Administered by:

BlueCross BlueShield of Texas

Your Health Care Benefits Program

Blue Premier SM Plan

Conroe Independent School District

Account #341642

Group #341643 – HMO Blue Premier Plan

September 1, 2022

A Message to Employees:

This Plan is offered by Your employer as one of the benefits of Your employment. The benefits provided are intended to assist You with many of Your health care expenses for Medically Necessary services and supplies. Coverage under this Plan is provided regardless of Your race, color, national origin, disability, age, sex, gender identity or sexual orientation. There are provisions throughout this Plan that affect Your health care coverage. It is important that You read the Plan carefully so You will be aware of the benefits and requirements of this Plan.

This Plan was designed to meet Your family's health care needs by providing access to a comprehensive network of Hospitals, Primary Care Physicians, Specialist, and other qualified Participating Providers while keeping Your cost for the coverage affordable.

The Claim Administrator for this Plan is Blue Cross and Blue Shield of Texas, a Division of Health Care services corporation (Claim Administrator). The Claim Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Please note: Capitalized words are defined terms and can be found in the **DEFINITIONS** section of this benefit booklet.

Read Your Benefit Booklet Carefully

Be sure to review the limitations and exclusions as well as the **COVERED SERVICES AND BENEFITS** portions of this benefit booklet.

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

Claim Administrator
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SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS

Blue Premier℠ Plan

The following chart summarizes the coverage available under Your Blue Premier Plan. For details, refer to **COVERED SERVICES AND BENEFITS**. All Covered Services (except in emergencies) must be provided by or through Your Participating Primary Care Physician/Practitioner, who may refer You for further treatment by Providers in the applicable network of Participating Specialists and Hospitals. Female Participants may visit a Participating OB/GYN Physician in their PCP's Provider network for diagnosis and treatment without a Referral from their PCP. Urgent Care, Virtual Visits and Retail Health Clinics do not require Primary Care Physician/Practitioner Referral.

IMPORTANT NOTE: Copayment and, if applicable, Co-Share shown below indicates the amount You are required to pay, are expressed as either a fixed dollar amount or a percentage of the Allowable Amount and will be applied for each occurrence unless otherwise indicated. Copayments/Deductibles and out-of-pocket maximums may be adjusted for various reasons as permitted by applicable law.

Out-of-Pocket Maximums Per Plan Year	
Per Individual Participant	$6,250
Per Family	$12,500
Deductible Per Plan Year	
Per Individual Participant	$1,200
Per Family	$3,000
Professional Services	
Primary Care Physician/Practitioner ("PCP") Office or Home Visit	$35 Copay
Participating Specialist Physician ("Specialist") Office or Home Visit	$50 Copay
Inpatient Hospital Services	
Inpatient Hospital Services, for each admission	20% Co-Share after Deductible
Outpatient Facility Services	
Outpatient Surgery	20% Co-Share after Deductible
Outpatient Hospital Based Infusion Therapy	20% Co-Share after Deductible
Radiation Therapy	20% Co-Share after Deductible
Dialysis	20% Co-Share after Deductible
Outpatient Laboratory and X-Ray Services	
Arteriograms, Computerized Tomography (CT Scan), Magnetic Resonance Imaging (MRI), Electroencephalogram (EEG), Myelogram, Positron Emission Tomography (PET Scan), per procedure	$100 Copay
Other X-Ray Services	No Co-Share
Outpatient Lab	No Co-Share
Presumptive and Definitive drug tests limited to 18 tests each per Plan Year	No Co–Share

SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS

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Rehabilitation Services*	
Rehabilitation Services and Therapies, per visit Limited to 60 visits per Plan Year combined for Physical Therapy, Speech Therapy and Occupational Therapy.	$35 Copay for PCP or $50 Copay for Specialist, 20% Co-Share after Deductible for Inpatient Hospital Services or
Chiropractic services, Limited to 20 visits maximum per Plan Year	$50 Copay for Outpatient Facility Services, as applicable. $50 Copay for Outpatient Professional Services, as applicable.
Maternity Care and Family Planning Services	
Maternity Care Prenatal and Postnatal Visit - Copay is applied to the first office visit only. Subsequent office visits are covered in full.	$35 Copay for PCP or $50 Copay for Specialist
Inpatient Hospital Services, for each admission	20% Co-Share after Deductible
Family Planning Services:	
• Diagnostic counseling, consultations and planning services • Insertion or removal of intrauterine device (IUD), including cost of device • Diaphragm or cervical cap fitting, including cost of device • Insertion or removal of birth control device implanted under the skin, including cost of device • Injectable contraceptive drugs, including cost of drug • Voluntary sterilization	$35 Copay for PCP or $50 Copay for Specialist; unless otherwise covered under Contraceptive Services described in **Health Maintenance and Preventive Services.**
• Vasectomy	$35 Copay for PCP or $50 Copay for Specialist or 20% Co-Share after Deductible for Outpatient Surgery, as applicable.
• Tubal Ligation	20% Co-Share after Deductible for Inpatient Hospital Services or 20% Co-Share after Deductible for Outpatient Surgery, as applicable.
Infertility Services	
• Diagnostic counseling, consultations, planning and treatment services	$35 Copay for PCP or $50 Copay for Specialist
Pregnancy Terminations, limited to Medically Necessary therapeutic terminations of pregnancy	$35 Copay for PCP or $50 Copay for Specialist, 20% Co-Share after Deductible for Inpatient Hospital Services or 20% Co-Share after Deductible for Outpatient Surgery, as applicable.

SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS

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Behavioral Health Services	
Outpatient Mental Health Care	$35 Copay
Inpatient Mental Health Care	20% Co–Share after Deductible
Serious Mental Illness	Benefits paid same as any other physical illness.
Chemical Dependency Services	Benefits paid same as any other physical illness.
Emergency Services	
Facility	$250 Copay, plus 20% Co-Share after Deductible, waived if admitted. (If admitted, any charges described in **Inpatient Hospital Services** will apply.)
Physician	20% Co-Share after Deductible
Urgent Care Services	
Urgent Care, per visit	$50 Copay Any additional charges as described in **Outpatient Laboratory and X-Ray Services** may also apply.
Retail Health Clinics	
Retail Health Clinics	$35 Copay
Telehealth and Telemedicine Services	
Telehealth and Telemedicine Medical Services	$35 Copay
Virtual Visits	
Virtual Visits	No Copay
Ambulance Services	
Ambulance Services, per service	20% Co-Share after Deductible
Extended Care Services	
Skilled Nursing Facility Services, for each day, up to 60 days per Plan Year	20% Co-Share after Deductible
Hospice Care, per visit	20% Co-Share after Deductible; unless otherwise covered under Inpatient Hospital Services.
Home Health Care, up to 120 visits per Plan Year	20% Co-Share after Deductible
Private Duty Nursing, up to 70 visits per Plan Year	20% Co-Share after Deductible
Health Maintenance and Preventive Services	
Well child care through age 17	No Copay
Periodic health assessments for Participants age 18 and older	No Copay

SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS

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Immunizations	
• Childhood immunizations required by law for Participants through age 6	No Copay
• Immunizations for Participants over age 6	No Copay
Bone mass measurement for osteoporosis	No Copay
Well-woman exam, once every 365 days from date of services, includes, but not limited to, exam for cervical cancer (Pap smear)	No Copay
Screening mammogram for female Participants age 35 and over and for female Participants with other risk factors, once every twelve months	No Copay
• Outpatient facility or imaging centers	No Copay
Contraceptive Services and Supplies	
• Contraceptive education, counseling and certain female FDA approved contraceptive methods, female sterilization procedures and devices	No Copay
Breastfeeding Support, Counseling and Supplies	No Copay
• Electric breast pumps limited to one (1) perbenefit period	
Hearing Loss	
• Screening test from birth through 30 days	No Copay
• Follow-up care from birth through 24 months	No Copay
Rectal screening for the detection of colorectal cancer for Participants age 45 and older:	
• Annual fecal occult blood test, once every twelve months	No Copay
• Flexible sigmoidoscopy with hemoccult of the stool, limited to 1 every 5 years	No Copay
• Colonoscopy, limited to 1 every 10 years	No Copay
Eye and ear screenings for Participants through age 17, once every twelve months	$35 Copay for PCP or $50 Copay for Specialist
Eye and ear screening for Participants age 18 and older, once every two years	$35 Copay for PCP or $50 Copay for Specialist
Early detection test for ovarian cancer (CA125 blood test), once every twelve months	$35 Copay for PCP or $50 Copay for Specialist
Exam for prostate cancer, once every twelve months	$35 Copay for PCP or $50 Copay for Specialist

SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS

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Dental Surgical Procedures	
Dental Surgical Procedures (limited Covered Services)	$35 Copay for PCP or $50 Copay for Specialist 20% Co-Share after Deductible for Inpatient Hospital Services or 20% Co-Share after Deductible for Outpatient Surgery, as applicable.
Cosmetic, Reconstructive or Plastic Surgery	
Cosmetic, Reconstructive or Plastic Surgery (limited Covered Services)	$35 Copay for PCP or $50 Copay for Specialist 20% Co-Share after Deductible for Inpatient Hospital Services or 20% Co-Share after Deductible for Outpatient Surgery, as applicable
Allergy Care	
Testing and Evaluation	$35 Copay for PCP or $50 Copay for Specialist
Injections	$35 Copay for PCP or $50 Copay for Specialist
Serum	$35 Copay for PCP or $50 Copay for Specialist
Diabetes Care	
Diabetes Self-Management Training, for each visit	$35 Copay for PCP or $50 Copay for Specialist
Diabetes Equipment	50% Co-Share after Deductible
Diabetes Supplies	50% Co-Share after Deductible
Prosthetic Appliances and Orthotic Devices	
Prosthetic Appliances and Orthotic Devices $1,000 maximum benefit for purchase of one (1) wig per 365 day period.	50% Co-Share after Deductible
Durable Medical Equipment	
Durable Medical Equipment	50% Co-Share after Deductible
Bariatric Surgery	
Bariatric Surgery	limited to $10,000 lifetime maximum
Hearing Services, Excluding hearing aids	
Speech and Hearing Services	Benefits paid same as any other physical illness

*__Benefits for Autism Spectrum Disorder(s) will not apply towards Rehabilitation Services and Therapies maximums.__

SCHEDULE OF COVERAGE

Plan Provisions Blue Distinction	Blue Distinction+ Designated Center	Blue Distinction Designated Center
Transplants	20% Co-Share after Deductible	20% Co-Share after Deductible
Travel and Lodging (for cancer, congenital heart disease and transplants)	No Charge (Limited to $10,000 lifetime maximum) (Lodging cannot be more than $50 per person per night. Meals are no longer included in lodging expenses)	
CAR-T (For more information, see Page 34)		20% Co-Share after Deductible
Gene Therapy (For more information, see Page 34)		20% Co-Share after Deductible

DEFINITIONS

Acquired Brain Injury means a neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

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

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

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and is not designed exclusively to test toxicity or disease pathophysiology. The trial must be:

A. conducted under an investigational new drug application reviewed by the United States Food and Drug Administration;
B. exempt from obtaining an investigational new drug application; or
C. approved or funded by:
    1. the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, or a cooperative group or center of any of the foregoing entities;
    2. a cooperative group or center of the United States Department of Defense or the United States Department of Veterans Affairs;
    3. a qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support groups; or
    4. the United States Departments of Veterans Affairs, Defense, or Energy if the study or investigation has been reviewed and approved through a system of peer review determined by the United States Secretary of Health and Human Services to:
        a. be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
        b. provide unbiased scientific review by individuals who have no interest in the outcome of the review.

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

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

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

- cytotoxicity testing (testing the result of food or inhalant by whether or not it reduces or kills white blood cells);
- urine auto injection (injecting one's own urine into the tissue of the body);
- skin irritation by Rinkel method;
- subcutaneous provocative and neutralization testing (injecting the patient with allergen); or
- sublingual provocative testing (droplets of allergenic extracts are placed in mouth).

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

Contract Month means the period of each succeeding month beginning on the administrative services agreement date.

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

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

Co-Share means the dollar amount or percentage of the Allowable Amount required to be paid by You or on Your behalf at the time of service to a Participating Provider in connection with Covered Services provided as described in **COVERED SERVICES AND BENEFITS**.

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

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

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

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

Deductible means the dollar amount required to be paid by You or on Your behalf to a Participating Provider before benefits are available in connection with Covered Services provided as described in **COVERED SERVICES AND BENEFITS**.

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

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

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

Effective Date of Coverage means the commencement date of coverage under this Plan as shown on the records of the Claim Administrator.

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

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

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

Experimental/Investigational means the use of any treatment, procedure, facility, equipment, drug, device or supply not accepted as Standard Medical Treatment of the condition being treated or any of such items requiring federal or other governmental agency Approval not granted at the time services were provided. "Approval" by a federal agency means that the treatment, procedure, facility, equipment, drug, device or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient. Approval by a federal agency will be taken into consideration by the Claim Administrator in assessing Experimental/Investigational status but will not be determinative. Medical treatment includes medical, surgical or dental treatment. "Standard Medical Treatment" means the services or supplies that are in general use in the medical community in the United States, and:

- have been demonstrated in peer-reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- are appropriate for the Hospital or Participating Provider; and
- the Health Care Professional has had the appropriate training and experience to provide the treatment or procedure.

The Claim Administrator shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational, and will consider factors such as the guidelines and practices of Medicare, Medicaid, or other government-financed programs and approval by a federal agency in making its determination.

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

Group means the employer or party that has entered into an administrative services agreement with the Claim Administrator under which the Claim Administrator will provide for or arrange health services for eligible Participants of the Group who enroll.

Group Health Plan (GHP) as applied to this benefit booklet means a self-funded employee welfare benefit plan as defined in subsection 160.103 of HIPAA. For additional information, refer to the definition of Plan Administrator.

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

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

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

Hospital means a duly licensed institution for the care of the sick which provides service under the care of a Physician including the regular provision of bedside nursing by registered nurses. It does not mean health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, custodial homes of the aged or similar institutions.

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

Identification Card means the card issued to the Employee by the Claim Administrator of the Plan indicating pertinent information applicable to his coverage.

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

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

Medical Director means a Physician of the Claim Administrator, or his designee, who is responsible for monitoring the provision of Covered Services to Participants.

Medically Necessary means services or supplies (except as limited or excluded herein) that are:

- essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, or bodily malfunction;
- provided in accordance with and consistent with generally accepted standards of medical practice in the United States;
- not primarily for Your convenience, or the convenience of Your Participating Provider; and
- the most economical supplies or levels of service appropriate for Your safe and effective treatment.

When applied to hospitalization, this further means that You require acute care as an inpatient due to the nature of the services rendered or Your condition, and You cannot receive safe or adequate care as an outpatient. In determining whether a service is Medically Necessary, the medical staff of the Claim Administrator may consider the views of the state and national medical communities and the guidelines and practices of Medicare, Medicaid, or other government-financed programs and peer reviewed literature. Although a Participating Provider may have prescribed treatment, such treatment may not be Medically Necessary within this definition. This definition applies only to the Claim Administrator's determination of whether health care services are Covered Services under this Plan.

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

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

1. The diagnosis or treatment of a mental disease, disorder, or condition listed in the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association*, as revised, or any other diagnostic coding system as used by the Claim Administrator or its designated behavioral health administrator, whether or not the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin;

2. The diagnosis or treatment of any symptom, condition, disease, or disorder by a Participating Provider when the Covered Service is:
    - individual, group, family, or conjoint psychotherapy,
    - counseling,
    - psychoanalysis,
    - psychological testing and assessment,
    - the administration or monitoring of psychotropic drugs, or
    - Hospital visits (if applicable) or consultations in a facility listed in **item 5**, below;
3. Electroconvulsive treatment;
4. Psychotropic drugs;
5. Any of the services listed in **items 1 - 4**, above, performed in or by a Hospital (if applicable), or other licensed facility or unit providing such care.

Mental Health Treatment Facility means a facility that:

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

Obstetrician/Gynecologist means a Participating Physician contracted by the Claim Administrator as an Obstetrician and/or Gynecologist who may be selected by a female to provide:

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

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

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

Participant means a Subscriber or Dependent(s) covered under this Plan. This Plan may refer to a Participant as You or Your.

Participating describes a Provider that has entered into a contractual agreement with the Claim Administrator for the provision of Covered Services to Participants.

Physician means a physician duly licensed to practice medicine in all of its branches.

Physician Assistant means a physician assistant licensed under Texas Occupations Code Chapter 204.

Plan Administrator means the Group Health Plan (GHP) or a named administrator of the Plan having fiduciary responsibility form its operation. The Claim Administrator is not the Plan Administrator.

Plan Year means the period beginning on the administrative services agreement Effective Date and ending on the day before the next administrative services agreement Effective Date. Please contact Your Employer for the Plan Year information.

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

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

Predetermination means an optional voluntary review of a Provider's recommended medical procedure, treatment or test, that does not require Prior Authorization, to make sure it meets approved HMO medical policy guidelines and Medical Necessity requirements.

Prior Authorization means a determination by the Claim Administrator that health care services proposed to be provided to a patient are Medically Necessary and appropriate.

Primary Care Physician/Practitioner or PCP means a Physician who is a Network Provider at the time Covered Services are rendered who is selected by or assigned to a Covered Person to coordinate and arrange for the Covered Person's medical care and who provides medical care within the scope of a license permitting him/her to legally practice medicine in the recognized areas of pediatrics, obstetrics and gynecology, internal medicine and family practice.

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

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

Provider means any Hospital, health care facility, laboratory, person or entity duly licensed to render Covered Services to a Covered Person or any other provider of medical or dental services, products or supplies which are Covered Services and/or the Independent Physician Association(s) that facilitate(s) provision of Covered Services to Covered Persons.

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

Referral means specific directions or instructions from Your PCP, in conformance with the Claim Administrator policies and procedures that direct You to a Participating Provider for Medically Necessary care.

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

Residential Treatment Center means a facility setting (including a Residential Treatment Center for Children and Adolescents) offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, wilderness programs, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities. Patients are medically monitored with 24 hour medical availability and 24 hour onsite nursing service for Mental Health Care and/or treatment of Substance Use Disorder. The Claim Administrator requires that any Mental Health Treatment Facility, Residential Treatment Center and/or Substance Use Disorder Treatment Center 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.

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

Retail Health Clinic means a Participating provider that has entered into a contractual agreement with the Claim Administrator to provide 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.

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

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

Routine patient care costs do not include:

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

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

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

Service Area means the geographical area served by the Claim Administrator and approved by state regulatory authorities. The Service Area includes the area shown and described in this Plan.

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

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

Subscriber means a person who meets all applicable eligibility and enrollment requirements of this Plan, and whose enrollment application and contributions have been received by the Claim Administrator.

Substance Use Disorder means the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance.

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

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral; or
2. Accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations; or
3. Licensed as a Substance Use Disorder treatment program by the Texas Commission on Alcohol and Drug Abuse; or

4. Licensed, certified, or approved as a Substance Use Disorder treatment program or center by any other state agency having legal authority to so license, certify, or approve.

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

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

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

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

Virtual Network Provider means a licensed Participating Provider that has entered into a contractual agreement with the Claim Administrator to provide diagnosis and treatment of injuries and illnesses through either (i) interactive audio communication (via telephone or other similar technology), or (ii) interactive audio/video examination and communication (via online portal, mobile application or similar technology).

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

You and Your means any Participant, including Subscriber and Dependents.

WHO GETS BENEFITS

Eligibility

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

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

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

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

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

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

   In addition, a Dependent shall include a child for whom Subscriber or Subscriber's spouse is a court-appointed legal guardian, provided proof of such guardianship is submitted with the prospective Dependent's enrollment application/change form; or
5. be a child of any age, as defined in **item 4** above, who is and continues to be incapable of sustaining employment by reason of mental retardation or physical handicap and is chiefly dependent upon Subscriber for economic support and maintenance. Subscriber must provide the Plan Administrator with a Dependent Child's Statement of Disability form, including a medical certification of disability, within thirty (30) days of the date of such medical certification and subsequently as may be required by the Plan Administrator, but not more often than once per year. The Plan Administrator's determination of eligibility shall be conclusive; or
6. have a court order for coverage to be provided for a spouse or minor child under Subscriber's Health Benefit Plan and a request for enrollment shall be made within thirty (30) days after issuance of the court order.

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

Loss of Eligibility. You must notify the Plan Administrator of any changes that will affect Your eligibility, or that of Your Dependents, for services or benefits under this Plan within thirty (30) days of the change.

Enrollment and Effective Date of Coverage

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

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

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

Other Enrollment Events. Coverage under this Plan for persons becoming eligible at times other than initial enrollment or the Group Open Enrollment Period will become effective as stated in **items 1-6** below, only if the Plan Administrator receives completed enrollment application/change form and applicable contributions timely. "Timely" means within thirty (30) days after the date of the event, unless otherwise specified and agreed upon by the Group and the Plan Administrator.

1. **Newly Eligible Employee.** Each new employee of Group who becomes eligible for coverage at a time other than the initial enrollment or Group Open Enrollment Period may enroll himself and eligible Dependents. If application is not made Timely, the newly eligible employee may not be added until the next Group Open Enrollment Period. The Effective Date of Coverage is the first day of the month following the date employee becomes eligible, unless otherwise specified and agreed upon by the Group and the Plan Administrator.

2. **Newly Eligible Dependents.** Subscriber may enroll any person who becomes newly eligible as a Dependent by completing and submitting to the Plan Administrator an enrollment application/change form within thirty (30) days after attaining eligibility. No proof of insurability shall be required. The Effective Date of Coverage will be the date of the event, i.e., marriage, birth, adoption, becoming a party in a suit for adoption or guardianship, unless otherwise specified and agreed upon by Group and the Plan Administrator. Newly eligible Dependents not added to coverage within thirty (30) days after the event will become effective in accordance with the provisions for late enrollees.

3. **Newborn Children Coverage.** Coverage will be automatic for Subscriber or Subscriber's spouse's newborn child for the first thirty (30) days following the date of birth. Coverage will continue beyond the thirty (30) days only if the child is an eligible Dependent and the Administrator through the Plan Administrator, receives all necessary forms and the required contributions within the 30-day period or a period consistent with the next billing cycle. The Effective Date of Coverage for newborn children shall be the newborn's date of birth.

4. **Newly Adopted Children**. Coverage will be automatic for a newly-adopted child of Subscriber for the first thirty (30) days after the date Subscriber is a party in a suit for adoption or thirty (30) days after the date the adoption is final. Coverage will continue beyond the thirty (30) days only if the child is an eligible Dependent and the Administrator through the Plan Administrator, receives all necessary forms and the required contributions within the 30-day period or a period consistent with the next billing cycle. The Effective Date of Coverage for newly-adopted children shall be the date You become a party in a suit for adoption or the date the adoption is final.

5. **Court-Ordered Dependents.** Dependent children for whom Subscriber has received a court order requiring Subscriber to provide health coverage will be covered for an initial period of thirty (30) days after the date Group receives notification of the court order. For coverage to continue beyond the thirty (30) days the Claim Administrator, through the Plan Administrator, must receive all necessary forms and the required contributions within the 30-day period or a period consistent with the next billing cycle. The Effective Date of Coverage for court-ordered Dependents will be the date the court order is received by Group.

   Coverage for a Dependent spouse for whom Subscriber has received a court order requiring You to provide health coverage will be effective on the first day of the month after the Plan Administrator receives the appropriate enrollment application/change form and applicable contributions, if the Plan Administrator receives such form and payments within thirty (30) days after issuance of the court order.

6. **Late Enrollees; Special Enrollment Events.** Eligible Subscribers or Dependents initially or newly eligible for enrollment who do not enroll within thirty (30) days after eligibility are late enrollees and may only be enrolled during a subsequent Group Open Enrollment Period. An eligible Subscriber or Dependent is not a late enrollee in the following situations:

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

      (1) **Marriage.** Subscriber may enroll Subscriber and Subscriber's spouse within thirty (30) days after the date of marriage. The Effective Date of Coverage is the first day of the month following the date of the event, unless otherwise specified and agreed upon by the Group and the Plan Administrator.

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

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

         (a) **Court-ordered child(ren):** A Subscriber may enroll himself, if not already covered, and such child(ren) subject to the court order. The Effective Date of Coverage is as of the date Group receives notice of the court order if the Plan Administrator receives enrollment application/change form(s) within thirty (30) days after the date Group receives a court order or notice of a court order, and You make or agree to make any additional contributions.
         (b) **Court-ordered spouse:** The Effective Date of Coverage is the first day of the month after the Plan Administrator receives enrollment application/change form, if the Plan Administrator receives application/change form within thirty (30) days after issuance of the court order and You make or agree to make any additional contributions, unless otherwise specified and agreed upon by Group and the Plan Administrator.

b. **Loss of Other Coverage.** Any individual eligible as a Subscriber or Dependent who did not enroll when initially eligible may enroll if each of the following is true, and if the Plan Administrator receives completed enrollment application/change forms and applicable contributions within thirty (30) days after the date coverage ends or after a claim is denied due to reaching the lifetime limit under another Health Benefit Plan, self-funded employer Health Benefit Plan, or other health insurance coverage (collectively referred to in this subsection as "Prior Health Benefit Plan"):

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

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

(3) You or any eligible Dependent lost coverage under a Prior Health Benefit Plan as a result of:

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

The Effective Date of Coverage under this subsection is the first day of the month on or following receipt of the application by the Claim Administrator through the Plan Administrator..

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

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

Provider Information

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

Only services that are performed, prescribed, directed or authorized in advance by the PCP or the Claim Administrator are covered benefits under this Plan except Emergency Care, Urgent Care, Virtual Visits, Retail Health Clinics or Covered Services provided to female Participants, who may directly access an Obstetrician/Gynecologist for: 1) well–woman exams; 2) obstetrical care; 3) care for all active gynecological conditions; and 4) diagnosis, treatment, and Referral for any disease or condition within the scope of the professional practice of the Obstetrician/Gynecologist.

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

Coverage Determinations

Certain services are covered pursuant to HMO medical policies and clinical procedure and coding policies, which are updated throughout the Calendar Year. The medical policies are guides considered by HMO when making coverage determinations and lay out the procedure and criteria to determine whether a procedure, treatment, facility, equipment, drug or device is Medically Necessary and is eligible as a Covered Service or is Experimental/Investigational, cosmetic, or a convenience item. The clinical procedure and coding policies provide information about what services are reimbursable under the Certificate of Coverage. The most up-to-date medical and clinical procedure and coding policies are available at www.bcbstx.com, or call customer service at the toll-free telephone number on the back of Your Identification Card.

Utilization Management

Utilization Management may be referred to as Medical Necessity reviews, utilization review (UR), or medical management reviews. Requirements for Medical Necessity may vary based upon Your plan benefits. Medically Necessary reviews may occur when a Provider requests a Prior Authorization before services are rendered. However, some services may require a Post-Service Medical Necessity Review if indicated by a medical policy.

Types of Utilization Management:

- Prior Authorization (includes out-of-network Referrals);
- Predetermination;
- Post-Service Medical Necessity Reviews.

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

Prior Authorization

Some Covered Services may also require Prior Authorization by HMO. Prior Authorization processes will be conducted in accordance with Texas Insurance Code, chapter 4201 or in accordance with the laws in the state of Texas. Renewal of an existing Prior Authorization issued by HMO can be requested by a Physician or Health Care Provider up to 60 days prior to the expiration of the existing Prior Authorization. For additional information and a current list of medical and health care services that require Prior Authorization, please visit the website at www.bcbstx.com.

Predetermination Review

Predetermination is an optional Medical Necessity review by HMO of a medical procedure, treatment or test, that has been recommended by Your Physician in order to determine if it meets approved Blue Cross and Blue Shield medical policy guidelines. A Predetermination review is not the same as Prior Authorization. Prior Authorization is a required process for the Provider to get approval from HMO before You are admitted to the Hospital or for certain types of Covered Services. A Predetermination review can help You avoid unexpected out-of-pocket costs by determining ahead of time if a recommended service will be covered by Your health care plan. If a service requires Prior Authorization, a Predetermination review is not available.

Predetermination review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions under this benefit booklet. Please coordinate with Your Provider to submit a request for Predetermination.

Below are some examples (not an exhaustive list) of some common services for which a Predetermination review is recommended:

- certain higher cost Durable Medical Equipment;
- surgeries that might be considered cosmetic; and
- services and supplies that may be Experimental/Investigational under certain circumstances.

General Provisions Applicable to All Predeterminations

1. **No Guarantee of Payment**

   A Predetermination is not a guarantee of benefits or payment of benefits by HMO. Actual availability of benefits is subject to Your eligibility and the other terms, conditions, limitations, and exclusions of this Certificate. Even if the service has been approved on Predetermination, coverage or payment can be affected for a variety of reasons. For example, the Member may have become ineligible as of the date of service or the Member's benefits may have changed as of the date of service.

2. **Request for Additional Information**

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

Post-Service Medical Necessity Review

A Post-Service Medical Necessity Review or Post-Service Claims request is the process of determining coverage after treatment has been provided and is based on Medical Necessity guidelines. A Post-Service Medical Necessity Review confirms Your eligibility, availability of benefits at the time of service, and reviews necessary clinical documentation to ensure service was Medically Necessary. A Post-Service Medical Necessity Review may be available when a Prior Authorization was not required but a Medical Necessity review was required due to medical policy.

General Provisions Applicable to All Post-Service Medical Necessity Reviews

1. **No Guarantee of Payment**

   A Post-Service Medical Necessity Review is not a guarantee of payment. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of HMO. Post-Service Medical Necessity Review does not guarantee payment of benefits by HMO, for instance You may become ineligible as of the date of service or Your benefits may have changed as of the date of service.

2. Request for Additional Information

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

Selecting a PCP

At the time You enroll, You must choose a PCP. If any Participant is a minor or otherwise incapable of selecting a PCP, the Subscriber should select a PCP on the Participant's behalf. If Your Dependents enroll, You and Your Dependents must choose a PCP from HMO's directory of Participating Providers in order to receive Covered Services. For the most current list of Participating Providers visit the website at www.bcbstx.com. You may also refer to Your Provider directory or call customer service at the toll-free telephone number on the back of Your Identification Card. The Claim Administrator may assign a PCP if one has not been selected. Until a PCP is selected or assigned, benefits will be limited to coverage for Emergency Care.

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

Your PCP

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

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

Changing Your PCP

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

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

Continuity of Care

If You are under the care of a Participating Provider who stops participating in HMO's network, the Claim Administrator will continue coverage for that Provider's Covered Services if all the following conditions are met:

- You have a disability, acute condition, Life-Threatening illness or are past the thirteenth (13th) week of pregnancy; and
- the Provider submits a written request to the Claim Administrator to continue coverage of Your care that identifies the condition for which You are being treated and indicates that the Provider reasonably believes that discontinuing treatment could cause You harm; and
- the Provider agrees to continue accepting the same reimbursement that applied when participating in HMO's network, and not to seek payment from You for any amounts for which You would not be responsible if the Provider were still participating in HMO's network.

Continuity coverage shall not extend for more than ninety (90) days (or more than nine (9) months if You have been diagnosed with a terminal illness) beyond the date the Provider's termination takes effect. If You are past the thirteenth (13th) week of pregnancy when the Provider's termination takes effect, coverage may be extended through delivery, immediate postpartum care and the follow-up check-up within the first six (6) weeks of delivery.

Specialist as PCP

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

Availability of Providers

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

Out-of-Network Services

You may obtain Covered Services from Providers who are not part of HMO's network of Participating Providers when receiving Emergency Care.

If Inpatient Hospital Services are required after receiving Emergency Care and post stabilization care at a non-Participating Hospital, You must notify HMO within forty-eight (48) hours of receiving Emergency Care, or as soon as possible without being medically harmful or injurious to You. HMO will review the Medical Necessity and Participating Provider availability of the Inpatient Hospital Services. If HMO determines the Inpatient Hospital Services are not Medically Necessary or are available from a Participating Provider, or if You do not notify HMO within forty-eight (48) hours, benefits at the non-Participating Hospital will not be covered.

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

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

- The request must be from a Participating Provider.
- Reasonably requested documentation must be received by the Claim Administrator.
- The Referral will be provided within an appropriate time, not to exceed five (5) business days, based on the circumstances and Your condition.
- When the Claim Administrator has allowed Referral to a non-Participating Provider, the Claim Administrator will reimburse the non-Participating Provider at the usual and customary rate or otherwise agreed rate, less the applicable Copayment(s). You are responsible only for the Copayments for such Covered Services.
- Before the Claim Administrator denies a Referral, a review will be conducted by a Specialist of the same or similar specialty as the type of Provider to whom a Referral is requested.

Inpatient Care by Non-PCP

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

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

Provider Communication

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

Your Responsibilities

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

Identification Card

Cards issued by the Claim Administrator to Participants under this Plan are for identification only. The Identification Card confers no right to services or other benefits under this Plan. To be entitled to any services or benefits, the holder of the Identification Card must be a Participant on whose behalf all applicable Premiums under this Plan have actually been paid.

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

- **Your Participant identification number**. This unique identification number is preceded by a three-character alpha prefix that identifies Blue Cross and Blue Shield of Texas as Your Claim Administrator.
- Any Copayment that may apply to Your coverage.
- Important telephone numbers.

Always remember to carry Your Identification Card with You and present it to Your Providers when receiving health care services or supplies.

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

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

1. The unauthorized, fraudulent, improper, or abusive use of Identification Cards issued to You and Your covered Dependents will include, but not be limited to, the following actions, when intentional:
    a. Use of the Identification Card prior to Your Effective Date of Coverage;
    b. Use of the Identification Card after Your date of termination of coverage under the Plan;
    c. Obtaining prescription drugs or other benefits for persons not covered under the Plan;
    d. Obtaining prescription drugs or other benefits that are not covered under the Plan;
2. The fraudulent or intentionally unauthorized, abusive, or other improper use of Identification Cards by any Participant can result in, but is not limited to, the following sanctions being applied to all Participants covered under Your coverage:
    a. Denial of benefits;
    b. Cancellation of coverage under the Plan;
    c. Recoupment from You or any of Your covered Dependents of any benefit payments made;
    d. Pre-approval of medical services for all Participants receiving benefits under Your coverage;
    e. Notice to proper authorities of potential violations of law or professional ethics.

Participant Claims Refund

You are not expected to make payments, other than required Copayments/Co-Share, for any benefits provided hereunder. However, if You make such payments, You may send the Claim Administrator a claim for reimbursement, and when a refund is in order, the Provider shall make such refund to You. Your claim will be allowed only if You notify the Claim Administrator within ninety (90) days from the date on which covered expenses were first incurred, unless it can be shown that it was not reasonably possible to give notice within the time limit, and that notice was given as soon as reasonably possible. However, benefits will not be allowed if notice of claim is made beyond one (1) year from the date covered expenses were incurred. You must provide written proof of such payment to the Claim Administrator within one (1) year of occurrence. Within fifteen (15) days of receipt of written notice of a claim, the Claim Administrator shall acknowledge receipt of claim and begin any necessary investigation. It may be necessary for the Claim Administrator to request additional information from You. Claims shall be acted upon within fifteen (15) business days of receipt of a completed claim unless You are notified that additional time is needed and why. The Claim Administrator will act on a completed claim no later than forty-five (45) days after the additional time notification is given to You. If the Claim Administrator notifies You that the Claim Administrator will pay a claim or part of a claim, the Claim Administrator will pay an approved claim not later than five (5) business days after the date notice is made. Visit the website at www.bcbstx.com or call customer service at the toll-free number on the back of Your Identification Card to obtain a medical claim form.

Claim or Benefit Reconsideration

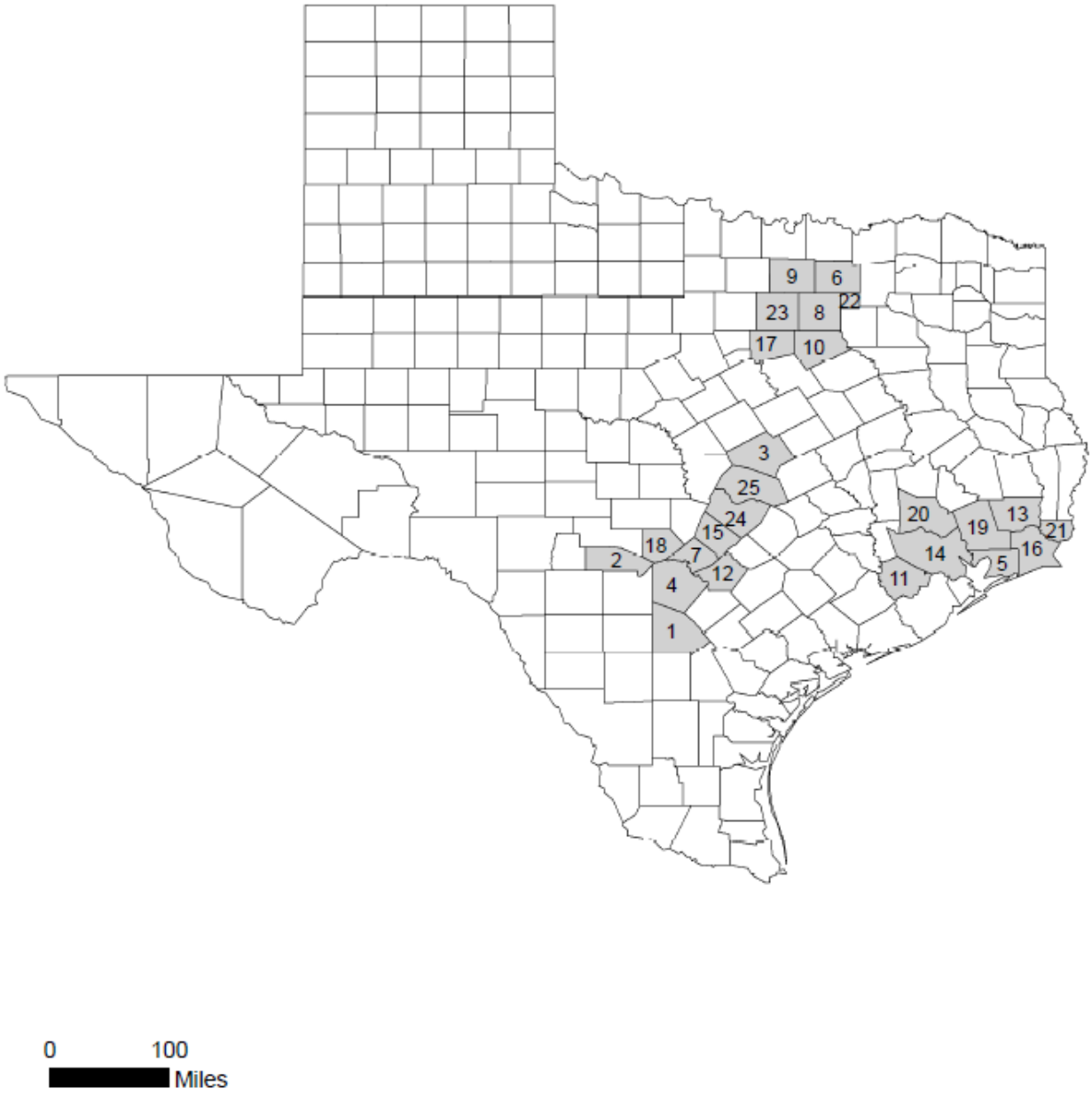
If a claim or a request for benefits is partly or completely denied by the Claim Administrator, You will receive a written explanation of the reason for the denial and be entitled to a full review. If You wish to request a review or have questions regarding the explanation of benefits, call or write customer service at the phone number or address on the back of Your Identification Card. If You are not satisfied with the information received either on the call or in written correspondence, You may request an appeal of the decision. You may obtain a review of the denial by following the process set out in **Claim Review and Appeal Procedures**.

Service Area

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

SERVICE AREA

Service Area. The Service Area covered by this Plan includes the counties shaded on the map below and as listed by county number on the following page.



County#	Name
1	Atascosa
2	Bandera
3	Bell
4	Bexar
5	Chambers
6	Collin
7	Comal
8	Dallas
9	Denton
10	Ellis
11	Fort Bend
12	Guadalupe
13	Hardin
14	Harris
15	Hays
16	Jefferson
17	Johnson
18	Kendall
19	Liberty
20	Montgomery
21	Orange
22	Rockwall
23	Tarrant
24	Travis
25	Williamson

Receipt of Claims by the Claim Administrator

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

After processing the claim, the Claim Administrator will notify the Participant by way of an *Explanation of Benefits* summary.

Claim Determinations

When the Claim Administrator receives a properly submitted claim, it has authority and discretion under the Plan to interpret and determine benefits in accordance with the Health Benefit Plan provisions. The Claim Administrator will receive and review claims for benefits and will accurately process claims consistent with administrative practices and procedures established in writing between the Claim Administrator and the Plan Administrator.

You have the right to seek and obtain a full and fair review by the Claim Administrator of any determination of a claim, any determination of a request for Prior Authorization, or any other determination made by the Claim Administrator in accordance with the benefits and procedures detailed in Your Health Benefit Plan.

If a Claim Is Denied or Not paid in Full

On occasion, the Claim Administrator may deny all or part of Your claim. There are a number of reasons why this may happen. We suggest that You first read the *Explanation of Benefits* summary prepared by the Claim Administrator; then review this benefit booklet to see whether You understand the reason for the determination. If You have additional information that You believe could change the decision, send it to the Claim Administrator and request a review of the decision as described as in **Claim Appeal Procedures** below.

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

The reason for determination;

- A reference to the Health Benefit Plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;
- A description of additional information which may be necessary to perfect the claim and an explanation of why such material is necessary;
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care Provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- In certain situations, a statement in non-English languages(s) that written notices of claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
- In certain situations, a statement in non-English languages(s) that indicates how to access the language services provides by the Claim Administrator;
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
- Any internal rule, guideline, protocol or other similar criterion on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge upon request;

- An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
- In the case of a denial of an Urgent Care Clinical Claim, a description of the expedited review procedure applicable to such claims. An Urgent Care Clinical Claim decision may be provided orally, so long as a written notice is furnished to the claimant three days of oral notification;
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

Timing of Required Notices and Extensions

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

1. **Urgent Care Clinical Claim** is any Pre-Service Claim that requires Prior Authorization, as described in this benefit booklet, for benefits for medical care or Treatment with respect to which the application of regular time periods for making health Claim decisions could seriously jeopardize the life of health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or Treatment.
2. **Pre-Service Claim** is any non-urgent request for benefits or a determination with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.
3. **Post-Service Claim** is notification in a form acceptable to the Claim Administrator that a service has been rendered or furnished to You. This notification must include full details of the service received, including Your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim charge, and any other information which the Claim Administrator may request in connection with services rendered to You.

Urgent Care Clinical Claims*

Type of Notice or Extension	Effective Date of Termination
If Your Claim is incomplete, the Claim Administrator must notify You within:	**24 hours**
If You are notified that Your Claim is incomplete, You must then provide completed Claim information to the Claim Administrator within:	**48 hours after receiving notice**
The Claim Administrator must notify You of the Claim determination (whether adverse or not):	
if the initial Claim is complete as soon as possible (taking into account medical exigencies), but no later than:	**72 hours**
after receiving the completed Claim (if the initial Claim is incomplete), within:	**48 hours**

* You do not need to submit Urgent Care Clinical Claims in writing. You should call the Claim Administrator at the toll-free number listed on the back of Your Identification Card as soon as possible to submit an Urgent Care Clinical Claim.

Pre-Service Claims

Type of Notice or Extension	Timing
If Your Claim is filed improperly, the Claim Administrator must notify You within:	**5 days**
If Your Claim is incomplete, the Claim Administrator must notify You within:	**15 days**
If You are notified that Your Claim is incomplete, You must then provide completed Claim information to the Claim Administrator within:	**45 days after receiving notice**
The Claim Administrator must notify You of any adverse Claim determination:	
if the initial Claim is complete, within:	**15 days***
if the initial Claim is incomplete, within:	**30 days****
If You require post-stabilization care after an Emergency within:	**the time appropriate to the circumstance not to exceed one hour after the time of request**

***** This period may be extended one time by the Claim Administrator for up to 15 days, provided that the Claim Administrator both (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies You, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claim Administrator expects to render a decision.

****** If additional information is necessary to decide the claim, the time period for making the decision is suspended from the day You are notified to the earlier of: (1) the date on which Your response is received by the Claim Administrator; or (2) the date established by the Claim Administrator for the furnishing of the requested information (at least 45 days). The number of days shown above includes a 15-day extension.

Post-Service Claims

Type of Notice or Extension	Timing
If Your Claim is incomplete, the Claim Administrator must notify You within:	**30 days**
If You are notified that Your Claim is incomplete, You must then provide completed Claim information to the Claim Administrator within:	**45 days after receiving notice**
The Claim Administrator must notify You of the Claim determination (whether adverse or not):	
if the initial Claim is complete, within:	**30 days***
if the initial Claim is incomplete, within:	**45 days****

***** This period may be extended one time by the Claim Administrator for up to 15 days, provided that the Claim Administrator both (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies You in writing, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Claim Administrator expects to render a decision.

****** If additional information is necessary to decide the claim, the time period for making the decision is suspended from the day You are notified to the earlier of: (1) the date on which Your response is received by the Claim Administrator; or (2) the date established by the Claim Administrator for the furnishing of the requested information (at least 45 days). The number of days shown above includes a 15-day extension.

Concurrent Care

For benefit determinations relating to care that is being received at the same time as the determination, such notice will be provided no later than 24 hours after receipt of Your Claim for benefits.

Claim Appeal Procedures

Claim Appeal Procedures - Definitions

An "**Adverse Benefit Determination**" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide in response to a claim, Pre-Service Claim or Urgent Care Clinical Claims, or make payment for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate. If an ongoing course of treatment had been approved by the Claim Administrator and the Claim Administrator reduces or terminates such treatment (other than by amendment or termination of the employer's benefit Plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A Rescission of coverage is also an Adverse Benefit Determination.

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

Expedited Clinical Appeals

If Your situation meets the definition of an expedited clinical appeal, You may be entitled to an appeal on an expedited basis. An **expedited clinical appeal** is an appeal of a clinically urgent nature related to health care services, including but not limited to, ongoing emergencies, procedures or treatments ordered by a health care Provider, as well as continued hospitalization. Before authorization of benefits for an ongoing course of treatment/continued hospitalization is terminated or reduced, the Claim Administrator will provide You with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an expedited pre-service or concurrent clinical appeal, the Claim Administrator will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. The Claim Administrator shall render a determination on the appeal within 24 hours after it receives the requested information, but no later than 72 hours after the appeal has been received by the Claim Administrator.

How to Appeal an Adverse Benefit Determination

You have the right to seek and obtain a full and fair internal review of any determination of a claim, any determination of a request for Prior Authorization, or any other determination made by the Claim Administrator in accordance with the benefits and procedures detailed in Your Health Benefit Plan.

An appeal of an Adverse Benefit Determination may be filed by You or a person authorized to act on Your behalf. In Urgent Care Clinical Claim situations, a health care Provider may appeal on Your behalf. With the exception of Urgent Care Clinical Claim situations, Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about You except to Your authorized representative. To obtain an Authorized Representative Form, You or Your representative may call the Claim Administrator at the number on the back of Your Identification Card.

If You believe the Claim Administrator incorrectly denied all or part of Your benefits, You may have Your claim reviewed. The Claim Administrator will review its decision in accordance with the following procedure:

- Within 180 days after You receive notice of a denial or partial denial, You may call or write to the Claim Administrator's Administrative Office. The Claim Administrator will need to know the reasons why You do not agree with the denial or partial denial. Send Your request to:

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

- The Claim Administrator will honor telephone requests for information. However, such inquiries will not constitute a request for review.
- In support of Your claim review, You have the option of presenting evidence and testimony to the Claim Administrator. You and Your authorized representative may ask to review Your file and any relevant documents and may submit written issues, comments and additional medical information during the internal review process.

  The Claim Administrator will provide You or Your authorized representative with any new or additional evidence or rationale and any other information and documents used in the internal review of Your claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale will be provided to You or Your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give You a chance to respond before the final determination is made. If the information is received so late that it would be impossible to provide it to You in time for You to have a reasonable opportunity to respond, the time periods below for providing notice of Final Internal Adverse Benefit Determination will be tolled until such time as You have had a reasonable opportunity to respond. After You respond, or have had a reasonable opportunity to respond but failed to do so, the Claim Administrator will notify You of the benefit determination in a reasonably prompt time taking into account the medical exigencies.

  The appeal determination will be made by the Claim Administrator or, if required by a Physician associated or contracted with the Claim Administrator and/or by external advisors, but who were not involved in making the initial denial of Your claim. Before You or Your authorized representative may bring any action to recover benefits, You must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by the Claim Administrator and, if applicable Your employer.

  If You have any questions about the claims procedures or the review procedure, write to the Claim Administrator's Administrative Office or call the toll-free Customer Service Helpline number shown in this benefit booklet or Your Identification Card.

Timing of Appeal Determinations

Upon receipt of a non-urgent pre-service appeal, the Claim Administrator shall render a determination of the appeal as soon as practical, but in no event more than 30 days after the appeal has been received by the Claim Administrator.

Upon receipt of a non-urgent post-service appeal, the Claim Administrator shall render a determination of the appeal as soon as practical, but in no event more than 60 days after the appeal has been received by the Claim Administrator.

Notice of Appeal Determination

The Claim Administrator will notify the party filing the appeal, You, and, if a clinical appeal, any health care Provider who recommended the services involved in the appeal, by a written notice of the determination.

The written notice to You or Your authorized representative will include:

1. A reason for the determination;
2. A reference to the benefit Plan provisions on which the determination is based, and the contractual, administrative or protocol for the determination;
3. Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care Provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Diagnosis/treatment codes with their meanings and the standards used are also available upon request;
4. In certain situations, a statement in non-English language(s) that written notice of claim denials and certain other benefit information may be available (upon request) in such non-English language(s);

5. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;
6. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
7. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
8. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
9. A description of the standard that was used in denying the claim and discussion of the decision;
10. Contact information for applicable office of health insurance consumer assistance or ombudsman.

If the Claim Administrator's decision is to continue to deny or partially deny Your claim or You do not receive timely decision, You may be able to request an external review of Your claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the **Standard External Review** section below.

If You Need Assistance

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

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

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

Standard External Review

You or Your authorized representative (as described above) may make a request for a standard external review or expedited external review of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination by an Independent Review Organization (IRO).

1. **Request for external review.** Within four (4) months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse benefit from the Claim Administrator, You or Your authorized representative must file Your request for standard external review.
2. **Preliminary review.** Within five (5) business days following the date of receipt of the external review request, the Claim Administrator must complete a preliminary review of the request to determine whether:
    a. You are, or were, covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
    b. The Adverse Benefit Determination or the Final Adverse Internal Benefit Determination does not relate to Your failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determinations);
    c. You have exhausted the Claim Administrator's internal appeal process unless You are not required to exhaust the internal appeals process under the interim final regulations. Please read the **Exhaustion** section below for additional information and exhaustion of the internal process; and
    d. You or Your authorized representative have provided all the information and forms required to process an external review.

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

External review is available for Adverse Benefit Determinations and Final Adverse Benefit Determinations that involve rescission and determinations that involve medical judgment including, but not limited to, those based on requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; determinations that a treatment is experimental or investigational; determinations whether You are entitled to a reasonable alternative standard for a reward under a wellness program; or a determination of compliance with the nonquantitive treatment limitation provisions of the Mental Health Parity and Addiction Equity Act.

3. **Referral to Independent Review Organization (IRO).** When an eligible request for external review is completed within the time period allowed, the Claim Administrator will assign the matter to an IRO. The IRO assigned will be accredited by URAC or similar nationally-recognized accrediting organization. Moreover, the Claim Administrator will ensure that the IRO is unbiased and independent. Accordingly, the Claim administrator must contract with at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent, unbiased methods of selection of IRO's, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The IRO must provide the following:

a. Utilization of legal experts where appropriate to make coverage to make coverage determinations under the Plan.

b. Timely notification to You or Your authorized representative, in writing, of request's eligibility and acceptance for external review. This notice will include a statement that You may submit in writing to the assigned IRO within 10 business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

c. Within five business days after the date of assignment of the IRO, the Claim Administrator must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Claim Administrator to timely provide the documents and information must not delay the conduct of the external review. If the Claim Administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit determination or Final Internal Adverse Benefit Determination. Within one business day after making the decision, the IRO must notify the Claim Administrator and You or Your authorized representative.

d. Upon receipt of any information submitted by You or Your authorized representative, the assigned IRO must within one business day forward the information to the Claim Administrator. Upon receipt of any such information, the Claim Administrator may reconsider the Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by the Claim Administrator must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Claim Administrator decided, upon completion of its reconsideration, to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within one business day after making such a decision, the Claim Administrator must provide written notice of its decision, the Claim Administrator must provide written notice of its decision to You and the assigned IRO. The assigned IRO must terminate the external review upon receipt of notice from the Claim Administrator.

e. Review all the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process. In addition to the documents and

information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- Your medical records;
- The attending Health Care Professional's recommendation;
- Reports from appropriate Health Care Professionals and other documents submitted by the Claim Administrator, You or Your treating provider;
- The terms of Your Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used by the Claim Administrator, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
- The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

f. Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the Claim Administrator and You or Your authorized representative.

g. The notice of final external review decision will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the Health Care Provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
- The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason or reasons for its decisions, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Claim Administrator or You or Your authorized representative;
- A statement that judicial review may be available to You or Your authorized representative; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

h. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claim Administrator, State or Federal oversight agency upon request, except where such disclosure would violate State of Federal privacy laws, and You or Your authorized representative.

4. **Reversal of Plan's decision.** Upon receipt of a notice of a final review decision, reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Claim Administrator must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

1. **Request for expedited external review.** You may request an expedited external review with the Claim Administrator at the time You receive:

   a. An Adverse Benefit Determination, if the Adverse Benefit Determination involved a medical condition of Yours for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function and You have filed a request for an expedited internal appeal; or

   b. A Final Internal Adverse Benefit Determination, if the determination involved a medical condition of Yours for which the timeframe for completion of a standard external review would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which You received emergency services, but have not been discharged from a facility.

2. **Preliminary review.** Immediately upon receipt of the request for expedited external review, the Claim Administrator must determine whether the request meets the reviewability requirements set forth in the **Standard External Review** section above. The Claim Administrator must immediately send You a notice of its eligibility determination that meets the requirements set forth in the **Standard External Review** section above.

3. **Referral to Independent Review Organization (IRO).** Upon a determination that a request is eligible for external review following the preliminary review, the Claim Administrator will assign an IRO pursuant to the requirements set forth in the **Standard External Review** section above. The Claim Administrator must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

   The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process.

4. **Notice of final external review decision.** The IRO will provide notice of the final external review decision, in accordance with the requirements set forth in the **Standard External Review** section above, as expeditiously as Your medical condition or circumstances require, but in no event no more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing verbal notice, the assigned IRO must provide written confirmation of the decision to the Claim Administrator and You or Your authorized representative.

Exhaustion

For standard internal review, You have the right to request external review once the internal review process has been completed and You have received the Final Internal Adverse Benefit Determination. For expedited internal review, You may request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not Your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if the Claim Administrator waives the internal review process or the Claim Administrator has failed to comply with the internal claims and appeals process.

The internal review process will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to You so long as the Claim Administrator demonstrates that the violation was for good cause or due to matters beyond the control of the Claim Administrator and that the violation occurred in the context of an ongoing, good faith exchange of information between You and the Claim Administrator.

External review may not be requested for an Adverse Benefit Determination involving a claim for benefits for a health care service that You have already received until the internal review process has been exhausted.

Interpretation of Employer's Plan Provisions

The Plan Administrator has given the Claim Administrator the initial authority to establish or construe the terms and conditions of the Health Benefit Plan and the discretion to interpret and determine benefits in accordance with the Health Benefit Plan's provisions.

The Plan Administrator has all powers and authority necessary or appropriate to control and manage the operation and administration of the Health Benefit Plan.

All powers to be exercised by the Claim Administrator or the Plan Administrator shall be exercised in a non-discriminatory manner and shall be applied uniformly to assure similar treatment to persons in similar circumstances.

Copayments/Co-Share

You are liable for certain Copayments/Co-Share and any Deductibles to Participating Providers, which are due at the time of service. The Copayment/Co-Share and any Deductibles due for specific Covered Services, benefit limitations and out-of-pocket maximums can be found in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**.

Deductibles

Benefits are available for Covered Services under this Plan after satisfaction of any applicable Deductibles indicated in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS.**

If You have several covered Dependents, all charges used to apply toward an individual Deductible amount will be applied towards the family Deductible amount shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS.** When the family Deductible amount is reached, no further individual Deductibles will have to be satisfied for the remainder of that Plan Year.

Out-of-Pocket Maximums

The Claim Administrator will determine when maximums have been reached for Covered Services based on information provided to the Claim Administrator by You and Participating Providers to whom You have made payments for Covered Services. Out-of-pocket maximums will include Copayments, Co-Share and any Deductibles. Once You reach the maximum, You are not required to make additional payments for Covered Services for the remainder of the Plan Year.

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

Requirements

All Covered Services, unless otherwise specifically described:

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

Professional Services

Services must be provided or arranged by the PCP and rendered by a licensed Physician. The Claim Administrator may allow other health Providers to provide Covered Services that may be provided under applicable state law by such Providers. Certain services may be restricted in **LIMITATIONS AND EXCLUSIONS.**

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

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

Inpatient Hospital Services

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

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

    a. Services, including donor expenses, for the following organ and tissue transplants are covered: kidney; corneal; liver; bone marrow; kidney-pancreas; heart; lung; heart-lung (heart and one lung or heart and both lungs); and peripheral stem cell transplants, but only if all the following conditions are met:

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

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

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

        (1) a recipient who is a Participant covered under this Plan;

(2) a donor who is a Participant covered under this Plan; or
(3) a donor who is not a Participant covered under this Plan.

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

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

d. No benefits are available for a Participant for the following services and supplies:
(6) expenses related to maintenance of life of a donor for purposes of organ or tissue donation;
(7) purchase of the organ or tissue other than payment for Covered Services and supplies identified above; and
(8) organ or tissue (xenograft) obtained from another species.

Blue Distinction® and Blue Distinction Specialty Care Program

Blue Distinction® ("Blue Distinction") is a national designation awarded by Blue Cross and Blue Shield Plans to health care Providers. The Blue Distinction Specialty Care program includes two levels of designation: Blue Distinction Centers (BDC) and Blue Distinction Centers+ (BDC+). The Blue Distinction Specialty Care program focuses on BDC and BDC+ providers that excel in providing safe, effective treatment for specialty care needs.

Blue Distinction Centers

The Blue Distinction designation uses nationally consistent criteria to designate high-performing providers based on objective, evidence-based selection criteria. The Blue Distinction Specialty Care program's purpose is to assist you in finding BDC and BDC+ providers that have met overall quality measures for patient safety and outcomes, fewer medical complications, lower readmission rates, and higher survival rates in the administration of specialty care.

Blue Distinction Centers provide care in the following specialty care areas:

- Cardiac Care
- Cellular Immunotherapy (CAR-T)
- Fertility Care*
- Substance Use Treatment and Recovery
- Gene Therapy
- Spine Surgery
- Bariatric Surgery
- Knee and Hip Replacement Surgery
- Maternity Care
- Transplants

* BDC and BDC+ Fertility Care programs are currently supported by plans with Fertility Care programs at the professional level.

Mandatory Blue Distinction Centers and Blue Distinction Centers+ Specialty Care Product

The Mandatory BDC and BDC+ Specialty Care product requires you to obtain Transplants, services at a Blue Distinction Center and/or Blue Distinction Center+ in order to obtain maximum benefits. If you choose to utilize a Non-Blue Distinction Center and/or Non-Blue Distinction Center+ you will be responsible for 100% of costs associated with any specialty care received at such facility.

For additional information regarding Blue Distinction Centers for specialty care, please contact a Customer Service Representative at the toll-free telephone number shown on your Identification Card or visit the following website: www.bcbs.com/why-bcbs/blue-distinction.

Outpatient Facility Services

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

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

Outpatient Laboratory and X-Ray Services

Laboratory and radiographic procedures, services and materials, including diagnostic x-rays, x-ray therapy, chemotherapy, fluoroscopy, electrocardiograms, laboratory tests and therapeutic radiology services must be ordered, authorized or arranged by the PCP and provided through a Participating facility. Prior Authorization may be required.

Rehabilitation Services

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

Treatment of Acquired Brain Injury will be covered the same as any other physical condition. Neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing or treatment; neurofeedback therapy, or remediation are covered if such services are necessary as a result of and related to an Acquired Brain Injury. Services may be provided at a Hospital, an acute or post-acute rehabilitation Hospital, an assisted living facility or any other facility at which appropriate services or therapies may be provided.

Maternity Care and Family Planning Services

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

Covered Services, which may require Prior Authorization, include:

1. prenatal visits;
2. use of Hospital delivery rooms and related facilities. A separate Hospital admission Copayment/Co-Share and any Deductible are not required for a newborn child at time of delivery. If a newborn child is discharged and readmitted to a Hospital more than five (5) days after the date of birth, a separate Hospital admission Copayment/Co-Share and any Deductibles for such readmission will be required;
3. use of newborn nursery and related facilities;
4. special procedures as may be Medically Necessary and authorized by the PCP or designated Obstetrician/Gynecologist; and postnatal visits. If the mother or newborn is discharged before the minimum hours of inpatient coverage have passed, the Claim Administrator provides coverage for Post-Delivery Care for the mother and newborn. Post-Delivery Care may be

provided at the mother's home or a Participating Provider's office or facility. A newborn child will not be required to receive health care services only from Participating Providers if born outside the Service Area due to an emergency or born in a non-network facility to a mother who is not a Participant. The Claim Administrator may require the newborn to be transferred to a Participating facility, at the Claim Administrator's expense, when determined to be medically appropriate by the newborn's treating Physician.

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

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

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

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

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

Pregnancy Terminations. Medically Necessary pregnancy terminations (abortions) must be provided by a licensed Physician, but the Claim Administrator may allow other health Providers to provide Covered Services that may be provided under applicable state law by such Providers, including 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. Elective, non-therapeutic abortions are not covered. Services may require Prior Authorization by the Claim Administrator.

Behavioral Health Services

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

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

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

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

Serious Mental Illness. Covered Services include treatment of Serious Mental Illness when authorized by the Claim Administrator or its designated behavioral health administrator and rendered by a Participating Provider which includes a Participating Psychiatric Day Treatment Facility. Services are subject to the same limitations as treatment of physical illness.

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

Emergency Services

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

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

If post stabilization care is required after an Emergency Care condition that originated in a Hospital emergency facility or in a comparable facility as defined in this paragraph has been treated and stabilized, the treating Physician or Provider will contact the Claim Administrator or its designee, who must approve or deny coverage of the post stabilization care requested within the time appropriate to the circumstances relating to the delivery of the service and the condition of the patient, but in no case may approval or denial exceed one hour of receiving the call. For the purposes of this paragraph, "comparable facility" includes the following:

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

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

This amount is calculated excluding any in-network Copayment/Co-Share and any Deductibles imposed with respect to the Participant.

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

Urgent Care Services

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

Unless designated and recognized by the Claim Administrator as an Urgent Care center, neither a hospital nor an emergency room will be considered an Urgent Care center.

Retail Health Clinic

Retail Health Clinics provide diagnosis and treatment of uncomplicated minor conditions in situations that can be handled without a traditional PCP office visit, Urgent Care visit or Emergency Care visit.

Virtual Visits

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

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

Ambulance Services

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

Air ambulance services are only covered when authorized by the PCP or the Claim Administrator 1) Ambulance transportation is Medically Necessary, and (2) terrain, distance, Your physical condition, or other circumstances require the use of air ambulance services rather than ground ambulance services.

Extended Care Services

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

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

Hospice Care. Care that is provided by a Hospital, Skilled Nursing Facility, Hospice, or a duly licensed Hospice Care agency, is approved by the Claim Administrator, and is focused on a palliative rather than curative treatment for Participant who have a medical condition and a prognosis of less than 6 months to live. For care provided in a Hospital, charges described in Inpatient Hospital Services apply.

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

Health Maintenance and Preventive Services

Covered Services, which may require Prior Authorization, and will not be subject to Copayment/Co-Share, Deductible or dollar maximums, include evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("UPSTF") or as required by state law:

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

1. well child care for Participants through age seventeen (17) which includes evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents;
2. periodic health assessments for Participants eighteen (18) and older, based on age, sex and medical history;
3. routine immunizations recommended by the American Academy of Pediatrics, U.S. Public Health Service for people in the United States and required by law; immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved. Examples of covered immunizations include diphtheria, haemophilus influenza type b, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, rotavirus and any other immunization that is required by the law for a child. (Allergy injections are not considered immunizations under this benefit provision.);
4. bone mass measurement for the detection of low bone mass and to determine risk of osteoporosis and fractures associated with osteoporosis, for qualified individuals including postmenopausal women who are not receiving estrogen replacement therapy; individuals with vertebral abnormalities, primary hyperparathyroidism or a history of bone fractures; or individuals receiving long-term glucocorticoid therapy or being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy;
5. preventive care and screenings provided with respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the HRSA such as a well-woman gynecological exam (once every twelve months) for female Participants, and a medically recognized diagnostic exam for the early detection of cervical cancer for female Participants age eighteen (18) and older. Your PCP or any Obstetrician/Gynecologist may perform the well-woman exam. The exam may include, but is not limited to, a conventional Pap smear screening; a screening using liquid-based cytology methods alone or in combination with a test approved by the United States Food and Drug Administration for the detection of human papillomavirus. You must first obtain a Referral from Your PCP for follow-up services related to treatment of a disease or condition that is not within the scope of an Obstetrician/Gynecologist. For help in selecting an Obstetrician/Gynecologist, refer to the Provider directory, contact Your PCP or call customer service;

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

7. preventive care and screenings provided with respect to women's services will be provided for the following Covered Services and will not be subject to a Copayment/Co-Share or any Deductibles:

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

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

   To determine if a specific drug or device is available under this Preventive Services benefit contact customer service at the toll-free number on the back of Your Identification Card.

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

   Contraceptive drugs and devices not available under this Preventive Services benefit may be covered under other sections of this Plan, and may be subject to any applicable Copayment/Co-Share and any Deductibles.

   Breastfeeding Support, Counseling and Supplies. Covered Services include support and counseling services obtained from a Participating Provider during pregnancy and/or in the post-partum period. Benefits will also be provided for the purchase of a manual, or an electric breast pump and supplies. Benefits for the purchase of an electric pump are limited to one per benefit period. Limited benefits will also be available for the rental (or, at the Claim Administrator's option, the purchase) of Hospital grade breast pumps, from a Participating Provider with a written prescription. You may be required to pay the full amount and submit a reimbursement claim form along with the written prescription to the Claim Administrator with itemized receipts for the manual, electric or Hospital grade breast pump and supplies. Visit the website at www.bcbstx.com to obtain a claim form.

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

8. Screening for anxiety in adolescent and adult women, including those who are pregnant or postpartum, who have not recently been screened;

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

10. a medically recognized diagnostic rectal screening exam for the detection of colorectal cancer for Participants age forty-five (45) or older. Covered Services include, a fecal occult blood test once every twelve months, a flexible sigmoidoscopy with hemoccult of the stool every five (5) years and a colonoscopy every ten (10) years.

Examples of other covered preventive services that are not subject to Copayment/Co-share or dollar maximums include smoking cessation counseling services and intervention (included FDA-approved tobacco cessation medications), healthy diet counseling, and obesity screening/counseling.

Drugs (including both prescription and over-the-counter) that fall within a category of the current "A" or "B" recommendations of the United States Preventive Services Task Force and that are listed on the ACA Preventive Services Drug List (to be implemented in the quantities and within the time period allowed under applicable law) will be covered and will not be subject to any Copayment Amount, Coinsurance Amount, Deductible, or dollar maximum when obtained from a Participating Pharmacy. Drugs on the Preventive Services Drug List that are obtained from a non-Participating Pharmacy, may be subject to Copayment Amount, Coinsurance Amount, Deductibles, or dollar maximums, if applicable.

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

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

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

11. early detection test for ovarian cancer. Benefits are available for a CA 125 blood test once every twelve months for female Participants age eighteen (18) and older. Your PCP or any Obstetrician/Gynecologist in Your PCP's network of Participating Providers may administer the test.
12. eye and ear screenings (once every twelve months) performed or authorized by the PCP for Participants through age seventeen (17) to identify vision and hearing problems. Eye screenings may be performed in a PCP's office and do not include refractions;
13. eye and ear screenings (once every two years) performed or authorized by the PCP for Participants eighteen (18) and older to identify vision and hearing problems. Eye screenings may be performed in a PCP's office and do not include refractions;
14. a physical exam and an annual prostate-specific antigen (PSA) test (once every twelve months) for the detection of prostate cancer for male Participants who are at least fifty (50) years of age and asymptomatic; or at least forty (40) years of age with a family history of prostate cancer or another prostate cancer risk factor.

Dental Surgical Procedures

General dental services are not covered, but limited oral surgical procedures are covered when prescribed by Your PCP and performed in a Participating Provider's office or in the inpatient or outpatient setting. If You are unable to undergo dental treatment in a dental office or under local anesthesia due to a documented physical, mental or medical reason, You shall have coverage for Medically Necessary, non-dental related services to the dental treatment. The following Covered Services may require Prior Authorization by the Claim Administrator:

1. treatment for accidental injury and such injury resulting from domestic violence or a medical condition, to Sound Natural Adult Teeth, the jaw bones or surrounding tissues, not caused by biting or chewing. "Sound Natural Adult Teeth" means teeth that are free of active or chronic clinical decay, have at least 50% bony support, are functional in the arch, and have not been excessively weakened by multiple dental procedures;

2. treatment or correction of a non-dental physiological condition which has resulted in severe functional impairment;
3. treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
4. diagnostic and surgical treatment of conditions affecting the temporomandibular joint (including the jaw or craniomandibular joint) as a result of an accident, a trauma, a congenital defect, a developmental defect, or a pathology; and
5. Dental Care (oral examination, x-rays, extractions, and non-surgical elimination of oral infection) required for the direct treatment of a medical condition, limited to:
   a. Dental services related to medical transplant procedures;
   b. Initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); and
   c. Direct Treatment of acute traumatic injury, cancer, or cleft palate.
6. removal of complete bony impacted teeth.

Cosmetic, Reconstructive or Plastic Surgery

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

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

Allergy Care

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

Diabetes Care

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

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

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

When the following diabetes equipment and supplies are obtained, You may be required to pay the full amount of their bill and submit a reimbursement claim form to the Claim Administrator with itemized receipts. Visit the website at www.bcbstx.com to obtain a medical claim form.

Diabetes equipment and supplies include, but are not limited to: blood glucose monitors; insulin pumps and necessary accessories; insulin infusion devices; podiatric appliances (including up to two pairs of therapeutic footwear per Plan Year). Diabetes equipment and supplies also include biohazard disposable containers.

Also included are repairs and necessary maintenance of insulin pumps not otherwise provided for under the manufacturer's warranty or purchase agreement, rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump.

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

Prosthetic Appliances and Orthotic Devices

The following covered appliances and devices must be provided or arranged by the PCP, and may require Prior Authorization by the Claim Administrator.

1. Initial Prosthetic Appliances are covered subject to restrictions in the **Schedule of Copayments and Benefit Limits** and **Limitations and Exclusions.**
2. Repair and replacement of Prosthetic Appliances and orthotic devices are covered unless the repair or replacement is a result of misuse or loss by You.
3. Orthopedic braces, such as orthopedic appliances used to support, align, or hold bodily parts in a correct position; crutches, including rigid back, leg, or neck braces; casts for treatment of any part of the legs, arms, shoulders, hips, or back; special surgical and back corsets; and Physician-prescribed, directed, or applied dressings, bandages, trusses, and splints that are custom designed for the purpose of assisting the function of a joint.
4. Breast prostheses and surgical brassieres after mastectomy.
5. One wig needed as a result of current chemotherapy or radiation treatment for cancer, subject to any maximum amount indicated on the **Schedule of Copayments and Benefit Limits**.

Durable Medical Equipment

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

DME is only covered at initial placement and when standard replacements are needed due to physical growth of Participants under 18 years of age, and must be consistent with the Medicare DME Manual. Examples of DME are: standard wheelchairs, crutches, walkers, orthopedic tractions, Hospital beds, oxygen, bedside commodes, suction machines, etc. Excluded items are listed in **Limitations and Exclusions**.

Ostomy Supplies

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

1. Pouches, face plates and belts;
2. Irrigation sleeves, bags, and ostomy irrigation catheters;
3. Skin barriers; and
4. Deodorants, filters, lubricants, tape, appliance cleaners, adhesive and adhesive remover.

Medical Supplies

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

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

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

Speech and Hearing Services

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

Therapies for Children with Developmental Delays

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

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

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

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

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

Autism Spectrum Disorder

Generally recognized services prescribed in relation to Autism Spectrum Disorder by a qualified Participating Provider in a treatment plan recommended by that Physician are available. No benefit maximums will apply.

Individuals providing treatment prescribed under that plan must be:

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

Treatment may include services such as:

- evaluation and assessment services;
- screening at 18 and 24 months;
- behavior training and behavior management;
- speech therapy;
- occupational therapy;
- physical therapy; or
- medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder.

Benefits for Autism Spectrum Disorder will not apply toward, and are not subject to, any Occupational Therapy, Physical Therapy, or Speech Therapy visits.

Routine Patient Costs for Participants in Certain Clinical Trials

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

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

Telehealth and Telemedicine Medical Services

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

LIMITATIONS AND EXCLUSIONS

The following benefits are not covered unless specifically provided for in **COVERED SERVICES AND BENEFITS**.

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

16. Personal or comfort items, including but not limited to televisions, telephones, guest beds, admission kits, maternity kits, and newborn kits provided by a Hospital or other inpatient facility.

17. Private rooms unless Medically Necessary and authorized by the Claim Administrator. If a semi-private room is not available, the Claim Administrator covers a private room until a semi-private room is available.

18. Any and all transplants of organs, cells, and other tissues, except as described in **Inpatient Hospital Services**. Services or supplies related to organ and tissue transplant or other procedures when You are the donor and the recipient is not a Participant are not covered.

19. Services or supplies for Custodial Care.

20. Services or supplies furnished by an institution that is primarily a place of rest, a place for the aged, or any similar institution.

21. Services or supplies for Dietary and Nutritional Services, including home testing kits, vitamins, dietary supplements and replacements, and special food items, except:

    a. an inpatient nutritional assessment program provided in and by a Hospital and approved by the Claim Administrator;
    b. dietary formulas necessary for the treatment of phenylketonuria or other heritable diseases;
    c. as described in **Diabetes Care**;
    d. as described in **Autism Spectrum Disorder.**; or
    e. as described in **Therapies for Children with Developmental Delays**.

22. Services or supplies for Cosmetic, Reconstructive or Plastic Surgery, including augmentation (enlargement) surgery, even when Medically Necessary, except as described in **Cosmetic, Reconstructive or Plastic Surgery**.

23. Services or supplies provided primarily for:

    a. Environmental Sensitivity; or
    b. Clinical Ecology or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists; or
    c. inpatient allergy testing or treatment.

24. Services or supplies provided for, in preparation for, or in conjunction with the following, except as described in **Maternity Care and Family Planning Services**.

    a. elective, non-therapeutic termination of pregnancy (abortions);
    b. sterilization reversal (male or female);
    c. gender reassignment surgery and related treatment, including hormone therapy and medical or psychological counseling;
    d. treatment of sexual dysfunction including medications, penile prostheses, and other surgery, and vascular or plethysmographic studies that are used only for diagnosing impotence;
    e. promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct-intraperitoneal insemination, trans-uterine tubal insemination, gamete intrafallopian transfer, pronuclear oocyte stage transfer, zygote intrafallopian transfer, and tubal embryo transfer;
    f. any services or supplies related to in vitro fertilization or other procedures when You are the donor and the recipient is not a Participant;

25. in vitro fertilization and fertility drugs.

26. Services or supplies in connection with routine foot care, including the removal of warts, corns, or calluses, or the cutting and trimming of toenails in the absence of diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency.

27. Services or supplies in connection with foot care for flat feet, fallen arches, or chronic foot strain.

28. Services or supplies for, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.

29. Services or supplies for dental care, except as described in **Dental Surgical Procedures.**

30. Non-surgical or non-diagnostic services or supplies for treatment or related services to the temporomandibular (jaw) joint or jaw-related neuromuscular conditions with oral appliances, oral splints, oral orthotics, devices, prosthetics, dental restorations, orthodontics, physical therapy, or alteration of the occlusal relationships of the teeth or jaws to eliminate pain or dysfunction of the temporomandibular joint and all adjacent or related muscles and nerves. Medically Necessary diagnostic and/or surgical treatment is covered for conditions affecting the temporomandibular joint (including the jaw or craniomandibular joint) as a result of an accident, trauma, congenital defect, developmental defect, or pathology, as described in **Dental Surgical Procedures.**

31. Alternative treatments such as acupuncture, acupressure, hypnotism, massage therapy, and aroma therapy.

32. Services or supplies for:
    a. intersegmental traction;
    b. surface EMGs;
    c. spinal manipulation under anesthesia;
    d. muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph, and Dynatron.

33. Galvanic stimulators or TENS units.

34. Disposable or consumable outpatient supplies, such as syringes, needles, blood or urine testing supplies (except as used in the treatment of diabetes); sheaths, bags, elastic garments, stockings and bandages, garter belts.

35. Excluded supplies include, but are not limited to, compression stockings, ace bandages, wound care or dressing supplies, prescribed or non-prescribed medical and disposable supplies that can be purchased over the counter.

    This exclusion does not apply to:
    a. Ostomy bags and related supplies for which benefits are provided as described under **Ostomy Supplies** section;
    b. Disposable supplies necessary for the effective use of Durable Medical Equipment for which benefits are provided as described under **Durable Medical Equipment** section;
    c. Urinary catheters, wound care or dressing supplies given by a Provider during treatment for Covered Services;
    d. Medical grade compression stockings when considered Medically Necessary. The stockings must be prescribed by a Physician, individually measured and fitted to the patient;
    e. Diabetic supplies for which benefits are provided as described under **Diabetes Services** section;
    f. Batteries, tubing, nasal cannulas, connectors, and masks except when used with Durable Medical Equipment.

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

36. Prosthetic Appliances or orthotic devices not described in **Diabetes Care** or **Prosthetic Appliances and Orthotic Devices** including, but not limited to:

    a. orthodontic or other dental appliances or dentures;
    b. splints or bandages provided by a Physician in a non-Hospital setting or purchased over the counter for the support of strains and sprains;
    c. Corrective orthopedic shoes, including those which are a separable part of a covered brace; specially-ordered, custom-made or built-up shoes and cast shoes; shoe inserts designed to support the arch or affect changes in the foot or foot alignment; arch supports; orthotics; braces; splints or other foot care items.

37. Supplies for smoking cessation programs and the treatment of nicotine addiction with the exception of prescription and over-the-counter medications for tobacco cessation and tobacco cessation counseling covered under **Preventive Services**.

38. The following psychological/neuropsychological testing and psychotherapy services:

    a. educational testing;
    b. employer/government mandated testing;
    c. testing to determine eligibility for disability benefits;
    d. testing for legal purposes (e.g., custody/placement evaluations, forensic evaluations, and court mandated testing);
    e. testing for vocational purposes (e.g., interest inventories, work related inventories, and career development);
    f. services directed at enhancing one's personality or lifestyle;
    g. vocational or religious counseling;
    h. activities primarily of an educational nature;
    i. music or dance therapy; or
    j. bioenergetic therapy.

39. Biofeedback (except for an Acquired Brain Injury diagnosis) or other behavior modification services.

40. Mental health services except as described in **Behavioral Health Services** or as may be provided under **Autism Spectrum Disorder**.

41. Residential Treatment Centers for Substance Use Disorder that are not:

    a. affiliated with a Hospital under a contractual agreement with an established system for patient Referral;
    b. accredited as such a facility by the Joint Commission on Accreditation of Hospitals;
    c. licensed as a Substance Use Disorder treatment program by the Texas Commission on Alcohol and Drug Abuse; or
    d. licensed, certified, or approved as a Substance Use Disorder treatment program or center by any other state agency having legal authority to so license, certify, or approve.

42. Trauma or wilderness programs for behavioral health or Substance Use Disorder treatment.

43. Inpatient mental health services that are provided:

    a. by a non-Participating Provider or non-Participating Mental Health Treatment Facility, Crisis Stabilization Unit or Residential Treatment Center for Children and Adolescents, although Participating Providers may refer Participants to non-Participating Providers for Covered Services not available from Participating Providers as outlined in **How the Plan Works**; or

    b. for the following diagnosed conditions: Alzheimer's disease, intractable personality disorders, mental retardation, educational testing or any other testing required by school system, psychiatric therapy on court order or as a condition of parole or probation, and chronic organic brain syndrome.

44. Hearing aids.

45. Cochlear implants.

46. Deluxe equipment such as motor driven wheelchairs and beds (unless determined to be Medically Necessary); comfort items; bedboards; bathtub lifts; over-bed tables; air purifiers; sauna baths; exercise equipment; stethoscopes and sphygmomanometers; Experimental and/or research items; and replacement, repairs or maintenance of the DME.

47. Over-the-counter supplies or medicines and prescription drugs and medications of any kind, except;

    a. as provided while confined as an inpatient,
    b. as provided under **Autism Spectrum Disorder;**
    c. as provided under **Diabetes Care;**
    d. contraceptive devices and FDA-approved over-the-counter contraceptive for women with a written prescription from a Participating Provider; or
    e. as covered under **Preventative Services.**

48. Male contraceptive devices, including over-the-counter contraceptive products such as condoms; female contraceptive devices, including over-the-counter contraceptive products such as spermicide, when not prescribed by a Participating Provider.

49. Self-administered drugs dispensed or administered by a Physician in his/her office.

50. Any services or supplies from more than one Provider on the same day(s) to the extent benefits were duplicated.

51. Any services or supplies provided for Non–Surgical Treatment of obesity.

52. Blood Pressure Cuffs.

53. Helicobacter pylori Serologic Testing.

54. Orthognathic surgery (except due to congenital anomaly, acute traumatic injury, dislocation, tumor, cancer, or sleep apnea.)

55. Hyperhidrosis Treatment.

56. Treatment of Subluxation Foot.

Termination of Coverage

Termination of Individual Coverage

Coverage under the Plan for You and/or Your Dependent will automatically terminate when:

- Your contribution for coverage under the Plan is not received by the Plan Administrator; or
- You no longer satisfy the definition of a Participant as defined in this Plan, including termination; of employment; or
- The Plan is terminated or the Plan is amended, at the direction of the Plan Administrator, to terminate the coverage of the class of Participants to which You belong; or
- A Dependent ceases to be Dependent as defined in the Plan

However, when any of these events occur, You and/or Your Dependents may be eligible for continued coverage. See **COBRA Continuation Coverage,** in the **GENERAL PROVISIONS** section of this Plan**.**

The Claim Administrator may refuse to renew coverage of an eligible Participant or Dependent for fraud or intentional misrepresentation of material fact by that individual.

Termination of the Group

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

Rescissions

Rescission is the cancellation or discontinuance of coverage that has retroactive effect. Your coverage may not be rescinded unless You or a person seeking coverage on Your behalf performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of a material fact. A cancellation or discontinuance of coverage that has only prospective effect is not a rescission. A retroactive cancellation or discontinuance of coverage based on a failure to timely pay required premiums or contributions toward the cost of coverage (including COBRA premiums) is not a rescission. You will be given 30 days advance notice of rescission. A rescission is considered an Adverse benefit Determination of which You may seek internal review and external review.

COBRA Continuation Coverage

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

Employees and their covered Dependents will not be eligible for the continuation of coverage provided by this section if the Group is exempt from the provisions of COBRA.

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

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

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

- divorce;
- Subscriber's death;
- Subscriber's entitlement to Medicare benefits; or
- cessation of covered Dependent child status under **Who Gets Benefits; Eligibility** of this Plan.

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

- the last day of the continued coverage whether eighteenth (18) month or thirty-sixth (36) month period;
- the first day on which timely payment of contribution is not made to the Plan subject to the administrative services agreement;
- the first day on which the administrative services agreement between Group and the Claim Administrator is not in full force and effect;
- the first day on which You are actually covered by any other group Health Benefit Plan. In the event You have a preexisting condition and would be denied coverage under the new Health Benefit Plan for a preexisting condition, continuation coverage will not be terminated until the last day of the continuation period, or the date upon which the preexisting condition becomes covered under the new Health Benefit Plan, whichever occurs first; or
- the date You are entitled to Medicare.

Extensions of Coverage Periods. The eighteen (18) month coverage period may be extended if an event which would otherwise qualify You for the thirty-six (36) month coverage period occurs during the eighteen (18) month period, but in no event may coverage be longer than thirty six (36) months from the event which qualified You for continuation coverage initially.

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

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

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

Contributions due to the Claim Administrator for the continuation of coverage under this section shall be due in accordance with the procedures of the administrative services agreement and shall be calculated in accordance with applicable federal law and regulations.

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

Coordination of Benefits

Coordination of Benefits ("COB") applies when You have health care coverage through more than one Health Care Plan. The order of benefit determination rules governs the order in which each Health Care Plan will pay a claim for benefits. The Health Care Plan that pays first is called the primary plan. The primary plan must pay benefits in accord 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 section only, the following words and phrases have the following meanings:

Allowable Expense means a health care expense, including deductibles, co-share, 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. In addition, any expense that a health care provider or physician by law or in accord with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

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

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

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

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

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

The rules establishing the order of benefit determination between this Plan and any other Health Care Plan covering You on whose behalf a claim is made are as follows:

1. The benefits of a Health Care Plan that does not have a coordination of benefits provision shall in all cases be determined before the benefits of this Plan.
2. If according to the rules set forth below in this section the benefits of another Health Care Plan that contains a provision coordinating its benefits with this Health Care Plan would be determined before the benefits of this Health Care Plan have been determined, the benefits of the other Health Care Plan will be considered before the determination of benefits under this Health Care Plan.

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

1. Nondependent or Dependent. The Health Care Plan that covers the person other than as a Dependent, for example as an employee, participant, 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, participant, policyholder, subscriber, or retiree is the secondary plan and the other Health Care Plan is the primary plan. An example includes a retired employee.

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

   a. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
      (1) The Health Care Plan of the parent whose birthday falls earlier in the Plan Year is the primary plan; or
      (2) If both parents have the same birthday, the Health Care Plan that has covered the parent the longest is the primary plan.
   b. For a Dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:
      (1) if a court order states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Health Care Plan of that parent has actual knowledge of those terms, that Health Care Plan is primary. This rule applies to plan years commencing after the Health Care Plan is given notice of the court decree.

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

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

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

         - the Health Care Plan covering the custodial parent;
         - the Health Care Plan covering the spouse of the custodial parent;
         - the Health Care Plan covering the noncustodial parent; then
         - the Health Care Plan covering the spouse of the noncustodial 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, participant, subscriber, or retiree or covering the person as a dependent of an employee, participant, 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, participant, policyholder, subscriber, or retiree longer is the primary plan, and the Health Care Plan that has covered the person the shorter period is the secondary plan.

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

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

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

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

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

For purposes of this provision, the Claim Administrator 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 the Claim Administrator 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 the Claim Administrator 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, the Claim Administrator shall have the right to recover such payment, to the extent of such excess, from among one or more of the following as the Claim Administrator shall determine: any insurance company or companies; or any Physicians or Provider to which such payments were made.

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

Subrogation

If the Plan pays or provides benefits for You or Your Dependents, the Plan is subrogated to all rights of recovery which You or Your Dependent have in contract, tort, or otherwise against any person, organization, or insurer for the amount of benefits the Plan has paid or provided. That means the Plan may use Your rights to recover money through judgment, settlement, or otherwise from any person, organization, or insurer.

For the purposes of this provision, subrogation means the substitution of one person or entity (the Plan) in the place of another (You or Your Dependent) with reference to a lawful claim, demand or right, so that he or she who is substituted succeeds to the rights of the other in relation to the debt or claim, and its rights or remedies.

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

If You or Your Dependent recover money from any person, organization, or insurer for an injury or condition for which the Plan paid benefits, You or Your Dependent agree to reimburse the Plan from the recovered money for the amount of benefits paid or provided by the Plan. That means You or Your Dependent will pay to the Plan the amount of money recovered by You through judgment, settlement or otherwise from the third party or their insurer, as well as from any person, organization or insurer, up to the amount of benefits paid or provided by the Plan.

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

Alternate Service Area Access

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

If You are temporarily residing in an Alternate Service Area, You may obtain Covered Services in the Alternate Service Area as described in this section. For a Subscriber, coverage is available if You are, or will be, residing in the Alternate Service Area at least ninety (90) days, limited to a maximum of one hundred eighty (180) days. For Dependents, including an eligible Dependent who permanently resides outside the Service Area and is subject to a valid medical court order, coverage is available if Dependent is or will be residing in the Alternate Service Area at least ninety (90) days, limited to a maximum of three hundred sixty-five (365) days. Participants may renew qualification within the Alternate Service Area by submitting a request for Alternate Service Area access and receiving approval from the Claim Administrator.

This Plan remains in full force and effect while You are in the Alternate Service Area, and You may avail Yourself of Covered Services under this Plan by returning to the Service Area. Emergency Care in the Alternate Service Area will be covered in accordance with the terms and conditions of this Plan. Coverage for services other than Emergency Care in the Alternate Service Area will be provided in accordance with the terms and conditions of the Plan in the Alternate Service Area (the "Alternate Plan") which the Claim Administrator will provide to You at the time of request for Alternate Service Area access. The terms and conditions of the Alternate Plan, including the benefits thereunder, may differ from this Plan and will determine the Covered Services, other than Emergency Care, that You may receive while in the Alternate Service Area.

To qualify for coverage in an Alternate Service Area, You must submit a request for Alternate Service Area access prior to relocating in an Alternate Service Area. You must select a PCP from a list of participating Providers for the Alternate Service Area. The Claim Administrator will determine the date coverage begins for the Alternate Service Area (either the effective date of Participant's eligibility or the first day of the month following the Claim Administrator's receipt of the request for Alternate Service Area access). If approved, the Claim Administrator will issue written notification.

The Claim Administrator's Ownership Interests

The Claim Administrator or its subsidiaries or affiliates may have ownership interests in certain Providers who provide covered services to Participants, and/or vendors or other third parties who provide covered services related to the benefits and requirements of this Plan or provide services to certain Providers.

Assignment

Rights and benefits under the Plan shall not be assignable, either before or after services and supplies are provided. In the absence of a written agreement with a Provider, the Claim Administrator reserves the right to make benefit payments to the Provider or the employee as the Claim Administrator elects. Payment to either party discharges the Plan's responsibility to the employee, or Dependents for benefits available under the Plan.

Balance Billing And Other Protections

Federal requirements including but not limited to the Consolidated Appropriations Act may impact your benefits. BCBSTX will apply federal requirements to your benefit plan where applicable. For some types of out-of-network care your health care provider may not bill you more than your in-network cost-sharing levels. If you receive the types of care listed below, your cost-share will be calculated as if you received services from an in-network provider. Those cost-share amounts will apply to any in-network deductible and out-of-pocket maximums.

- 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; and
- Air ambulance services from out-of-network providers, if your plan covers in-network air ambulance services.

There are limited instances when an out-of-network provider of the care listed above may send you a bill for up to the amount of that provider's billed charges. You are only responsible for payment of the out-of-network provider's billed charges if, in advance of receiving services, you signed a written notice that informed you of:

- the Provider's Out-of-Network status;
- in the case of services received from an Out-of-Network Provider at a network facility, a list of network Providers at the facility who could offer the same services;
- information about whether Prior Authorization or other care management limitations may be required in advance of services; and
- a good faith estimate of the Provider's charges.

Your Provider cannot ask you to be responsible for paying billed charges for certain types of services, including emergency medicine, anesthesiology, pathology, radiology, and neonatology, and other Specialists as may be defined by applicable law.

Cancellation

Except as otherwise provided herein, the Claim Administrator shall not have the right to cancel or terminate any Plan issued to any Subscriber while the administrative services agreement remains in force and effect, and while said Subscriber remains in the eligible class of employees of Group, and his contributions are paid in accordance with the terms of this Plan.

Clerical Error

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

Entire Plan

This Plan, any attachments, amendments, the administrative services agreement, and the individual applications, if any, of Subscribers constitute the entire contract between the parties and as of the effective date hereof, supersede all other contracts between the parties.

Force Majeure

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

Form or Content of Plan

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

Gender

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

Incontestability

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

Limitation of Liability

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

Modifications

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

Notice

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

The Claim Administrator, or Group by agreement between the Claim Administrator and Group, may send You notices under this Plan. These notices may be delivered:

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

Patient/Provider Relationship

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

Participant Data Sharing

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

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

Overpayment

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

If no refund is received, Your Group's benefit plan and/or the Claim Administrator has the right to deduct any refund for any Overpayment due, up to an amount equal to the Overpayment, from:

(a) any future benefit payment made to any person or entity under this Plan, whether for the same or a different Participant; or,

(b) any future benefit payment made to any person or entity under another Blue Cross and Blue Shield-administered ASO benefit program; or,

(c) any future benefit payment made to any person or entity under another Blue Cross and Blue Shield insured group benefit plan or individual policy; or,

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

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

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

Relationship of Parties

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

Reports and Records

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

- disclose all facts pertaining to Your care, treatment and physical condition to the Claim Administrator, or a medical, dental, or mental health professional that the Claim Administrator may engage to assist it in reviewing a treatment or claim;

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

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

Subtitles

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

Value Based Design Programs

This Plan has the right to offer medical management programs, quality improvement programs, and health behavior wellness, incentive, maintenance, or improvement programs that allow for a reward, a contribution, a differential in premiums, a differential in medical, prescription drug, or equipment Copayments, Coinsurance, Deductibles, or costs, or a combination of these incentives or disincentives for participation in any such program offered or administered by this Plan or an entity chosen by this Plan to administer such program. In addition, discount or incentive programs for various health or wellness-related, insurance-related, or other items and services may be available from time to time. Such programs may be discontinued without notice.

Individuals in wellness programs who are unable to participate in these incentives or disincentives due to an adverse health factor shall not be penalized based upon an adverse health status and, unless otherwise permitted by law, this Plan will allow a reasonable alternative to any individual for whom it is unreasonably difficult, due to a medical condition, to satisfy otherwise applicable wellness program standards.

Contact this Plan for additional information regarding any value based programs offered by this Plan.

NOTICES

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.

NOTICE

BLUE CROSS AND BLUE SHIELD OF TEXAS,
A DIVISION OF HEALTH CARE SERVICE CORPORATION

Inter-Plan Arrangements

Out-of-Area Services

The Claim Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements." Whenever you obtain healthcare services outside of our Service Area, the claims for those services may be processed through one of these Inter-Plan Arrangements.

Typically, when accessing care outside of our Service Area, you will obtain care from healthcare Providers that have a contractual agreement (i.e., are "participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating Providers. Our payment practices in both instances are described below.

We cover only limited healthcare services received outside of our Service Area. As used in this section, "Covered Services" include Emergency Care, Urgent Care and follow-up care obtained outside the geographic area that we serve. Any other services will not be covered when processed through any Inter-Plan Arrangements unless such services are authorized by Claim Administrator.

A. BlueCard® Program

Under the BlueCard Program, when you obtain Covered Services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare Providers.

The BlueCard Program enables you to obtain Covered Services, as defined above, from a healthcare Provider participating with a Host Blue, where available. The participating healthcare Provider will automatically file a claim for you, so there are no claim forms for you to fill out. You will be responsible for the Copayment amount indicated in the benefit booklet.

Emergency Care Services: If you experience a Medical Emergency while traveling outside our Service Area, go to the nearest Emergency or Urgent Care facility.

Whenever you access Covered Services and the claim is processed through the BlueCard Program, the amount you pay for such services, if not a flat dollar Copayment, is calculated based on the lower of:

- the billed charges for Covered Services, or
- the negotiated price that the Host Blue makes available to us.

Often, this "negotiated price" is a simple discount that reflects the actual price the Host Blue pays to your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with an individual Provider or a Provider group that may include settlements, incentive payments, and/or other credit or charges. Occasionally, it may be an average price based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, Claim Administrator would then calculate your liability for any Covered Services according to the applicable law in effect when care is received.

B. Non-Participating Healthcare Providers outside our Service Area

Liability Calculation

Except for Emergency Care and, Urgent Care with follow-up care, services received from a non-participating Provider outside of our Service Area will not be covered.

For Emergency Care and Urgent Care with follow-up care services received from non-participating Providers within the state of Texas, please refer to the "Emergency Services" section of the benefit booklet.

For Emergency Care and, Urgent Care with follow-up care services that are provided outside of the state of Texas by a non-participating Provider, the amount(s) you pay for such services will be calculated using the methodology described in the "Emergency Services" section for non-participating Providers located inside our Service Area. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

C. Blue Cross Blue Shield Global Core

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands you may be able to take advantage of the Blue Cross Blue Shield Global Core Program when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts/deductibles, coinsurance, etc. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services.

You must contact the Claim Administrator to obtain Prior Authorization for non-emergency inpatient services.

- **Outpatient Services**

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**

When you pay for Covered Services outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the Plan, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

Administered by:

BlueCross BlueShield of Texas

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