- The correction of damage caused by accidental injury

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

The following are **not covered services**:

- Routine dental care
- Standard dental treatments
- Dental appliances

Diabetic Equipment, Supplies and Self-Management

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

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

- Insulin pumps (both external and implantable) and insulin pump supplies including:
  - Adhesive supplies
  - Batteries
  - Durable and disposable devices to assist in the injection of insulin
  - Infusion sets
  - Insulin cartridges
  - Insulin infusion devices
  - Other disposable supplies
  - Skin preparation items
- Podiatric appliances, including up to two pairs of therapeutic shoes per benefit period to prevent complications of diabetes
- Supplies:
- Biohazard disposable containers
- Glucagon emergency kit
- Injection aids
- Insulin and insulin analogs
- Insulin syringes
- Lancets and lancet devices
- Prescribed oral medications for controlling blood sugar levels
- Tablets which test for glucose, ketones and protein
- Test strips for glucose monitors
- Visual reading strips and urine test strips

Covered services also include:

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

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

- Biohazard disposable containers
- Glucagon emergency kit
- Injection aids
- Insulin syringes
- Lancets and lancet devices
- Tablets which test for glucose, ketones and protein
- Test strips for glucose monitors
- Visual reading strips and urine test strips

Diagnostic Services

Covered services include:

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

The following are covered diagnostic and diagnostic imaging service examples:

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

Diagnostic imaging is covered to the same extent as **Mammography Screening** under **PREVENTIVE CARE**, without age restrictions, after you have met your deductible.

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

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

Durable Medical Equipment

Covered services include:

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

The following are covered equipment examples:

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

The following are examples of non-covered equipment:

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

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

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

Emergency Services

Covered services include:

- **Emergency medical care** when you receive covered services that meet the definition of **emergency medical care** (see **GLOSSARY**), and services are received from an **in-network provider** or an **out-of-network provider** in a **hospital** emergency department, freestanding emergency room, or other comparable facility.

All treatment received during the first 48 hours following the start of a medical emergency will be eligible for **in-network benefits**. After 48 hours, **in-network benefits** will be available only if you use **in-network providers**. If after the first 48 hours of treatment following the start of a medical emergency, and if you can safely be transferred to the care of an **in-network provider** but are treated by an **out-of-network provider**, only **out-of-network benefits** will be available. If you continue to be treated by an **out-of-network provider** after you receive **emergency medical care** and you can safely be transferred to the care of an **in-network provider**, only **out-of-network benefits** will be available.

For **out-of-network emergency medical care** services provided by non-contracting **providers**, the **allowable amount** shall be our usual and customary rate or at a rate agreed to between us and the non-contracting **provider**, not to exceed billed charges. Our 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 noncontracting **allowable amount** as defined in this plan.

Non-emergency services

Services provided in an emergency room, freestanding emergency room, or other comparable facility that are not **emergency medical care** may be excluded from emergency services coverage. Non-emergency services may be covered under another benefit if applicable.

Fertility Preservation Services

Covered services include standard procedures to preserve fertility consistent with:

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

These benefits are available if you will receive treatment for cancer that the American Society of Clinical Oncology or the American Society for Reproductive have established may directly or indirectly cause impaired fertility, including:

- Surgery
- Chemotherapy
- Radiation

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.

Foot (Podiatric)

Covered services include:

- Examinations and treatment for conditions that affect your feet and lower legs by a **physician** or podiatrist.

The following are **not covered services**:

- Supplies in connection with foot care for flat feet, fallen arches, or chronic foot strain
- Orthopedic shoes, custom made shoes, built up shoes or cast shoes
- Arch supports or shoe inserts to support the arch
- In the absence of diabetes: the removal of warts, corns, calluses or cutting of toenails

Note: These exclusions do not apply to podiatric appliances when provided as diabetic equipment

Hearing Aid

Covered services include:

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

The following are **not covered services**:

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

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

Hearing Exams

Covered services include:

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

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

Hearing Impairment Screening Test for Newborns

Covered services include:

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

Hearing Implants

Covered services include:

- One cochlear implant, including an external speech processor and controller, per impaired ear

- Habilitation and rehabilitation services
- Fitting and dispensing services
- The provision of ear molds as necessary to maintain optimal fit
- Treatment related to the maintenance of your cochlear implants

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

Home Health Care

Covered services include:

- **Home health care** visits with a **hospital** program for home health care or an independent licensed home health care agency.

Visits may include:

- Professional services of an RN, LPN or LVN
- Medical social service consultations
- Health aide services while you are receiving covered nursing or therapy services
- Services of a licensed registered dietitian or licensed certified nutritionist, when authorized by your supervising physician and when medically necessary (includes diabetes self-management training)
- Medical and surgical supplies
- Prescribed drugs
- Oxygen and its administration
- Physical, occupational, speech, and respiratory therapy services by licensed therapists

The following are **not covered services**:

- Durable medical equipment
- Food or home delivered meals
- Maintenance therapy
- Home infusion therapy
- Homemaker services
- Services provided primarily for **custodial care**
- Transportation services

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

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

Hospice Care

Covered services include:

- Inpatient, outpatient or hospice facility agency services
- In-home services which are part of a plan of care
- Physical, speech, and respiratory therapy services by licensed therapists

- Homemaker and counseling services routinely provided by the hospice agency, including bereavement counseling

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

The following are **not covered services**:
- Home delivered meals
- Transportation services
- **Custodial care**

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

Infusion Therapy

Covered services include:
- Infusion and injectable therapy

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

Inpatient Hospital Admission

Covered services include:
- Inpatient care received in a **hospital** setting; this includes:
  - Bed, board and general nursing care when you are in a semi-private room, an intensive care unit or a private room
- Ancillary services such as:
  - Anesthesia supplies and services rendered by an employee of the **hospital** or **other professional provider**
  - Lab work
  - Medical and surgical dressings, supplies, casts and splints
  - Operating, delivery and treatment rooms
  - Subdermal implanted devices or appliances necessary for the improvement of physiological function
  - Therapy service
  - Whole blood, blood processing and administration

*If you are in a private room, **benefits** will be limited by the **hospital's** rate for its most common type of room with two or more beds.

Inpatient Hospital Preadmission Testing

Covered services include:

- Preoperative tests as an outpatient, if the tests would have been covered had you received them as an inpatient in a **hospital**

The following are not covered services:

- Preoperative tests if you cancel or postpone the surgery

Jaw Joint Disorder Treatment

Covered services include:

- The diagnosis, services, supplies and surgical treatment of jaw joint disorder by a provider for:
  - Temporomandibular joint dysfunction (TMJ) (including the jaw and the craniomandibular joint)
  - Myofascial pain dysfunction (MPD)
  - Related jaw disorders

The following are **not covered services** for the treatment of TMJ and all adjacent muscles:

- Non-surgical therapies such as dental restorations, orthodontics, or physical therapy)
- Non-diagnostic services or supplies such as oral appliances, oral splints, oral orthotics, devices or prosthetics

Maternity Care

Covered services include:

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

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

Charges for well-baby nursery care, including the initial examination and administration of a newborn screening test (which includes the test kit required by the state of Texas) during the mother's **hospital admission** for the delivery will be considered inpatient **hospital** services and will be subject to the benefit provisions and benefit maximums.

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

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

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

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

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

Complications of pregnancy do not include:

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

The following are **not covered services**:

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

Nutritional Support

Covered services include:

- Dietary formulas needed for the treatment of phenylketonuria or other heritable diseases
- Amino acid-based formulas, regardless of the formula delivery method, used for 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 shown by the results of biopsy
  - Disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract

A prescription from your physician is required

Orally Administered Anticancer Drug

Covered services include:

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

Organ and Tissue Transplant

Covered services include:

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

The following criteria apply:

- **Prior authorization** for the transplant procedure has been obtained as required under your plan
- You meet the criteria established by us in pertinent written medical policies
- You meet the protocols established by the **hospital** in which the transplant is performed.

The following are **not covered services**:

- Living and/or travel expenses of the recipient or a live donor
- Expenses related to maintenance of life of a donor for purposes of organ or tissue donation
- Purchase of the organ or tissue
- Organs or tissue (xenograft) obtained from another species
- A transplant operation or post-transplant care performed in China or another country known to have participated in forced organ harvesting
- A human organ to be transplanted was procured by a sale or donation originating in China or another country known to pave participated in forced organ harvesting

Orthotic and Prosthetic

Covered services include:

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

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

The following are **not covered services**:

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

Osteoporosis

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

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

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

- You are a postmenopausal woman not receiving estrogen replacement therapy
- You have:
  - Vertebral abnormalities
  - Primary hyperthyroidism
  - A history of bone fractures

- You are:
  - Receiving long-term glucocorticoid therapy
  - Being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy

Outpatient Services

Covered services include:

- Services performed at a medical facility without an overnight stay and are not referenced elsewhere in the **COVERED SERVICES** section of this benefit booklet. Examples of outpatient services:
  - Chemotherapy
  - Dialysis treatment
  - Electroconvulsive therapy
  - Radiation therapy treatments
  - Respiratory therapy
  - Surgery
  - Urgent care

Ovarian Cancer Early Detection Test

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

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

Prostate Cancer Detection Tests

Covered services include:

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

Skilled Nursing Facility Services

Covered services include skilled nursing facility services.

Skilled nursing facility care includes:

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

The following are **not covered services**:

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

Speech-Language

Covered services include:

- Those of a **physician** or licensed speech therapist to diagnose, treat, prevent or restore speech, language, voice and swallowing disorders.

Telehealth, Telemedicine, Teledentistry

Covered services include:

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

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

Telehealth service means a health service, other than a **telemedicine medical service** or a **teledentistry dental service**, delivered by a health professional licensed, certified, or otherwise entitled to practice in Texas and acting within the scope of the health professional's license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.

Telemedicine medical service means a health care service delivered by a **physician** or **behavioral health provider** licensed in Texas, or a health professional acting under the delegation and supervision of a **physician** or **behavioral health provider** licensed in Texas, and acting within the scope of the **physician's** or health professional's license to a patient at a different physical location that the **physician** or health professional using telecommunications or information technology.

Therapies for Children with Developmental Delays

Covered services include:

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

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

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

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

- Cognitive development

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

Individualized family service plan means an initial and ongoing treatment plan developed by the Texas Interagency Council on Early Childhood Intervention.

Urgent Care

Covered services include:

- Services and supplies to treat an urgent condition at an urgent care center

Virtual Visits

Covered services include:

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

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

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

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

Vision Exam

Covered services include:

- One annual routine adult vision exam

The following are **not covered services**:

- Treatment of myopia and other errors of refraction, including refractive surgery
- Orthoptics or visual training
- Scanning of the cornea with computerized ophthalmic diagnostic imaging (topography)
- Examinations for the prescription or fitting of contact lenses
- Frames, spectacle lenses and/or contact lenses

PREVENTIVE CARE

In addition to the **covered services** in this benefit booklet, all preventive **covered services** will be considered **medically necessary covered services** and will not be subject to any **deductible**, **coinsurance**, **copayment** and/or **benefit** maximum when such services are received from an **in-network provider** or **participating pharmacy.** Preventive care services from **out-of-network providers** may be subject to **deductible**, **copayment** and/or **coinsurance**, except for certain state or federally mandated **benefits** (example: childhood immunizations).

Preventive **covered services** are intended to help keep you healthy, supporting you in achieving your best health through early detection.

The following agencies set the preventive care guidelines:

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

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

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

- Routine annual physicals
- Immunizations
- Well-child care
- Cancer screening mammograms
- Bone density test
- Screening for colorectal cancer
- Smoking cessation counseling services
- Healthy diet counseling
- Obesity screening/counseling

Examples of covered immunizations included are:

- Diphtheria

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

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

- One screening by low-dose mammography (including digital mammography and breast tomosynthesis) for occult breast cancer every 12 months for a **participant** 35 years of age and older
- A diagnostic, medically recognized screening exam for the detection of colorectal cancer for **participants** who are 45 years of age or older and who are at normal risk for developing colon cancer, and a follow-up colonoscopy if the findings are abnormal

To see a complete listing of the preventive health services available to you at no cost through an **in-network provider** visit www.healthcare.gov/coverage/preventive-care-benefits/ or call the number on the back of your insurance **identification card.**

For frequencies and any limits that may apply, contact your **physician** or visit www.bcbstx.com/provider/clinical/clinical-resources/preventive-care.

MEDICAL LIMITATIONS AND EXCLUSIONS

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

- Any services or supplies that are not **medically necessary**.
- Any services or supplies determined to be **experimental/investigational** or unproven.
- Any services or supplies provided by a person who is related by blood or marriage.
- Any services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment whether or not **benefits** are, or could upon proper claim be, provided under the Workers' Compensation law.
- Any services or supplies provided for long term or **custodial care**.
- Any services or supplies provided for injuries sustained either:
  - As a result of war, declared or undeclared, or any act of war
  - While on active or reserve duty in the armed forces of any country or international authority.
- Any services or supplies that do not meet accepted standards of medical and/or dental care
- Any service or supplies by more than one provider on the same day(s) for the same covered service.
- Any charges:
  - Resulting from the failure to keep a scheduled visit with a **physician** or **other provider**
  - For completion of any insurance forms
  - For acquisition of medical records
  - Resulting from failure to pay your cost share(s)
  - Incurred while not covered under this **plan**
- Services and supplies for the following except as listed as covered in the **COVERED SERVICES** section of your benefit booklet:
  - Dietary and nutritional services
  - Long term or custodial care
  - Private duty nursing services
  - Any services related to a non-covered service
- Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.
- Any services or supplies provided for, in preparation for, or in conjunction with any of the following:
  - Sterilization reversal (male or female)
  - Sexual dysfunctions
  - In vitro fertilization
  - Assisted reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct intra-peritoneal insemination, trans-uterine tubal insemination, gamete intra-fallopian transfer, pronuclear oocyte stage transfer, zygote intra-fallopian transfer, and tubal embryo transfer.
- Abortions are limited to pregnancies that, as certified by a physician, places the woman in danger of death.
- Treatment of decreased blood flow to the legs with pneumatic compression device high pressure rapid inflation deflation cycle.
- Treatment of tissue damage or disease in any location with platelet-rich plasma.

- Services or supplies for smoking cessation programs and the treatment of nicotine addiction. With the exception of prescription and over-the-counter drugs for tobacco cessation, which may be covered under the **PHARMACY BENEFITS** portion of your plan, and tobacco cessation counseling covered in this benefit booklet, supplies for smoking cessation programs and the treatment of nicotine addiction are excluded.
- Any services or supplies provided for the following treatment modalities:
  - Acupuncture (dry needling, or trigger-point acupuncture)
  - Massage therapy
  - Intersegmental traction
  - All types of home traction devices and equipment
  - Vertebral axial decompression sessions
  - Surface Electromyography EMGs
  - Spinal manipulation under anesthesia
  - Muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron;
  - Balance testing through computerized dynamic posturography sensory organization test.
- Testing of:
  - Blood for measurement of levels of: Lipoprotein a; small dense low density lipoprotein; lipoprotein subclass high resolution; lipoprotein subclass particle numbers; lipoprotein associated phospholipase A2, which are fat/protein substances in the blood that might be ordered in people with suspected deposits in the walls of blood vessels
  - Urine for measurement of collagen cross links, which is a substance that might be ordered in people with suspected high bone turnover
  - Cervicovaginal fluid for amniotic fluid protein during pregnancy, which might be ordered in people suspected to have fluid leaking from around the baby (premature ruptured membranes)
- Any services, supplies or drugs provided to a **participant** incurred outside the United States, except for emergency care.
- Outpatient prescription drugs or medicines, except for contraceptive drugs, devices or other products, and immunosuppressive drugs prescribed in connection with a human organ transplant or as otherwise listed in your benefit booklet.
- Any services or supplies provided for reduction of obesity or weight, including surgical procedures, even if the participant has other health conditions which might be helped by a reduction of obesity or weight, except for healthy diet counseling and obesity screening/counseling as may be provided under the **PREVENTIVE SERVICES** section of your benefit booklet.
- Any of the following applied behavior analysis (ABA) services:
  - Services with a primary diagnosis that is **not autism spectrum disorder**
  - Services by a provider that is not properly credentialed
  - Activities primarily of an educational nature
  - Respite, shadow, or companion services
- Any of the following Vitamin B12 testing:
  - testing or screening for a vitamin B12 deficiency in healthy, asymptomatic individuals
  - testing to screen or confirm a vitamin B12 deficiency
  - vitamin B12 testing within three (3) months of beginning treatment for a B12 deficiency
- Vitamin D testing – routine screening for vitamin D deficiency with serum testing in asymptomatic individuals and/or during general encounters

- Hemoglobin A1c testing in any of the following situations:
  - If you have had a blood transfusion within the past 120 days
  - If you have a condition associated with increased red blood cell turnover
  - If you are also being measured for fructosamine
- Influenza testing
  - Viral culture testing for influenza in an outpatient setting
  - Outpatient influenza testing in asymptomatic patients
  - Serology testing for influenza under any circumstance
- Any of the following cardiac biomarker measurements:
  - For the diagnosis of a heart attack if you have symptoms of acute coronary syndrome such as chest pains
  - If you have symptoms of acute coronary syndrome and received services in a setting that cannot perform an evaluation for a heart attack
- 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 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
  - Both qualitative (type of drug) testing and presumptive (to verify presence of drugs) testing on the same specimen. Folate testing - Measurement of RBC folate. 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
- Pancreatic enzyme testing in any of the following situations
  - More than once per visit
  - As part of ongoing assessment or therapy of chronic pancreatitis
  - 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: 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
- Cardiovascular disease risk assessment testing in any of the following situations:
  - High-sensitivity C-Reactive Protein 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 as a screening test for the general population or for monitoring response to therapy
- Measurement of High-sensitivity cardiac troponin T for cardiovascular risk assessment and stratification in the outpatient setting
- Homocysteine testing for cardiovascular disease risk assessment screening, evaluation and management
- Novel Cardiovascular Biomarkers such as measurement of novel lipid and non–lipid biomarkers 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)
- Serum Intermediate Density Lipoprotein as an indicator of cardiovascular disease risk
- Measurement of lipoprotein-associated phospholipase as an indicator of risk of cardiovascular disease
- Measurement of secretory type II phospholipase 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
- All other tests for assessing CHD risk

- Allergen testing in the following situations:
  - Routine re-testing for confirmed allergies to the same allergens, except in children and adolescents with positive food allergen results to monitor for allergy resolution
  - The Antigen Leukocyte Antibody test (ALCAT)
  - In-vitro testing of allergen specific IgG or non-specific IgG, IgA, IgM, and/or IgD in the evaluation of suspected allergy
  - Basophil Activation flow cytometry testing for measuring hypersensitivity to allergens
  - In-vitro allergen testing using bead-based epitope assays
  - In-vitro testing of allergen non-specific IgE
- The following testosterone tests:
  - Testing for serum free testosterone and/or bioavailable testosterone as primary testing (i.e., in the absence of prior serum TOTAL testosterone testing)
  - Testing for serum total testosterone, free testosterone, and/or bioavailable testosterone in asymptomatic individuals or in individuals with non-specific symptoms
  - Testing for serum testosterone for the identification of androgen deficiency in women
  - Salivary testing for testosterone
  - Measurement of serum dihydrotestosterone in individuals except in diagnosing 5-alpha reductase deficiency in individuals with ambiguous genitalia, hypospadias, or microphallus
- Thyroid disease testing 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
  - Testing for thyroid dysfunction during a general exam without abnormal findings for asymptomatic nonpregnant individuals
- Onychomycosis testing in the following situation:
  - 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

PHARMACY BENEFITS

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

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

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

You are responsible for any **deductibles**, **copayments** and/or **coinsurance** amounts, and pricing differences shown on your **SUMMARY OF BENEFITS**.

Your Cost

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

Covered Drugs

Diabetes Supplies for Treatment of Diabetes

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

Covered diabetic supplies include:

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

A separate **copayment** 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

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

- The pharmacist is unable to contact your **provider** after reasonable effort
- The pharmacist has documentation showing the patient was previously prescribed **insulin** or **insulin-related equipment or supplies** by a **provider**
- The pharmacist assesses the patient to determine whether the emergency refill is appropriate

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

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

Insulin-related equipment or supplies means needles, syringes, cartridge systems, prefilled pen systems, glucose meters, continuous glucose monitor supplies, and test strips but does not include insulin pumps.

Injectable Drugs

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

Nutritional Support

Covered services include:

- Dietary formulas needed for the treatment of phenylketonuria or other heritable diseases
- Amino acid-based formulas, regardless of the formula delivery method, used for 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 shown by the results of biopsy
  - Disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract

A prescription from your physician is required

Orally Administered Anticancer Drugs

Covered services include orally administered anticancer drugs that are used to kill or slow the growth of cancerous cells.

When you receive certain orally administered anticancer drugs from a **participating pharmacy**, no cost share will apply. Coverage of prescribed orally administered anticancer drugs when received from a non-preferred specialty pharmacy or non-**participating pharmacy** will be provided on a basis no less favorable than intravenously administered or injected cancer drugs.

Preventive Care

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

Select Vaccinations Obtained Through Select Participating Pharmacies

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

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

Smoking Cessation

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

Member Rewards Rx

Member rewards Rx is a free, voluntary program in which you can earn a cash reward for choosing a cost-effective prescription alternative. You 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 both:

- Have active coverage on the date you shop for a rewards-eligible prescribed drug opportunity
- 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 drug 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. 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. We may discontinue or change this program upon 180 days' notice to you. 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 us, 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

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

- The billed charges
- The **allowable amount**
- Other contractually determined payment amounts

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

Non-Participating Pharmacy

If you have a **prescription drug order** filled at a **non**-**participating pharmacy**, you will pay the **pharmacy** the total cost. You may submit a claim with an itemized receipts verifying that the **prescription order** was filled. We will reimburse you for **covered drugs** less:

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

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

However, if you:

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

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

Extended Prescription Drug Supply Program

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

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

Day Supply

Benefits for **covered drugs** are provided up to the maximum day supply limit as indicated on **SUMMARY OF BENEFITS**. We have the right to determine the day supply. Payment for **covered drugs** under this **plan** may not be paid if drugs are dispensed or delivered in a way intended to change the maximum day supply limit.

Mail-Order Program

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

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

Specialty Pharmacy Program

This program provides delivery of drugs directly to your **health care provider**, administration location or to your home if you are undergoing treatment for a complex medical condition.

The specialty **pharmacy** program delivery service offers:

- Coordination of coverage between you, your **health care provider** and us
- Educational materials with reference to you or your **dependent's** particular condition and information for managing potential drug side effects
- Syringes, sharps containers, alcohol swabs and other supplies with every shipment of FDA approved self-injectable drugs
- Access to a pharmacist 24 hours a day, 7 days a week, 365 days a year

When you obtain **specialty drugs** from a **specialty pharmacy program provider,** coverage will be provided according to the **Specialty Pharmacy Program** in your **SUMMARY OF BENEFITS** section of this **benefit booklet**.

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

MedsYourWay™

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

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

telephone number on the back of your **identification card** or access Blue Access for Members℠ (BAM). Participation in MedsYourWay is not mandatory and you may choose not to participate in the program at any time by contacting your customer service representative at the toll-free telephone number on the back of your **identification card** or access Blue Access for Members℠ (BAM). In the event MedsYourWay fails to provide, or continue to provide, the program as stated, there will be no impact to you. In such an event, you will pay the amount shown on your **SUMMARY OF BENEFITS**.

Member Pay the Difference

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

How Payment is Determined

Prescription drug products are separated into tiers. Generally, each drug is placed into one of six drug tiers:

- Tier 1 includes mostly **generic drugs (preferred)** and may contain some **brand name drugs**
- Tier 2 includes mostly **generic drugs (non-preferred)** and may contain some **brand name drugs**
- Tier 3 includes mostly **brand name drugs (preferred)** and may contain some **generic drugs**
- Tier 4 includes mostly **brand name drugs (non-preferred)** and may contain some **generic drugs**
- Tier 5 includes mostly **specialty drugs (preferred)** and may contain some **generic drugs**
- Tier 6 includes mostly **specialty drugs (non-preferred)** and may contain some **generic drugs**

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

About Your Benefits

Covered Drug List

We select the drugs listed on the **drug list** based upon the recommendations of a committee, which is made up of **physicians** and pharmacists from across the country, some of whom are affiliated with us. The committee considers existing drugs approved by the FDA, as well as those newly FDA approved for inclusion on the **drug list**. Entire drug classes are also regularly reviewed. Newly marketed drugs may not be covered until the committee has had an opportunity to evaluate them. Some of the factors committee members evaluate include:

- Each drug's safety
- Effectiveness
- Cost
- How it compares with drugs currently on the drug list

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

Exception Requests

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

If you have a health condition that may jeopardize your life, health, or keep you from regaining function, or your current drug therapy uses a non-**covered drug**, your **provider**, may be able to ask for an expedited review process. We will let you, and your **provider**, know the coverage decision within 1 business day after they receive your request for an expedited review.

If the coverage request is denied, we will let you and your **provider** know why it was denied and offer you a covered alternative drug (if applicable). If your exception is denied, you may appeal the decision according to the appeals process you will receive with the denial determination. You have the right to seek review by an Independent Review Organization as described in the **How to Appeal a Final Internal Adverse Determination to an Independent Review Organization (IRO)** subsection. Call us if you have any questions.

Prescription Refills

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

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

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

The refills are allowed:

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

Covered prescription contraceptives 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 drugs in certain drug categories. Limits may include:

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

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

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

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

Insulin Drug Program

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

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

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

Multi-Category Split Fill Program

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

Step Therapy

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

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

If it is **medically necessary**, coverage can be obtained for the prescription drugs subject to the Step Therapy Program without trying an alternative drug first. In this case, your **provider** must contact us to obtain **authorization** for coverage of such drug. If authorization is granted, the **provider** will be notified, and the drug will then be covered at the applicable payment levels shown on your **SUMMARY OF BENEFITS**.

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

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 have been met. A documented treatment with a therapeutic alternative drug may be required for continued coverage of the targeted drug.

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

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

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
- If the generic or equivalent drug is added to our drug list

Step therapy programs do not apply to prescription drug treatment for the treatment of **stage-four advanced, metastatic cancer** or **associated conditions.**

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

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

- **Stage-four advanced, metastatic cancer** means a cancer that has spread from the primary or original site of the cancer to nearby tissues, lymph nodes, or other areas or parts of the body.
- **Associated conditions** means the symptoms or side effects associated with **stage-four advanced, metastatic cancer** or its treatment and which, in the judgment of the **provider**, further jeopardize the health of a patient if left untreated.

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

Prior Authorizations

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

- Safe
- Effective
- Part of a specific treatment plan

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

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

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

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

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

Controlled Substance Limitations

If we determine that you may be receiving quantities of controlled substance drugs not supported by FDA approved dosages or recognized safety or treatment guidelines, any coverage for additional drugs may be subject to review to assess whether **medically necessary** or appropriate and restrictions may include but not be limited to a certain **provider** and/or **pharmacy** of your choice and/or quantities and/or days' supply for the prescribing and dispensing of the controlled substance drug. If you do not choose such **provider** and/or **pharmacy** within a reasonable time, we will make the choice. Additional **copayments** and/or **coinsurance amounts** may apply.

Therapeutic Equivalents and Therapeutic Alternatives

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

Right of Appeal

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

Pharmacy Limitations and Exclusions

Pharmacy Benefits are not available for:

- New to market FDA approved drugs which have not been reviewed by us prior to coverage of the drug.
- Non-FDA approved drugs.
- **Legend drugs** which are not approved by the FDA for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation.
- Drugs/products which are not included on the **drug list**, unless specifically covered elsewhere in this **benefit booklet** and/or such coverage is required in accordance with applicable law or regulatory guidance.
- Drugs which do not by law require a **prescription order**, except as indicated under **Preventive Care** in **PHARMACY BENEFITS**, from a **physician** or authorized **provider** (except insulin, insulin analogs, insulin pens, prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and select vaccinations administered through certain **participating pharmacies** as shown on your **SUMMARY OF BENEFITS**); and **legend drugs** or covered devices for which no valid **prescription order** is obtained.
- 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 or **hospital** grade breast pumps is provided under the medical portion of this **plan**.

- 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.
- Administration or injection of any drugs.
- Vitamins (except those vitamins which by law require a **prescription order** and for which there is no non-prescription alternative, or as indicated under **Preventive Care** in **PHARMACY BENEFITS**).
- Drugs injected, ingested or applied in a **physician's** or authorized **provider's** office or during confinement while a patient is in a **hospital**, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.
- **Covered drugs**, devices, or other **pharmacy** services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
- **Covered drugs**, devices, or other **pharmacy** services or supplies for which **benefits** are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or the laws, regulations or established procedures of any county or municipality, 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 you for prescription drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
- Any special services provided by the **pharmacy**, including counseling and delivery.
- **Covered drugs** for which the **pharmacy's** usual retail price to the public is less than or equal to your cost share determined under this **plan**.
- **Infertility** and fertility drugs.
- Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
- Fluoride supplements, except as required by the Affordable Care Act for **dependent** children.
- Drugs required by law to be labeled: "Caution – Limited by Federal Law to Investigational Use," or experimental drugs, even though a charge is made for the drugs.
- Drugs dispensed in quantities in excess of the day supply amounts called out in your **SUMMARY OF BENEFITS** or as shown under the **Day Supply** subsection of **PHARMACY BENEFITS**, or refills of any prescriptions in excess of the number of refills specified by the **physician** or authorized **provider** or by law, or any drugs or medicines dispensed more than one year following the **prescription order** date.
- Fluids, solutions, nutrients, or drugs (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous intramuscular (in the muscle), unless approved by the FDA for self-administration, intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting. **Note**: this exclusion does not apply to

formulas covered under the **Nutritional Support** subsection of **PHARMACY BENEFITS**. A **prescription order** from your **provider** is required.

- Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control.
- Drugs, that the use or intended use of which would be illegal, unethical, imprudent, abusive or otherwise improper.
- Drugs that are not considered **medically necessary** or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines.
- Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the **identification card**.
- Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under your **employer's** group health care plan, or for which **benefits** have been exhausted.
- Rogaine, minoxidil, or any other drugs, medications, solutions, or preparations used or intended for use in the treatment of hair loss, hair thinning, or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise, for cosmetic purposes.
- Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
- **Prescription orders** for which there is an over-the-counter product available with the same active ingredient(s) in the same strength, unless we determine otherwise.
- Retin A or pharmacologically similar topical drugs for **participants** over the age of 39
- Athletic performance enhancement drugs
- Bulk powders
- Surgical supplies
- Ostomy products
- Diagnostic agents. This exclusion does not apply to diabetic test strips.
- Drugs used for general anesthesia.
- Drugs to treat sexual dysfunction.
- Allergy serum and allergy testing material.
- Injectable drugs, except self- administered **specialty drugs** or those approved by the FDA for self-administration.
- Self-administered drugs dispensed or administered by a **physician** in their office.
- **Prescription orders** which do not meet the required step therapy criteria.
- **Prescription orders** which do not meet the required **prior authorization** criteria.
- Replacement of drugs or other items that have been lost, stolen, destroyed or misplaced.
- Shipping, handling or delivery charges.
- Nonsedating antihistamine drugs and combination drugs containing a nonsedating antihistamine and decongestant.
- Repackagers, institutional packs, clinical packs, or other custom packaging.
- **Prescription orders** written by a member of your immediate family, or a self-prescribed **prescription order**.
- Drugs in certain drug classes where there is an over the counter alternative available.
- brand name (preferred) and brand name (non-preferred) drug proton pump inhibitors.
- Drugs we determine to have inferior efficacy or significant safety issues
- Cannabis, meaning all parts of the plant genus Cannabis containing delta-9-tetrahydrocannabiol (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.

UTILIZATION MANAGEMENT

Utilization Management

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

Medical Necessity reviews may occur:

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

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

Prior Authorization

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

Some Texas licensed **providers** may qualify for an exemption from required **prior authorization** requirements for a particular health care service if the **provider** met legal criteria for that heath care service. If so, **prior authorization** is not required for a service where an exemption applies and will not be denied based on **medical necessity** or medical appropriateness of care. Other **providers** providing your care may not be exempt from such requirements. Exemptions do not apply for services that are materially misrepresented or where the **provider** failed to substantially perform the particular service.

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

Prior Authorization Responsibility

In-Network Provider Prior Authorization

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

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

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

Out-of-Network Prior Authorization

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

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

Recommended Clinical Review Option

A r**ecommended clinical review** is:

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

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

Contacting Medical and Behavioral Health

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

Post-Service Medical Necessity Review

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

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

Failure to Obtain Prior Authorization

If **prior authorization** is not obtained:

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

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

CLAIM FILING AND APPEALS PROCEDURES

Filing of Claims Required

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

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

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

Filing a Medical Claim	Requirement	Deadline
Notice of claim	• You must give us written notice within 20 days after receiving services for **benefits** under this **plan.** • Once we receive your notice, we will provide you or your **employer** with the claim forms for filing a **proof of loss** claim within 15 days.	• If you do not give us written notice within 20 days but can as soon as possible, it will not reduce your claim. • If the claim forms are not provided within 15 days, we will accept a written description that must detail the nature and extent of loss within 90 days of your loss.
Proof of Loss (claim)	• A completed claim form and any additional information required. • File each **participant's** expenses separately. **Deductibles** and **benefits** are applied to each **participant** separately. Include itemized bills from the **provider**, lab, etc., on their letterhead showing the services given, dates of service, charges, and **participant's** name.	• No later than 90 days after you have incurred expenses for **covered benefits**. • We won't void or reduce your claim if you can't send us notice and **proof of loss** within the required time. But you must send us notice and proof as soon as reasonably possible. • **Proof of loss** may not be given later than 1 year after the time proof is otherwise required, except if you are legally unable to notify us.
Benefit Payment	• Written proof must be provided for all **benefits**. • If any portion of a claim is contested by us, the uncontested portion of the claim will be paid after the receipt of **proof of loss.**	• **Benefits** will be paid as soon as the necessary proof to support the claim is received.

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

Filing a Prescription Drug Claim	Requirement	Deadline
Mail-Order Program	• A completed mail service prescription drug claim form	• Within 20 days. • **Proof of loss** may not be given later than 1 year after the time proof is otherwise required, except if you are legally unable to notify us.
Prescription Drug Claims	• A completed Prescription Reimbursement Claim Form • Include itemized bills from the **pharmacy** showing the name, address, and telephone number of the **pharmacy**, **participants** prescription drugs received, including the name and quantity of the drug, prescription number and date of purchase	• Within 20 days. • Proof of loss may not be given later than 1 year after the time proof is otherwise required, except if you are legally unable to notify us.

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

Please mail completed claim forms to:

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

Who Receives Payment
Benefit payments are made directly to contracting **providers** when they bill us. If unpaid at your death, any **benefits** payable to you will be paid to your beneficiary or to your estate.

Except as provided in the **ASSIGNMENT AND PAYMENT OF BENEFITS** section**,** rights and **benefits** under the **plan** are not assignable before or after services and supplies are provided.

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

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

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

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

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

REVIEW OF CLAIM DETERMINATIONS

Claim Determinations

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

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

Timing of Required Notices and Extensions

There are four types of claims as defined below:

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

- **Pre-Service Claim** means any non-urgent request for **benefits** that involves services you have not yet received and requires **prior authorization**.

- **Post-Service Claim** means notification in a form acceptable to us that a service has been rendered or furnished to you.

This notification must include full details of the service received, including:

- Your name, age, and gender
- Identification number
- Name and address of the **provider**
- An itemized statement of the service rendered or furnished
- Date of service
- Diagnosis
- Claim charge

- Any other information which we may request in connection with services rendered to you.

- **Concurrent Care Claim** means a claim occurs when you need us to approve more services than we already have approved. Examples are extending a **hospital** stay or adding visits to a **provider**. We will notify you of our determination for such a request within 24 hours after receipt of your claim for **benefits**.

Type of Notice (Claim) or Extension	Time Period
Urgent Care Clinical Claim	
If your claim is incomplete, we must notify you within:	24 hours
If you are notified that your claim is incomplete, you must provide information to complete your claim to us within:	48 hours after receiving notice
If the initial claim is complete (taking into consideration medical needs), within:	72 hours. If you are an inpatient at a healthcare facility when services are recommended, we will issue a determination within 24 hours after we receive the request.
If your claim involves post-stabilization treatment after emergency treatment or a life-threatening condition, within:	One hour from the receipt of the request. If the request is received after required operating hours, we will make the determination within one hour upon resuming required operating hours. You do not need to submit **urgent care clinical claims** in writing. Please call us at the toll-free telephone number listed on the back of your **identification card** as soon as possible to submit an **urgent care clinical claim**.
Pre-Service Claims	
Upon receipt of all information necessary to complete the review within:	3 calendar days after claim is received
If post-stabilization care is required after an emergency, within:	1 hour after claim is received
Post-Service Claims (Retrospective Review)	
If your claim is incomplete, you will be notified within:	30 days after claim is received
After receiving the completed claim (if the initial claim was incomplete) within:	45 days, if we extended the period, minus any days already used during the review*
Concurrent Care Claim	
We will notify you of our determination for such a request within:	24 hours after receipt of your claim for **benefits**

We may extend the initial 30-day period one time for up to 15 days, only if we determine that an extension is necessary. We will notify you in writing, prior to the expiration of the initial 30−day period of the reasons why an extension of time is necessary and the date we expect to decide. If the initial 30-

day period is extended because we require additional information from you or your **provider**, the period for us deciding is paused from the date we send a notice of extension to you until we receive the additional information or when the additional information was to be submitted, whichever date is earlier.

If a Claim Is Denied or Not Paid in Full

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

- Reasons for the determination
- A reference to the benefit **plan** provisions or the contractual, administrative, or protocol basis for the determination
- A description of additional information necessary and an explanation of why it is necessary
- Subject to privacy laws and other restrictions, if any:
- Identification of the claim
- Date of service
- Health care **provider**
- Claim amount (if applicable)
- Statement describing denial codes with their meanings and standards used
- Diagnosis/treatment codes with their meanings and the standards used (upon receipt)
- An explanation of our internal review/appeals and external review processes (and how to initiate a review/appeal or external review)
- A statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal
- A statement in non-English 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 us (in certain situations)
- Copies of all documents, records, and other information relevant to the claim (provided free of charge on request)
- Copy of rule, guideline, protocol or other similar criterion (provided free of charge on request)
- An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances
- **Experimental/investigational** treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request (if the denial was based on **medical necessity**)
- Urgent care clinical claims:
    - Description of the expedited review procedure applicable
    - Decision may be provided orally, so long as a written notice is given to the claimant within 3 days of verbal notification
    - Contact information for applicable office of health insurance consumer assistance or ombudsman (as appropriate).

Claim Appeal Procedures

Claim Appeal Procedures and Definitions

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

- **Experimental/ investigational**
- Not **medically necessary** or appropriate

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

Expedited Clinical Appeal means an appeal of a clinically urgent nature related to a denial of health care services, including, but not limited to:

- Procedures or treatments ordered by a **provider**
- Emergency care
- Continued hospitalization
- A step therapy exception request
- If you were receiving prescription drugs or intravenous infusions and coverage was discontinued

If your situation meets the definition of an expedited clinical appeal, you may be able to appeal our decision on an expedited basis.

Expedited Clinical Appeals

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

How to Appeal an Adverse Benefit Determination

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

You, or an authorized representative, may act on your behalf, and file an adverse benefit determination appeal. In some circumstances, your **provider** may appeal on your behalf. If you choose an authorized representative, we must be notified in writing. To obtain an Authorized Representative Form, you, or your authorized representative may call us at the toll-free telephone number on the back of your **identification card.**

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

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

The review of our decision will take place as follows:

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

Please note: This appeal process does not prohibit you from pursuing a civil action 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.

If You Need Assistance

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

Claim Review Section
Blue Cross and Blue Shield of Texas
PO Box 660044
Dallas, TX 75266-0044

Notice of Appeal Determination

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

The written notice to you includes:

- The reasons for the determination, including the guidelines used in denying the claim and a discussion of the decision, benefit plan provisions, contractual, administrative, or procedure basis.
- The identification of the claim, date of service, health care **provider**, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used - subject to privacy laws and other restrictions, if any. Upon request, diagnosis/treatment codes with their meanings and the standards used.
- An explanation of our 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 the Employee Retirement Income Security Act (ERISA) following a final denial on external appeal.
- If available, and upon request, a document in non-English language(s) showing how to access the language services provided by us, including a written notice of claim denials and certain other **benefit** information.
- The right to request, without any cost to you, reasonable access to, and copies of, all documents, records, and other information related to the claim for benefits.
- Any internal rule, guideline, procedure, or other similar reasons relied upon in the determination, and instructions on getting a copy of these, upon request, without any cost to you.
- An explanation of the scientific or clinical decision relied upon in the determination, or instructions on getting a copy of the explanation, upon request, without any cost to you.
- Health Insurance Consumer Assistance or Ombudsman contact information (as appropriate).

If we deny your appeal, in whole or in part, or you do not receive a timely decision, you may request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described below under the **How to Appeal a Final Internal Adverse Determination to an Independent Review Organization (IRO)** section.

How to Appeal a Final Internal Adverse Determination to an Independent Review Organization (IRO)
An independent review is a review made by an organization independent of us. This is called an independent review organization (IRO).

IRO Procedures and Definitions

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

- **Experimental/ investigational**
- **Medically necessity**, appropriateness, health care setting, level of care, or effectiveness

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

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

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

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

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

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

You must submit the request for independent review form to us within four (4) months after receipt of the adverse determination.

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

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

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

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

If the process for appeal and review places your health in serious jeopardy, you are not prohibited from pursuing other appropriate remedies under the law, including, injunctive relief, a declaratory judgment, or other relief If your **plan** is governed by the Employee Retirement Income Security Act (ERISA), you have the right to bring a civil action under 502(a) of ERISA.

If You Need Assistance

If you need assistance with the internal claims and appeals or the external review processes, please call the toll-free telephone number on the back of your **identification card** for contact information. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Actions Against Us

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

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

Please Mail Completed Claim Forms to:

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

GENERAL PROVISIONS

This section includes:

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

Agent
Your employer is not the agent of BCBSTX.

Amendments
We and your **employer** may agree to amend or change the **plan** at any time. We must provide notice of any material modification (as defined under section 102 of ERISA) to you and your **dependents** not later than 60 days before the modification's **effective date**. We must provide this notice for any material modification of any of the plan terms of the **plan** or plan coverage that affects the content of the most recent Summary of Benefits and Coverage (SBC) and that occurs other than in connection with a renewal or reissuance of coverage. The Summary of Benefits and Coverage (SBC) is a document that summarizes plan **benefits**, cost-sharing, and limitations, as required under the Affordable Care Act.

Assignment and Payment of Benefits
If a written assignment of **benefits** is made by you or your **dependents** to a **provider** and the written assignment is delivered to us with the claim for **benefits**, we will make any payment directly to the **provider**. Payment to the **provider** discharges our responsibility to you and your **dependents** for any **benefits** available under the **plan**.

Benefits You Are Qualified to Receive
We supply only the **benefits** specified in this **benefit booklet**. Only you and your **dependents** may receive **benefits** from us. You and your **dependents** may not transfer your rights to **benefits** to anyone else.

Benefits for **covered services** specified in this **benefit booklet** will be covered only for those **providers** specified in this **benefit booklet**.

Complying 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 and the **contract** that insures you is not issued in your state.

Any **benefit** or provision of this **benefit booklet** which conflicts with applicable statutes of the state the **employee** lives, on the **effective date** of the **benefit booklet**, will be amended to comply to:

- The minimum requirements of the applicable statutes, or
- The **benefits** or provisions of this **benefit booklet** to the extent they exceed the minimum requirements.

Disclosure Authorization
If you file a claim for **benefits**, you must authorize any health care **provider**, insurance company, or other entity to provide us all information and records or copies of records relating to you or your **dependent's** diagnosis, treatment, or care. 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.

Entire Contract
The entire **contract** is made up of a **plan**, including the agreement between Blue Cross and Blue Shield and the group, any addenda, this **benefit booklet**, along with any exhibits, appendices, addenda and/or other required information, and the individual application(s) of the persons covered under the **certificate**, **benefit** and premium notification documents, if any, and rate summary documents, if any. All statements contained in the application will be considered representations and not warranties. No such statements will be used to void the insurance, reduce the **benefits**, or be used in defense of a claim for loss incurred unless it is contained in a written application.

No agent has the authority to change or waive any part of the **plan**, to extend the time for payment of premiums, or to waive any of the rights or requirements of Blue Cross and Blue Shield of Texas. No modifications of the **plan** will be valid unless shown by an endorsement or amendment of the **plan**, signed by an officer of Blue Cross and Blue Shield of Texas and delivered to your group.

Identity Theft Protection
Identify theft protection services are available to you at no additional cost.

The identity theft protection services include:
- Credit monitoring
- Fraud detection
- Credit/identity repair
- Insurance to help protect your information

These identity theft protection services are currently provided by our chosen outside vendor. Accepting or declining these services is optional for you and your **dependents**.

You may accept identity theft protection services by enrolling in the program online at www.bcbstx.com or by calling 800-521-2227.

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

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

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

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

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

To do this we may:

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

Member Rewards Medical

Member Rewards is a free, program that you can choose that eligible **participants** can earn a percentage of the claim savings in a cash reward by selecting quality, low-cost **network** facilities for qualified elective, non- emergency 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 done by calling the number on the back of your insurance **identification card**, who will shop for services and facilities for you.

When you choose a rewards eligible service, you will earn a part 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:

- Have active coverage on the date you shop for a rewards-eligible service
- Have active coverage on the date the medical service is given
- Complete the rewards-eligible service within thirteen months of shopping

Cash reward 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 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 work 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 change **benefits** or claims processing. The **plan** may stop or change this program upon 180 days' notice to **participants**. To keep eligibility for a reward, you must complete shopping for a rewards-eligible service prior to the program termination following a program termination notice. Rewards may be paid out up to 90 days after program termination. All rewards earned under this program will be funded by us, 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 needed for your procedure or service.

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

Network Demographics

To learn more about the number or insureds, **providers** and **hospitals** in the service area, please call the customer service number on your **identification card.**

Network Adequacy Waivers and Local Market Access Plans

Waivers or local market access plans approved by the Texas Department of Insurance may be obtained by calling the customer service number shown on the back of your **identification card**.

New Medical Technology

We keep up to date on:

- Medical breakthroughs
- Experimental treatments
- Newly approved drugs

The medical policy department evaluates the following for potential inclusion in the benefit packages we offer:

- New technologies
- New medical procedures
- New drugs
- New devices

Our Medical Policy Group thoroughly assesses clinical literature and accepted medical practice standards with ongoing reviews and decisions.

Paper Check – Automatic Clearing House/Electronic Funds

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

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

Participant/Provider Relationship

The choice of a health care **provider** should be made by you or your **dependents**.

We:

- Do not provide services or supplies but only pay for eligible expenses incurred by you or your **dependents**
- Are not liable for any act or omission by any health care **provider**
- Do not have any responsibility for a health care **provider's** failure or refusal to provide services or supplies to you or your **dependents**

The selected health care **provider** has rules and regulations that apply to care, and treatment received by you or your **dependents.** The care and treatment are available only for sickness or injury treatment acceptable to the health care **provider**.

We, **in-network providers**, and/or other contracting **providers** are independent contractors concerning each other. We in no way control, influence, or take part in the health care treatment decisions by **providers**. We do not give 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 us nor are they our **employees**.

Refund of Benefit Payments

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

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

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

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

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

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

Rescission of Coverage

Rescission means 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.

Rescission is not considered:

- A cancellation or non-renewal of coverage due to failure to pay required premiums in the required time or contributions toward the cost of coverage (including COBRA premiums)
- A cancellation started by you or your authorized representative
- A future cancellation or discontinuance of coverage

Rescission is subject to 30 days' prior notification and is retroactive to the **effective date**. In the event of cancellation, we 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 the cancellation is changed.

At any time when we are allowed to rescind coverage already in force or is otherwise permitted to make prior changes to this **benefit booklet**, we may at our option make an offer to revise the **benefit booklet** already in force and/or change the rating category/level. If a revision, the **benefit booklet** will be reissued prior to the form it would have been issued had the misstated or omitted information been known at the time of application.

Please call us at the toll-free number listed on the back of your **identification card** for more information about your appeal rights concerning **rescission** and/or revision. 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 asked.

Service Area

The **plan service area** is statewide.

State Government Programs

- If you are also a Medicaid recipient, any **benefits** for services or supplies under the plan will not be excluded solely because **benefits** are paid or payable under Medicaid. Any benefits available under this plan will be payable to the Texas Health and Human Services Commission to the extent required by the *Texas Insurance Code*.
- 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:
    - The Texas Health and Human Services Commission is paying **benefits** pursuant to provisions in the Human Resources Code
    - 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
    - We receive written notice at our 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.

Subrogation

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

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

Right of Reimbursement

In areas where subrogation rights are not recognized, or where subrogation rights are ruled out by factual circumstances, we will have a right of reimbursement.

If you or your **dependent** receive money from any person, organization, or insurer for an injury or condition for which we paid **benefits** under this **plan**, you or your **dependent** agree to reimburse us from the money received for the amount of **benefits** paid or provided by us. That means you or your **dependent** will pay us the amount of money received by you through judgment, settlement or otherwise from the third party or their insurer, as well as from any person, organization or insurer, up to the amount of **benefits** paid or provided by us.

Right to Recovery by Subrogation or Reimbursement

You or your **dependent** agree to promptly give us all information which you have concerning your rights of recovery from any person, organization, or insurer and to help us protect and obtain our reimbursement and subrogation rights. You, your **dependen**t or your attorney will notify us before settling any claim or suit to allow us to enforce our rights by taking part in the settlement of the claim or suit. You or your **dependent** further agree not to allow our reimbursement and subrogation rights to be limited or harmed by any acts or failure to act on your part.

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**.

- 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.

- 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**.

- 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**.

- 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.

- 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 amounts** 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 to 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 plans 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 plan** 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 his or her own coverage as a **dependent** under a spouse's **health care plan**, paragraph 5. below applies.

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

3. **Active, Retired, or Laid-off Employee.** The **health care plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The **health care plan** that covers that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a **dependent** of an active employee and that same person is a **dependent** of a retired or laid-off employee. If the **health care plan** that covers the same person as a retired or laid-off employee or as a **dependent** of a retired or laid-off employee does not have this rule, and as a result, the **health care plans** do not agree on the order of benefits, this rule does not apply. This rule does not apply if paragraph 1. above can determine the order of benefits.

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

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

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

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

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

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 this **plan** for you and/or your **dependents** will automatically end when:

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

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

We may refuse to renew the coverage of an **eligible person** 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 end upon reaching the limiting age shown in the definition of **dependent** if the **child** continues to be both:

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

Termination of the Group

The coverage of all **participants** will end if the group is stopped 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 allowed 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 total disability period or for 90 days following the **contract**'s termination date, whichever is less.

If your coverage under the **plan** is replaced with coverage issued by a succeeding insurance company which provides equal or greater **benefits** than those provided by this **contract**, this extension of **benefits** for total disability is not applicable.

A succeeding insurance company means an insurer that has replaced our coverage with its coverage.

Total disability or totally disabled means as applied to:

- An **employee**, the complete inability of the **employee** to perform all 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
- A retiree, the complete inability of the retiree to continue all the normal duties or activities of a person in good health who is the same sex and about the same age
- A **dependent**, confinement as a bed patient in a **hospital.**

Continuation Privilege

- Any **participant** whose insurance under the **contract** has been ended for any reason, except forced termination of employment for a specific reason, or discontinuance of the whole **contract** or 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 the three months immediately before termination, shall be allowed a continuation privilege as outlined below.

Continuation of group coverage must be requested in writing and provided to either the **employer** or **contract** holder within 60 days following the later of:

- The date the group coverage would otherwise end
- The date the **participant** is given notice of the right of continuation by either the **employer** or the group **contract** holder

A **participant** choosing continuation must pay the amount of contribution needed to the **employer** or **contract** holder, 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 first election of coverage. All later payments must be made no later than 30 days after the payment due date.

Continuation may not end until the earliest of:

- The date on which the maximum continuation period is ending, which is:
- For **participants** not eligible for COBRA continuation coverage, nine months after the start date of state continuation coverage
- For **participants** covered under COBRA continuation coverage, six months following the expiration of any period of COBRA continuation coverage
- The date the payments were not paid on time that would end coverage
- The date on which the entire group coverage ends
- The date on which the **participant** is or could be covered under Medicare
- The date on which the **participant** 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
- The date the **participant** is eligible for similar **benefits** whether or not covered under any coverage for individuals in a group, whether on an insured or uninsured basis

- Similar **benefits** are provided or available to the **participant**, by or following the requirements of any state or federal law, other than COBRA continuation coverage

Additional Continuation for Certain Dependents – State

If coverage ends because 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 ends due to any of these circumstances:

- The **contract** is canceled
- The **dependent** does not make any premium payments in the required time

Continuation ends after the earliest of the following:

- The third anniversary of the break of the family relationship or the retirement or death of the **participant**
- The insured does not make premium payments within the time needed to make the payments
- The insured becomes eligible for 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
- The **contract** is canceled

Notification Requirements

The **dependent** must notify us within 15 days of the **employee's** death, retirement, or divorce. We will at once 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 us of the desire to select the right of continuation or the choice expires. Coverage stays in effect during the 60-day period provided premium is paid.

COBRA Continuation – Federal

Under 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 **contract** holder 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 decide 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 needed to show 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 prior **calendar year**. This refers to the number of full-time and part-time **employees** employed, not the number of **employees** covered by a **plan**.

Loss of Coverage

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

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

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

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

- The last day of the eighteen (18) month period for events which have a maximum continuation period of eighteen (18) months
- The last day of the thirty-six (36) month period for events which have a maximum continuation period of thirty-six (36) months
- The first day for which prompt payment of premium is not made to the **plan** with respect to the qualified beneficiary
- The date the **employer** stops providing any group health **plan** to any **employee**
- The date, after the date of the election, the qualified beneficiary first becomes covered under any other **employer** group **plan**
- The date, after the date of the election, the qualified beneficiary first becomes qualified for 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 first qualifying event.

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

Notice of COBRA Continuation Rights

The **employer** handles supplying the necessary notification to **participants** as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986.

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

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

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

- The **employer** is responsible for supplying 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
- We will give the **employer** this **benefit booklet** as a description of **benefits** available under this **plan**. Upon written request by the **employer**, we will send any information which we have that will help the **employer** in making its annual reports
- Claims for **benefits** must be made in writing within the required time period as described in the provisions of this **plan**. Claim filing and claim review health procedures are found in the **CLAIM FILING AND APPEALS PROCEDURES** section of this **benefit booklet**
- We are not the "administrator" as that term is defined by ERISA or the "**plan administrator**" or "plan sponsor" with regard to the **plan**
- This **benefit booklet** is a Certificate of Coverage and not a Summary Plan Description
- The **employer** has delegated to us the final authority and discretion to interpret the **plan** provisions and to make eligibility and **benefit** determinations

GLOSSARY

Allowable Amount means the maximum amount determined by us 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 us 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 us 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:
  - The provider's billed charges
  - Our 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 us. 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 us. 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 **in-network providers** adjusted by a predetermined factor established by us. Such factor shall be not less than 75% and shall be updated not less than every two years.

  We will utilize the same standard claim processing rules and/or edits that it utilizes in processing standard **in-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 we do not have any claim edits or rules, we 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 us 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 our non-contracting **allowable amount** for a particular service, you may call customer service at the number on the back of your **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 us 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 medical 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 preapproved or have received **prior authorization** based upon the unavailability of an **in-network provider** and balance billing is not prohibited by Texas or Federal law **–** The **allowable amount** will be our usual and customary rate as defined by Texas law or as prescribed under applicable law and regulations, or at a rate agreed to between us and the **out-of-network provider**, not to exceed billed charges.

- For **out-of-network emergency medical care**, care provided by an **out-of-network** facility-based **provider** in an **in-network hospital**, ambulatory surgery center or birthing center, or services provided by an **out-of-network** laboratory or diagnostic imaging **s**ervice in connection with care delivered by an **in-network provider –** The **allowable amount** will be our usual and customary rate or at a rate agreed to between us and the **out-of-network provider** as prescribed by the Texas Insurance Code, not to exceed billed charges. Our 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 **benefit booklet**.

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

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

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

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

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

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

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

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

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

Contract means your **employer** issued group benefits contract.

Contract Date means the corresponding date in each year after the **contract effective date** for as long as the **contract** is in force.

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

Covered Drugs means any prescription drug:

- Which is included on the applicable **drug list**
- Which is **medically necessary** and is ordered by an authorized **provider** for you or your **dependent**

- Which is not consumed at the time and place that the **prescription order** is written
- For which the FDA has given approval for at least one indication
- Which is dispensed by a **pharmacy,** and you received while covered under the **plan**, except when received from a **provider's** office, or during confinement while a patient in a **hospital** or other acute care institution or facility (refer to **Limitations and Exclusions**)

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

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

Custodial Care means 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 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 drugs, etc.) and are to assist with activities of daily living (e.g., bathing, eating, dressing, etc.).

Deductible means the amount, if any, you must pay before we start paying **contract benefits**. You do not send this amount to us. We subtract this amount from covered expenses on claims you and health care professionals send us. Some services can be covered before the **deductible** is met. Refer to your **SUMMARY OF BENEFITS** for any **deductibles** applicable to your coverage.

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

Child means a:
- Natural **child**
- A step**child**
- A foster **child**
- A grandchild who is your dependent for federal income tax purposes at the time application for coverage of the child is made
- An adopted **child** including those placed with you for adoption (including a child for whom you, your spouse or your domestic partner is a party in a legal action in which the adoption of the child is sought)

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

A **dependent** can also be a child of any age who is medically certified as **disabled** and **dependent** upon you, your spouse or domestic partner.

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

- Diet
- Regulation or management of diet or
- The assessment or management of nutrition

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** reaches the limiting age. You must give satisfactory proof of the disability and dependency through your **employer** to us 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, we may require periodic certification of the **child's** physical or mental condition but not more often than annually after the two-year period following the **child's** attainment of the limiting age.

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

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

Domestic Partnership means long-term committed relationship of indefinite duration with a person which meets the following criteria:

- You and your **domestic partner** have lived together for at least 6 months;
- Neither you nor your **domestic partner** is married to anyone else or has another **domestic partner**;
- Your **domestic partner** is at least 18 years of age and mentally competent to consent to **contract**;
- Your **domestic partner** resides with you and intends to do so indefinitely;
- You and your **domestic partner** have an exclusive mutual commitment similar to marriage; and
- You and your **domestic partner** are jointly responsible for each other's common welfare and share financial obligations.

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

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

Eligible Employee means an **employee** who works on a full-time basis, who usually works at least 30 hours a week, and who otherwise meets the **participation criteria** established by a **large employer**. The term includes a sole proprietor, a partner, and an independent contractor, if the individual is included as an **employee** under a health benefit plan of a **large employer** regardless of the number of hours the sole proprietor, partner, or independent contractor works weekly, but only if the plan includes at least

two other eligible employees who work on a full-time basis and who usually work at least 30 hours a week. **Participation criteria** means any criteria or rules established by a **large employer** to determine the **employees** who are eligible for enrollment or continued enrollment under the terms of a health benefit plan. The **participation criteria** may not be based on **health status related factors**.

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:

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

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

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

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

As used herein, medical treatment includes medical, surgical, or dental treatment.
Standard medical treatment means the services or supplies that are in general use in the medical community in the United States, and:

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

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

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

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

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

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

Health Status Related Factor means:

- Health status
- Medical condition, including both physical and mental health
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability, including conditions arising out of acts of family violence
- Disability

Hospital means a short-term acute care facility which:

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

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

Infertility means a disease, condition, or status characterized by the inability to conceive a **child** or to carry a pregnancy to live birth after one year of regular unprotected sexual intercourse for a woman 35

years of age or younger, or after 6 months for a woman over 35 years of age (conceiving but having a miscarriage does not restart the 12-month or 6-month term for determining **infertility**); A person's inability to reproduce either as a single individual or with a partner without medical intervention; or A licensed **physician's** findings based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing.

Intensive Outpatient Program means a freestanding or **hospital**-based program that provides services for at least 3 hours per day, 2 or more days per week, to treat mental health or substance use disorder or specializes in the treatment of co-occurring mental health conditions and substance use disorder. Requirements: Our claims administrator requires that any mental health and/or substance use disorder **intensive outpatient program** must be licensed in the state where it is located, or accredited by a national organization that is recognized by our claims administrator, as set forth in the current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy. **Intensive outpatient program** services may be available with less intensity if you are recovering from severe and/or chronic mental health conditions and/or substance use disorders. If you are recovering from severe and/or chronic mental health conditions and/or substance use disorder, services may include psychotherapy, pharmacotherapy, and other interventions aimed at supporting recovery such as the development of recovery plans and advance directives, strategies for identifying and managing early warning signs of relapse, development of self-management skills, and the provision of peer support services. **Intensive outpatient programs** may be used as an initial point of entry into care, as a step up from routine outpatient services, or as a step down from acute inpatient, residential care or a partial hospitalization treatment program.

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

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

Large Employer means a person (individual, corporation, partnership, or other legal entity) who employed an average of at least 51 **employees** on business days during the preceding **benefit period** and who employs at least two **employees** on the first day of the plan year.

Late Enrollee means any **employee** or **dependent** eligible for enrollment who requests enrollment in an **employer's health benefit plan:**

- After the expiration of the initial enrollment period established under the terms of the first plan for which that **participant** was eligible through the **employer**
- At the expiration of an **open enrollment period**, or
- After the expiration of a special enrollment period

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

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

- Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, or bodily malfunction
- Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States
- Not primarily for the convenience of the **participant**, physician, **behavioral health provider**, the **hospital**, or the **other provider**
- The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the **participant**. When applied to hospitalization, this further means that the **participant** requires acute care as a bed patient due to the nature of the services provided or the **participant's** condition, and the **participant** cannot receive safe or adequate care as an outpatient. We do not determine course of treatment or whether particular health care services are received. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between the **participant**, **physician**, **behavioral health provider**, the **hospital**, or the **other provider**

If more than one health intervention meets the requirements listed above, **medically necessary** means the most cost effective in terms of type of intervention or setting, frequency, extent, site, duration, which is safe and effective for the patient's illness, injury, or disease and supports good health.

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

National Drug Code (NDC) means a national classification system for the identification of drugs.

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

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

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

- Chemical dependency treatment center
- Crisis stabilization unit or facility
- Durable medical equipment **provider**
- Home health agency
- Home infusion therapy **provider**
- Hospice
- Imaging center
- Independent laboratory
- Prosthetics/Orthotics **provider**
- Psychiatric day treatment facility

- Renal dialysis center
- Residential treatment center
- Skilled nursing facility
- Therapeutic center

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

- Advanced practice nurse
- Board certified behavior analyst
- Doctor of chiropractic
- Doctor of dentistry
- Doctor of optometry
- Doctor of podiatry
- Doctor in psychology
- Licensed acupuncturist
- Licensed audiologist
- Licensed chemical dependency counselor
- Licensed dietitian
- Licensed hearing instrument fitter and dispenser
- Licensed marriage and family therapist
- Licensed clinical social worker
- Licensed occupational therapist
- Licensed physical therapist
- Licensed professional counselor
- Licensed speech-language pathologist
- Licensed surgical assistant
- Nurse first assistant
- Physician assistant
- Psychological associates who work under the supervision of a doctor in psychology

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 provider** 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 once you pay this amount in **deductibles**, **copayments** and **coinsurance** for **covered services**, we pay 100% of the **allowed amount** for **covered services** for the rest of the **benefit period**.

Partial Hospitalization Treatment Program means our claim administrator approved the planned program of a **hospital** or substance use disorder treatment facility for the treatment of mental health conditions or substance use disorder treatment in which patients spend days or nights. This behavioral healthcare is typically 5 to 8 hours per day, 5 days per week (not less than 20 hours of treatment services per week). The program is staffed similarly to the day shift of an inpatient unit, i.e., medically supervised

by a physician and nurse. The program shall ensure a psychiatrist sees the patient face to face at least once a week and is otherwise available, in person or by telephone, to provide assistance and direction to the program as needed. Patients at this level of care do not require 24-hour supervision and are not considered a resident at the program. The claim administrator requires that any mental health condition and/or substance use disorder **partial hospitalization treatment program** must be licensed in the state where it is located or accredited by a national organization that is recognized by the claim administrator as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

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

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

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

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

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

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

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**.

Plan Year means the period commencing on the **contract date** and ending on the day before the next **contract date**. Please contact your **employer** for **plan year** information.

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

Prescription Order means an order from an authorized **provider** to a pharmacist for a drug or device to be dispensed. Orders by a **provider** located outside the United States to be dispensed in the United States are not covered under the **plan.**

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:

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

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

Residential Treatment Center means a facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a level of security, supervision, and structure **medically necessary** to meet the needs of patients served or to be served by such facility. **Residential treatment centers** must be licensed by the appropriate state and local authority as a residential treatment facility or its equivalent under the laws or regulations of such locality and/or must be accredited by a national accrediting body as a **residential treatment center** or its equivalent.

Accepted accrediting bodies are The Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), Accreditation Association for Ambulatory Healthcare (AAAHC), Council on Accreditation of Services for Families and Children Inc. (COA), or National Integrated Accreditation of HealthCare Organizations (NIAHOSM). This includes any specialized licensing that may be applicable given the services to be provided or population to be served.

As they do not provide the level of care, security, or supervision appropriate of a **residential treatment center**, the following shall not be included in the definition of **residential treatment center**:

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

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

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.

Specialty Drug means **specialty drug** that are: used to treat complex medical conditions, and are typically given by injection, but may be topical or taken by mouth. They also often require careful adherence to treatment plans, may have special handling or storage requirements, and may not be stocked by retail pharmacies.

Specialty Pharmacy Program Provider means a **participating pharmacy** which has entered into a written agreement with us to provide **specialty drugs** to you.

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

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

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

- An ambulatory (day) surgery facility
- A freestanding radiation therapy center
- A freestanding birthing center

NOTICES

BlueCross BlueShield of Texas

Health care coverage is important for everyone.

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984. We provide free communication aids and services for anyone with a disability or who needs language assistance.

We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability. If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St., 35th Floor
Chicago, IL 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Complaint Forms: https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

	To receive language or communication assistance free of charge, please call us at 855-710-6984.
Español	Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo.
العربية	لتلقي المساعدة اللغوية أو التواصل مجانًا، يرجى الاتصال بنا على الرقم 855-710-6984.
繁體中文	如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。
Français	Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984.
Deutsch	Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an.
ગુજરાતી	ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કૉલ કરો.
हिंदी	निःशुल्क भाषा या संचार सहायता प्राप्त करने के लिए, कृपया हमें 855-710-6984 पर कॉल करें।
Italiano	Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984.
한국어	언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요.
Navajo	Niná: Doo bilagáana bizaad dinits'á'góó, shá ata' hodooni nínízingo, t'áájíík'eh bee náhaz'á. 1-866-560-4042 jį' hodíilni.
فارسی	برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید.
Polski	Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984.
Русский	Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984.
Tagalog	Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984.
اردو	مفت میں زبان یا مواصلت کی مدد موصول کرنے کے لیے، براہ کرم ہمیں 855-710-6984 پر کال کریں۔
Tiếng Việt	Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984.

YOUR RIGHTS WITH A PREFERRED PROVIDER BENEFIT PLAN (PPO)

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.

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, the Host Blue's Participating Provider is required to obtain prior authorization review. If prior authorization review is not obtained, the Participating Provider will be sanctioned based on the Host Blue's contractual agreement with the Provider, and the member will be held harmless for the Provider sanction.

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 the 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 preauthorized 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 BlueCard Worldwide 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.

NOTICE OF CERTAIN MANDATORY BENEFITS

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.

Inpatient Stay following Birth of a Child

For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her 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 female 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 or her 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 will have the option of receiving the care at her 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's or child's physician determines the inpatient care is medically necessary, or (b) the mother 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 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 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 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.

NOTICE OF CERTAIN MANDATORY BENEFITS

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.

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

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA). See your employer or Group Administrator should you have any questions about COBRA.

INTRODUCTION

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it**.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18–month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

PLAN CONTACT INFORMATION

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

Texas Department of Insurance Notice

- You have the right to an adequate network of preferred providers (also known as "network providers").
  - If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.
  - If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network deductible and out-of-pocket maximum.
- You have the right, in most cases, to obtain estimates in advance:
  - from out-of-network providers of what they will charge for their services; and
  - from your insurer of what it will pay for the services.
- You may obtain a current directory of preferred providers at the following website: www.bcbstx.com or by calling the Customer Service number on the back of your ID card for assistance in finding available preferred providers. If the directory is materially inaccurate, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.
- If you are treated by a provider or hospital that is not a preferred provider, you may be billed for anything not paid by the insurer.

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.	

bcbstx.com

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