BlueCross BlueShield of Texas









Your Health Care Benefits Program

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

Blue Essentials℠ Plan

For Employees of SAN FELIPE DEL RIO CISD

Group # 395733
3957330002.0126

Effective January 1, 2026

BLUE CROSS AND BLUE SHIELD OF TEXAS
a Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent License of the Blue Cross and Blue Shield Association
(herein called "BCBSTX" or "HMO")
1001 East Lookout Drive
Richardson, Texas 75082
1-877-299-2377
www.bcbstx.com

EVIDENCE OF COVERAGE
INTRODUCTION

NOTICE TO CONSUMER

This Consumer Choice of Benefits - Health Maintenance Organization (HMO) health care plan, either in whole, or in part, excludes or limits certain state mandated benefits normally required under Texas law. This health care plan may provide a more affordable health care plan for you; however, it may provide you with fewer health care plan benefits than those normally afforded as state mandated health care benefits under Texas law. Please consult with your insurance agent to determine which state mandated health care benefits are excluded under this Certificate of Coverage.

This is your Evidence of Coverage ("Certificate"). Please read the information in this Certificate carefully so you will have a full understanding of your health care **benefits**. It explains your **covered services** and how you obtain them while you are a **member**, and coverage is valid. This Certificate is part of the **group agreement** between the **group** and Blue Cross and Blue Shield of Texas ("BCBSTX")("HMO"). It is governed by applicable federal and state law and determines the terms and conditions of your coverage.

This Certificate applies only to your **HMO** coverage. It does not limit your ability to receive health care services that are not **covered services**. No **participating provider** or other **provider**, institution, facility, or agency is an agent or **employee** of the **HMO**.

Please note: Except as shown under the **GENERAL PROVISIONS: COBRA Continuation Coverage** section, coverage is not provided for any services received before coverage starts or after coverage ends.

The defined terms throughout this Certificate are in **bold font** and defined in the **GLOSSARY** or applicable section.

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

This Certificate is not a Medicare supplement policy or a Workers' Compensation insurance policy. If you are eligible for Medicare, please review the Guide to Health Insurance for people with Medicare available from BCBSTX.

Have a complaint or need help?

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

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

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

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

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

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

¿Tiene una queja o necesita ayuda?

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

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

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

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

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

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

TABLE OF CONTENTS

QUICK REFERENCE

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

CUSTOMER SERVICE

Medical Benefits	Call	Website
Customer Service	Please see telephone number on the back of your **identification card**	www.bcbstx.com BCBSTX Provider Directory Wellness Other Online Services and Information
Prior Authorization (for Behavioral Health and for Non-Behavioral Health)	Please see telephone number on the back of your **identification card**	
Inpatient Admissions (for Behavioral Health and for Non-Behavioral Health)	Please see telephone number on the back of your **identification card**	

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

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

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 of 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 on your **identification card**.

SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS

Blue Essentials℠ Network

This is your **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS.** It shows your cost share for your coverage offered by your **HMO plan**. You should review this along with the **MEDICAL LIMITATIONS AND EXCLUSIONS** section.

All **covered services** (except in emergencies) must be provided by or through your **participating primary care physician/practitioner (PCP)**. Your **PCP** may refer you for further treatment by **providers** in the applicable **network** of **participating specialists** and **hospitals**.

Members may visit a **participating** OB/GYN **physician** in their PCP's **provider network** without a **referral** from their **PCP**.

The following services do not require a **referral** from your **PCP**:

- **Urgent care**
- Outpatient professional **behavioral health**
- **Retail health clinics**

NOTE: The **copayments** and, if applicable, **coinsurance** below show the amount you must pay as either a fixed dollar amount or a percentage of the **allowable amount**. **Copayments** and any applicable **coinsurance** or **deductibles** will be applied for each **covered service** given by a **participating provider** or **emergency care** received from a **non-participating provider** unless otherwise indicated. You will not be responsible for any **copayments**/**coinsurance** once the **deductible(s)** and **out-of-pocket maximum(s)** listed below have been met. **Copayments**/**coinsurance, deductibles** and **out-of-pocket maximums** may be adjusted for various reasons allowed by applicable law. Some services may require **prior authorization**.

Please review the **COVERED SERVICES** section for more information about the **covered services** listed below.

Benefit Period	Calendar year

Deductible

	Deductible Per Calendar Year **You Pay**
Individual	$1,200
Family	$2,400

Out-of-Pocket Maximum

	Out-of-Pocket Maximums You Pay
Individual	$6,900
Family	$13,800
• **Out-of-pocket maximum** includes **pharmacy benefits**.	

Allergy Care

Description	In-Network You Pay
Allergy Evaluations, Injections, Serum and Testing	20% coinsurance after deductible

Ambulance Services

Description	In-Network You Pay
Ambulance Services	20% coinsurance after deductible

Autism Spectrum Disorder

Description	In-Network You Pay
Autism Spectrum Disorder	Covered based on type of service and where it is received

Bariatric Surgery

Description	In-Network You Pay
Bariatric Surgery	Covered based on type of service and where it is received

Behavioral Health Services (Mental Health/Substance Use Disorder)

Description	In-Network You Pay
Chemical Dependency Services	$15 copay for in-office or home visit or benefits paid same as any other illness for other services, as applicable.
Inpatient Mental Health Care	20% coinsurance after deductible
Outpatient Mental Health Care	$15 copay for in-office or home visit or benefits paid same as any other illness for other services, as applicable.
Serious Mental Illness	$15 copay for in-office or home visit or benefits paid same as any other illness for other services, as applicable.
Telehealth and Telemedicine Services	$15 copay
Office Visit	$15 copay
• A referral is not needed for an in-network **HMO** outpatient behavior health services.	

Chiropractic Care

Description	In-Network You Pay
Chiropractic Care	$15 copay for PCP or $70 copay for specialist
Limits	Prior Authorization is Required

Cosmetic, Reconstructive or Plastic Surgery

Description	In-Network You Pay
Cosmetic, Reconstructive or Plastic Surgery (Limited Covered Services)	$15 copay for PCP or $70 copay for specialist, 20% coinsurance after deductible for inpatient hospital services or 20% coinsurance after deductible for outpatient surgery, as applicable.

Dental and Oral Surgical Procedures

Description	In-Network You Pay
Dental and Oral Surgical Procedures (Limited Covered Services)	$15 copay for PCP or $70 copay for specialist, 20% coinsurance after deductible for inpatient hospital services or 20% coinsurance after deductible for outpatient surgery, as applicable.

Diabetes Care

Description	In-Network You Pay
Diabetes Self-Management Training, for each visit	$15 copay for PCP or $70 copay for specialist
Diabetes Equipment	20% coinsurance after deductible
Diabetes Supplies	20% coinsurance after deductible

- Some diabetes supplies are only available utilizing **pharmacy benefits**, through a participating pharmacy. You must pay the applicable **PHARMACY BENEFITS** amount shown in the **PHARMACY SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** and any applicable pricing differences.

Durable Medical Equipment (DME)

Description	In-Network You Pay
Durable Medical Equipment (DME)	20% coinsurance after deductible

Emergency Services

Description	In-Network You Pay
Emergency Care Facility Charges	20% coinsurance after deductible, waived if admitted.
Emergency Care Physician Charges	20% coinsurance after deductible
• If admitted, any charges described in inpatient hospital services will apply.	

Fertility Treatment and Infertility Services

Description	In-Network You Pay
Diagnostic Counseling, Consultations, Planning and Treatment Services	$15 copay for PCP or $70 copay for specialist
• .	

Hearing and Speech Services and Hearing Aids

Description	In-Network You Pay
Hearing and Speech Services	Benefits paid same as any other physical illness
Hearing Aids	20% coinsurance after deductible
Limits	One(1) hearing aid per ear each 36-month period One (1) audiometric examination every thirty-six (36) months
Cochlear Implants	20% coinsurance after deductible
Limits	Limit one (1) per impaired ear, with replacements as medically necessary or audiologically necessary.
• **Benefits** for autism spectrum disorder will not apply towards, and are not subject to, any rehabilitation service visits maximum. • For cochlear implants additional charges as described in **Outpatient Hospital Services** may also apply.	

Home Health Care

Description	In-Network You Pay
Home Health Care	20% coinsurance after deductible per visit
• Covered when prescribed by a **PCP** and authorized by the **HMO**.	

Hospice Care

Description	In-Network You Pay
Hospice	20% coinsurance after deductible

Infusion Therapy

Description	In-Network You Pay
Outpatient Infusion Therapy Performed in hospital setting	20% coinsurance after deductible

Inpatient Hospital Services

Description	In-Network You Pay
Inpatient Services	20% coinsurance after deductible
Inpatient Rehabilitation	20% coinsurance after deductible

Maternity Services

Description	In-Network You Pay
Maternity Care	Covered based on type of service and where it is received
Maternity Related Newborn Care	Covered based on type of service and where it is received

- For maternity care: prenatal and postnatal visit - **copayment** is applied to the first office visit only. Afterwards, office visits are covered in full.
- Inpatient **prior authorization** is not needed for the following length of stays:
  - 48 hours following an uncomplicated vaginal delivery.
  - 96 hours following an uncomplicated delivery by caesarean section.

Occupational Therapy Services

Description	In-Network You Pay
Occupational Therapy in the office	$15 copay for PCP or $70 copay for specialist
Occupational Therapy in an outpatient setting	20% coinsurance after deductible
Limits	Prior Authorization is Required

- **Benefits** for **autism spectrum disorder** will not apply towards and are not subject to any rehabilitation services visits maximum.

Outpatient Hospital Services

Description	In-Network You Pay
Certain Diagnostic Procedures & Imaging Services (MRI, CT Scan, PET Scan)	20% coinsurance after deductible
Certain Diagnostic Procedures & Imaging Services (Lab, X-Ray & Other Diagnostic Services)	20% coinsurance after deductible
Outpatient Surgery	20% coinsurance after deductible
Radiation Therapy	20% coinsurance after deductible
Dialysis	20% coinsurance after deductible

Physical Therapy Services

Description	In-Network You Pay
Physical Therapy in the Office	$15 copay for PCP or $70 copay for specialist
Physical Therapy in an Outpatient Setting	20% coinsurance after deductible
Limits	Prior Authorization is Required
• **Benefits** for **autism spectrum disorder** will not apply towards and are not subject to, any rehabilitation service visits maximum.	

Physician and Specialist Services

Description	In-Network You Pay
Primary Care Office Visit or Consultation	$15 copay
Retail Health Clinic Visit	$15 copay
Specialty (Specialist) Office Visit or Consultation	$70 copay
Telehealth, Teledentistry & Telemedicine Services Primary care Consultation	$15 copay
Telehealth, Teledentistry & Telemedicine Services Specialty Consultation	$70 copay

Preventive Care Services

Description	In-Network You pay
All Other Preventive Care Services	No copay
Diagnostic eye, and Ear Screenings for Members through Age 17	$15 copay for PCP or $70 copay for specialist
Diagnostic eye, and Ear Screening for Members Age 18 and Older	$15 copay for PCP or $70 copay for specialist
Early Detection Test for Cardiovascular Disease	$15 copay for PCP or $70 copay after deductible for specialist
Early Detection Test for Ovarian Cancer (CA125 blood test)	$15 copay for PCP or $70 copay for specialist
Exam for Prostate Cancer	$15 copay for PCP or $70 copay for specialist
• Please see the **COVERED SERVICES** section for **benefit** limitations on preventive care services.	

Prosthetic Appliances and Orthotic Devices

Description	In-Network You Pay
Prosthetic Appliances and Orthotic Devices	20% coinsurance after deductible

Speech Therapy

For information on speech therapy please refer to the **Hearing and Speech Services** table in this section

Skilled Nursing Facility

Description	In-Network You Pay
Skilled Nursing Facility	20% coinsurance after deductible
Limits	Up to 60 days per benefit period

Sterilization

Description	In-Network You Pay
Vasectomy	$15 copay for PCP or $70 copay for specialist or 20% coinsurance after deductible for outpatient surgery, as applicable.

Urgent Care

Description	In-Network You Pay
Urgent Care Services	$50 copay after deductible
• Additional charges described under **Outpatient Hospital Services** may apply.	

Wigs

Description	In-Network You Pay
Wigs	20% coinsurance after deductible
Limits	$300 maximum benefit for purchase of one (1) wig needed as a result of current chemotherapy or radiation treatment for cancer.

PHARMACY SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS

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

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

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

Retail Pharmacy

	Retail Pharmacy **You Pay**
Tier 1	$15 copay
Tier 2	$60 copay
Tier 3	$100 copay
Out-of-Area Drug	$100 copay
• One copayment amount per 30-day supply, up to a 30-day supply only. • Extended Prescription Drug Supply Program (if allowed by the **prescription order**) – One **copayment** amount per 30-day supply, up to a 90-day supply.	

Mail-Order Pharmacy Program

	Mail-Order Pharmacy **You Pay**
Tier 1	$45 copay
Tier 2	$180 copay
Tier 3	$300 copay
• Extended Prescription Drug Supply Program (if allowed by the **prescription order**) – One **copayment** amount per 90-day supply, up to a 90-day supply only • Cost share will be based on day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.	

Specialty Pharmacy Program

	Specialty Pharmacy **You Pay**
Tier 4	$200 copay
• One copayment amount per 30-day supply, up to a 30-day supply only. • Coverage for specialty drugs are limited to a 30-day supply. However, some specialty drugs have FDA approved dosing regimens exceeding the 30-day supply limits and may be allowed greater than a 30-day supply, if allowed by your plan **benefits**. • Cost-share will be based on the day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.	

Vaccines

Select Vaccinations Obtained through the Pharmacy Vaccine Network	Pharmacy Vaccine Network Pharmacy You Pay
	$0 copay

Please Note:

- **Diabetes supplies** are covered as described in **PHARMACY BENEFITS**. All provisions listed in **PHARMACY BENEFITS** will apply, including **copayment**/**coinsurance**, **deductibles**, and any pricing differences.
- The **copayment** for insulin included in the **drug list** will not exceed $25 per prescription for a 30-day supply, regardless of the amount or type of insulin needed to fill the prescription.
- Certain **covered drugs** may be available at no cost through a **participating pharmacy** for the following categories of medication: severe allergic reactions, hypoglycemia, opioid overdoses and nitrates. For further information, call the number on the back of your **identification card**.
- Select **covered drugs** determined by the **plan** may be covered with no **member** cost share to make these medications affordable to members.
- Note: For members with a chronic, complex, rare, or life-threatening medical condition, covered drugs that will be administered by a provider in a physician's office may be obtained from a **non-participating pharmacy** by the **provider**, after the **provider** has determined that disease progression, patient harm, or death is probable, or where the **provider** has concerns about patient adherence or timely delivery. These services are covered under the medical benefit and the cost-sharing requirements will be the same as if they were obtained from a **participating pharmacy**.

For additional information regarding the applicable **drug list**, please call customer service or visit the website at https://www.bcbstx.com.

GLOSSARY

Allowable Amount means the maximum amount determined by the **HMO** to be eligible for consideration of payment for a particular **covered service**, **covered drug,** or covered supply provided by a **participating provider.** Your **copayment/coinsurance** and any **deductibles** are based on the provisions of the **participating provider** and **participating pharmacy** contracts and the terms of this **plan**.

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

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

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

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

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

Contract Month means the period of each succeeding month beginning on the **group agreement effective date**.

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

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

Covered Drug(s) means any prescription drug:

- Which is included on the applicable **drug list**.
- Which is **medically necessary** and is ordered by an authorized **provider** for you or your **dependent**.
- For which a separate charge is customarily made.
- Which is not consumed at the time and place that the prescription order is written.
- For which the U.S. Food and Drug Administration (FDA) has given approval for at least one indication.
- Which is dispensed by a pharmacy, and you received while covered under the plan, except when received from a provider's office, or during confinement while a patient in a hospital or other acute care institution or facility (please refer to the **MEDICAL LIMITATIONS AND EXCLUSIONS** section).

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

Covered Services means a service or supply in this Certificate for which **benefits** will be provided.

- **Non-Covered Service** means a service or supply for which benefits will not be provided.

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.
- Care that is not a necessary part of medical treatment for recovery including, but not limited to:
  - Helping you bathe.
  - Helping you with daily living activities
  - Helping you dress.
  - Helping you eat and prepare special diets.
  - Helping you with medication.
  - Helping you with routine medical needs
  - Helping you walk

Custodial Care Services means those services that can be safely provided by trained or capable non-professional personnel which do not require the technical skills, professional training, and clinical assessment ability of medical and/or nursing personnel.

Deductible means the amount you pay for a **covered service** before benefits are paid by the **plan**.

Dependent(s) or Dependent Child(ren) means the **subscriber's** family **members** who meet the eligibility requirements of the **WHO GETS BENEFITS** - **Dependent Eligibility** section and have been enrolled by the **subscriber**.

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

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

Domestic Partner means a person with whom you have entered into a **domestic partnership** in accordance with the **employer's plan** guidelines. **Please Note: Domestic partner** coverage is available at your **employer's** discretion. Contact your **employer** for information on whether **domestic partner** coverage is available for your **group** and if COBRA-like **benefits** are available.

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

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

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

Effective Date of Coverage (Effective Date) means the date the coverage for a **participant** begins.

Employee means an individual employed by a **group**/**employer**. For purposes of this **plan**, the term **employee** will also include those individuals who are no longer an **employee** of the **employer**, but who

are participants covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or continued under the appropriate provisions of the Texas Insurance Code.

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

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

- **Standard Medical Treatment** means the services or supplies that are in general use in the medical community in the United States, and:
  - Have been demonstrated in peer-reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated.
  - Are appropriate for the **hospital** or other **provider** in which they are performed.
  - The **physician** or **other professional** has had the appropriate training and experience to provide the treatment or procedure.

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

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

Gender Transition means a medical process by which an individual's anatomy, physiology, or mental state is treated or altered, including by the removal of otherwise healthy organs or tissue, the introduction of implants or performance of other plastic surgery, hormone treatment, or the use of drugs, counseling, or therapy, for the purpose of furthering or assisting the individual's identification as a member of the opposite biological sex or group or demographic category that does not correspond to the individual's biological sex.

Gender Transition Procedure or Treatment means a medical procedure or treatment performed or provided for the purpose of assisting an individual with a **gender transition**.

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

Grace Period means a period of thirty (30) days after all but the first **premium** due date, during which period **premiums** may be paid to the HMO without lapse of coverage occurring. If payment is not

received within thirty (30) days, coverage will be terminated after the 30th day and you will be liable for the cost of services received during the **grace period**.

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

Group Agreement means the agreement the group has with the **HMO**.

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 (**HMO**) that provides **benefits** for health care services.

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

HMO (Health Maintenance Organization) means Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation. The Certificate may refer to the **HMO** as "We", "Us" and/or "BCBSTX".

Hospital means a short-term acute care facility which:

- Is duly licensed as a **hospital** by the state in which it is located and meets the standards established for such licensing and is either accredited by the Joint Commission or is certified as a **hospital provider** under **Medicare**.
- Is primarily engaged in providing inpatient medical care and treatment of sick and injured persons through medical, diagnostic, and major surgical services.
- Provides all services on its premises under the supervision of a staff of **physicians** or **behavioral health providers**.
- Provides 24-hour a day nursing services by or under the supervision of a registered nurse.
- Has in effect a **hospital** utilization review plan.

Hospital Services (except as expressly limited or excluded in this Certificate) means those **medically necessary covered services** that are generally and customarily provided by acute general **hospitals**; and prescribed, directed or authorized by the **PCP**.

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

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

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.

Medically Necessary/Medical Necessity 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 are consistent with generally accepted standards of medical practice in the United States.
- Not primarily for the convenience of the **member** or **participating provider**.

- The most economical supplies or levels of service appropriate for the safe and effective treatment or the **member**.

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

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

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

Member means a **subscriber** or **dependent(s)** covered under the **HMO**. This Certificate may refer to a **member** as "you" or "your".

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

Out-of-Area means not within the **service area**.

Out-of-Pocket Maximum means once you pay this amount in **copayment**/**coinsurance** and any **deductibles** for **covered services**, we pay 100% of the **allowed amount** for **covered services** for the rest of the **benefit period**.

Participating Provider or **Participating** means a **provider** that has entered into a contractual agreement with the **HMO** for the provision of **covered services** to **members**.

- **Non-Participating Provider** means a **provider** that has not entered into a contractual agreement with the **HMO**.

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

- **Non-Participating Pharmacy** means a **pharmacy** which has not entered into a written agreement with the **HMO** to provide pharmaceutical services to you under this Certificate.

Pharmacy means a state and federally licensed establishment where the practice of pharmacy occurs, that is physically separate and apart from any **provider's** office, and where **legend drugs** and devices are dispensed under **prescription orders** to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which they practice.

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

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

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

Preferred Participating Pharmacy means a **participating pharmacy** which has a written agreement with the **HMO** to provide pharmaceutical services to **members** or an entity chosen by the **HMO** to administer its prescription drug program that has been designated as a **preferred participating pharmacy**.

Premium means the amount the **group** or you are required to pay to the **HMO** to continue coverage.

Prescription Order means a written or verbal order from your authorized **provider** to a pharmacist for a drug or device to be dispensed.

Prior Authorization means a determination by the **HMO** that health care services proposed to be provided to a patient are **medically necessary** and appropriate. The **prior authorization** processes will be conducted in accordance with Texas Insurance Code, chapter843, or in accordance with the laws in the state of Texas.

Primary Care Physician/Practitioner or PCP means the **participating physician**, **physician** assistant (PA) or advanced practice nurse (APN) who is primarily responsible for providing, arranging and coordinating all aspects of your health care. You and your **dependents** must each select a **PCP** from those listed by the **HMO** to provide primary care services. You may choose a PCP who is a family practitioner, internist, pediatrician and/or obstetrician/gynecologist (OB/GYN). The PA or APN must work under the supervision of a **participating** family practitioner, internist, pediatrician and/or OBGYN in the same **HMO network**.

Professional Services means those **medically necessary covered services** provided by **physicians** and other **health care professionals** in accordance with this Certificate. All services must be performed, prescribed, directed, or authorized in advance by the **PCP**.

Provider means any duly licensed institution, **physician**, **health care professional** or other entity which is licensed to provide health care services.

Referral means specific directions or instructions from your **PCP**, in conformance with the **HMO's** policies and procedures that direct you to a **participating provider** for **covered services**.

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

Service Area means the geographical area or areas served by the **HMO** and approved by state regulatory authorities. The **service area** includes the area shown and described in this Certificate.

Specialist means a duly licensed **physician**, other than a **PCP**.

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

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

WHO GETS BENEFITS

No eligibility rules or variations in **premium** will be imposed based on your health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status related factor. Coverage under this Certificate is provided regardless of your race, color, national origin, disability, existence of pregnancy, age, sex, gender identity, sexual orientation, political affiliation, or expression. Coverage under this **plan** does not require documentation certifying a COVID-19 vaccination or require documentation of post-transmission recovery as a condition for obtaining coverage or receiving **benefits** under this **plan**. **No person, however, is eligible to re-enroll who had coverage terminated under the General Provisions, Termination of Coverage section**. Variations in the administration, processes or **benefits** under this Certificate are based on clinically indicated, reasonable medical management practices, or are part of permitted wellness incentives; disincentives, and/or other programs that do not constitute discrimination.

Eligibility Requirements

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

Employee Eligibility

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

- Reside, live, or work in the **service area**.
- Meet the definition of an eligible person as specified by your **employer**.
- Satisfy any probationary or waiting period requirements established by the **group**.

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

Dependent Eligibility

If you apply for coverage, you may also include coverage for your **dependents**.

You may be required to submit proof of **dependent** eligibility with the **dependent's** enrollment application/change form before coverage will be extended. This includes documents certifying marriage, **dependent child** disability status, and/or proof of legal guardianship.

Eligible **dependents** must:

- Meet all eligibility criteria established by the **group.**
- Reside in the **service area** or live with a **subscriber** who works in the **service area**, unless coverage is court ordered.

Eligible **dependents** are:

- Your spouse.

- Your **domestic partner** (**Please Note: Domestic partner** coverage is available at your **employer's** discretion. Contact your **employer** for information on whether **domestic partner** coverage is available for your **group**.)
- Your natural child until the month they turn age 26.
- Any other child such as a stepchild, child of a **domestic partner**, eligible foster child, an adopted child (including a child for whom you or your spouse or your **domestic partner** is a party in a legal action in which the adoption of the child is sought), under 26 years of age.
- A child for whom you or your spouse or **domestic partner** is a court-appointed legal guardian, until 26 years of age, provided proof of such guardianship is submitted with the prospective **dependent's** enrollment application/change form.
- Your grandchild, until 26 years of age, who is claimed as a **dependent** on your Federal income tax return. Proof must be furnished at time of enrollment.
- **Dependent** child for whom you are responsible for economic support and maintenance by reason of intellectual disability or physical handicap. You must provide the **HMO** with the **dependent child's** Statement of Disability form. The disability form must include a medical certification of disability. This must be done within thirty-one (31) days of the date of such medical certification. The **HMO** may require this on a yearly basis.

Please Note: A child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage or any combination of these factors does not affect eligibility.

Applying For Coverage

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

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

Coverage will be effective as specified below if you apply during a qualifying enrollment period.

Eligibility Changes

You must notify the HMO of any changes that will affect your or your dependent's eligibility for services or benefits under this Certificate within thirty-one (31) days of the change. Your coverage will not be terminated by the HMO due to health status or health care needs.

Initial Enrollment Period

Each eligible **employee** of the **group** shall be entitled to apply for coverage for themself and eligible **dependents** during the initial enrollment period. Everyone 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 **HMO**.

Open Enrollment Period

Your **employer** will designate an **open enrollment period** during which time you may apply for or change coverage for you and your eligible **dependents**. No proof of insurability will 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 **HMO**.

Special Enrollment Periods
Coverage under this Certificate for persons becoming eligible at times other than the initial enrollment period or the **open enrollment period** will become effective no later than the first of the month following the event.

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

- You or your **dependent** lose other health insurance coverage or COBRA continuation of coverage.
- You lose a **dependent** though death, divorce, or end a **domestic partnership**.
- You gain a **dependent** through marriage, establishment of a **domestic partnership**, or court ordered coverage.
- You gain a **dependent** through birth, adoption, legal guardianship, or placement of a foster child.
- You become newly eligible for coverage because of entering a class of **employees** who are eligible to participate in the **group plan**.

Medicaid or Child Health Plan Special Enrollment Coverage
Coverage begins no later than the first of the month if you apply within 60 days of the following qualifying event:

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

Other Special Enrollment Periods

- Your child reaches the maximum age of 26.
- You lose coverage under your **plan** as specified under the **Termination of Coverage** section.

Late Enrollment
If your application is not received by the **HMO** within 31 days from the eligibility date or date of the event, you will be considered a **late enrollee**, unless otherwise specified and agreed upon by the **employer** and the **HMO**. You will become eligible to apply for coverage during your **employer's** next **open enrollment period**. Your coverage will become effective on the **contract date**.

When Coverage Begins

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

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

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

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

Coverage is automatic for the first 60 days for the following qualifying events. For coverage to continue beyond this time, you must apply for this change within the 60-day period:

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

Loss of Other Health Insurance Coverage
Coverage begins no later than the first of the month if you apply within 31 days of the following qualifying events:

- You or your **dependent(s)** lose other health insurance coverage or COBRA continuation of coverage.

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

- You or your **dependent(s)** were covered under other health insurance coverage at the time you were initially eligible to enroll.
- You or your **dependent(s)** lost other health insurance coverage as a result of:
  - Divorce or legal separation or end of a **domestic partnership**.
  - Death of a spouse or **domestic partner**.
  - Termination of employment or reduction in hours.
  - COBRA continuation of coverage is terminated as explained in the **GENERAL PROVISIONS** section.
  - The prior **health benefit plan** is no longer offering any **benefits** to the class of similarly situated individuals that include you or your **dependent(s)**.
  - If coverage was through an **HMO**, you or your **dependent**(s) are no longer residing, living, or working in the service area of the health maintenance organization and no other benefit option is available.
  - Termination of contribution toward the **premium** made by the former **employer.**
- You or your **dependent(s)** did not lose prior coverage due to failure to pay **premiums** or fraud.
- If it was required, you stated 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.

Health Insurance Premium Payment (HIPP) Reimbursement Program
Coverage begins on the first day of the month following the **HMO's** receipt of enrollment forms or written notice from the Texas Health and Human Services Commission. This, along with **premium** payment, must be received within 60 days of the individual becoming eligible for participation in the HIPP Reimbursement Program. This provision applies to:

- You or your **dependent** who is a recipient of medical assistance under the state of Texas Medicaid Program.
- You or your **dependent** who is enrolled in a Children's Health Insurance Program (CHIP).

You may enroll yourself, if not already covered, and any **dependent** eligible through this provision.

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

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

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

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

UTILIZATION MANAGEMENT

Utilization Management

Utilization management may be called a **medical necessity** review or utilization review, which is used for a procedure, service, inpatient admission, and/or length of stay and is based on the **HMO** medical policy and/or level of care criteria.

Medical necessity reviews may occur:

- Prior to care.
- During care.
- After care has been completed (**post-service medical necessity review**).

Please refer to **medically necessary/medical necessity** under the **GLOSSARY** section for more information about any limitations and/or special conditions pertaining to your **benefits**.

Some services may require **prior authorization** before the start of services, while other services will be subject to a concurrent or **post-service medical necessity review**. You may request a **medical necessity** review for services normally subject to a **post-service medical necessity review** through a **recommended clinical review** as defined below.

Prior Authorization

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

Prior authorization requires the **provider** to get approval from the **HMO** before you are admitted to the **hospital** or for certain types of **covered services**. Renewal of an existing **prior authorization** issued by the **HMO** may be requested by a **provider** up to 60 days prior to the expiration of an existing **prior authorization**.

Upon receipt of a request for **prior authorization** from a **provider**, the **HMO** will review and issue a determination:

- Not later than the 3rd calendar day after receipt by the **HMO** for non-hospitalization care.
- Within 24 hours of receipt for inpatient and concurrent hospitalization care.
- Within one hour of receipt if the proposed services involve post stabilization treatment or a **life-threatening disease or condition**.
- Some Texas-licensed **providers** may qualify for an exemption from **prior authorization** requirements for a particular health care service if the **provider** met criteria set forth by applicable law for the particular health care service. If so, where an exemption applies for a particular service, **prior authorization** is not required and will not be denied based on **medical necessity** or medical appropriateness of care. Other **providers** providing Your care may not be exempt from such requirements. Exemptions do not apply for services that are materially misrepresented or where the **provider** failed to substantially perform the particular service.

For additional information and a current list of health care services that require **prior authorization**, please visit the **HMO** website at www.bcbstx.com.

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

Length of Stay/Service Review

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

A length of service review/concurrent **medical necessity** review means you, your **provider**, or other authorized representative submits a request to extend care beyond the approved time limit. The **HMO** will provide a decision within the timeframes described under the **Review of Claim Determinations** section.

An extension of a previously approved length of stay/service will be based solely on whether continued inpatient care or other health care services are **medically necessary**. If the extension is determined not to be **medically necessary**, the coverage for the length of stay/service will not be extended, except as otherwise described under the **CLAIM FILING AND APPEALS PROCEDURES** section.

Recommended Clinical Review Option

A **Recommended Clinical Review** is:

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

To determine if a **recommended clinical review** is available for a specific service, please visit our website at www.bcbstx.com for the **recommended clinical review list**. Once a decision has been made on the services reviewed as part of the **recommended clinical review** process, the same services will not be reviewed for **medical necessity** after they have been performed.

If a **recommended clinical review** determines the proposed services are not **medically necessary**, you have the right to file an appeal as described under the **CLAIM FILING AND APPEALS PROCEDURES** section. All appeal and review requirements related to **medical necessity** determinations, including independent review, apply to services where your **provider** requests a **recommended clinical review**.

Contacting Behavioral Health

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

Post-Service Medical Necessity Review

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

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

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

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

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

- **Recommended Clinical Review** means an optional voluntary review of **provider's** recommended medical procedure, treatment or test, that does not require **prior authorization**, to make sure it meets approved Blue Cross and Blue Shield medical policy guidelines and **medical necessity** requirements.

HOW THE PLAN WORKS

You are entitled to **medically necessary** medical care and services from **participating providers** including surgical, diagnostic, therapeutic, and preventive services that are provided in the **service area**. Some services may not be covered. To be covered, a **medically necessary** service must also be described under **COVERED SERVICES.** Even though a **physician** or **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.**

Your Insurance Identification Card

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

How Your Cost Share Works

Your **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** lists what you pay for each type of **covered service**. In general, this is how your **benefits** works:

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

Allowable Amount

The **allowable amount** is the amount we will pay for **covered services** you receive under your **plan**.

We have established an **allowable amount** for **medically necessary** services, supplies, and procedures provided by **participating providers** that have contracted with us.

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

Copayments/Coinsurance

Some of the care and treatment you receive under your **plan** will require that a **copayment**/**coinsurance** and any **deductibles** be paid at the time you receive a service. Please refer to your **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**.

Deductible(s)

Benefits under your **plan** will be available for **covered services** and for **covered drugs** after you meet your **deductible** as shown under your **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** section.

How Individual Deductibles Work

Benefits will be available after your individual **deductible** amount, shown under your **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS,** have been met.

How Family Deductibles Work

- 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 under 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 **benefit period.**

Out-of-Pocket Maximum(s)

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

Out-of-pocket maximums paid by you, or on your behalf, in a **benefit period**, shall not exceed two hundred percent (200%) of the total annual **premium**. We will determine when maximums have been reached for **covered services** and for **covered drugs** based on information provided to us by you, and **participating providers**, to whom you have made payments for **covered services** and for **covered drugs**. **Out-of-pocket maximums** will include **copayments**/**coinsurance** and any **deductibles**.

How Individual Out-of-Pocket Maximums Work

Once you reach the maximum, you are not required to make additional payments for **covered services** or **covered drugs** for the remainder of the **benefit period**.

How Family Out-of-Pocket Maximums Work

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 under the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS.** When the family **out-of-pocket maximum** amount is reached, you are not required to make additional payments for **covered services** or **covered drugs** for the remainder of the **benefit period**.

Please Note: Your **group** has made additional **pharmacy benefits** available. **Copayment**/**coinsurance** and any **deductibles** for **pharmacy benefits** do not apply to the medical **out-of-pocket maximum** amount but will apply to the **out-of-pocket maximums** for **pharmacy benefits** indicated under the **PHARMACY SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**.

Provider Information

Only services that are performed, prescribed, directed or authorized in advance by the **PCP** or **HMO** are covered **benefits**, except for **emergency care**, **participating urgent care**, and **retail health clinics** or **covered services** provided to **members**, who may directly access an obstetrician/gynecologist (OB/GYN) for:

- Well woman exams
- Obstetrical care

- Active gynecological conditions
- Diagnosis, treatment, and **referral** for any disease or condition within the OB/GYN's practice.

The **HMO** and **participating providers** do not have financial responsibility for services you seek or receive from a **non-participating provider** or facility, except as set forth below, unless both your **PCP** and **HMO** have made prior **referral** authorization arrangements.

Your PCP

Your **primary care physician (PCP)** coordinates your medical care either by providing treatment or by issuing a **referral** directing you to **participating providers**. Except for **emergency care**/medical emergencies or certain direct-access **specialist benefits** described in this Certificate, only those services which are provided by or referred by your **PCP** will be covered. It is your responsibility to consult with the **PCP** in all matters regarding your medical care.

If your **PCP** performs, suggests, or recommends a course of treatment for you that includes services that are **not covered services**, the entire cost of any such **non-covered services** will be your responsibility.

Selecting a PCP

Upon enrollment, you must choose a **primary care provider (PCP)** for all members from the **HMO's** directory of **participating providers** to receive **covered services**.

For **dependent children**, you may designate any **participating provider** who specializes in pediatric care as their **PCP**.

The most current **provider** directory can be found at www.bcbstx.com. You may refer to your **provider** directory or call customer service at the toll-free telephone number on the back of your **identification card**. If a **PCP** is not chosen, we may assign one, and your **benefits** will be limited to coverage for **emergency care**.

In addition to a **PCP**, **members** may also select an Obstetrician/Gynecologist (OB/GYN) in your **PCP's network** of **participating providers** for gynecological and obstetric conditions, including annual well-woman exam and **maternity care**, without first obtaining a **referral** from a **PCP** or calling the **HMO**.

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

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, to request a change form, or for assistance in completing the form. The change will become effective on the first day of the month following the **HMO's** receipt and approval of the request.

In the event of termination of a **participating provider**, the **HMO** will use its best efforts to provide reasonable advance notice to you. Special circumstances may allow for you to be eligible to continue receiving treatment from a **participating provider** after the **effective date** of termination. Please see the

Continuity of Care section below.

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 the **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 under **CLAIM FILING AND APPEALS PROCEDURES.** If your request is approved, the **specialist's** designation as your **PCP** will not be effective retroactively, because **"**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 **HMO** cannot guarantee the availability or continued participation of a particular **provider.** Either the **HMO** or any **participating provider** may terminate the **provider** contract or limit the number of **members** that will be accepted as patients. If the **PCP** initially selected cannot accept additional patients, you will be given an opportunity to make another **PCP** selection. You must then cooperate with the **HMO** to select another **PCP**.

Out-of-Network Services

You may obtain **covered services** from **providers** who are not part of the **HMO's** network of **participating providers** when receiving **emergency care**. Also, court-ordered **dependents** living outside the **service area** may use **non-participating providers**.

If **covered services** are not available from **participating providers** within the **service area**, the **HMO** will allow, upon approval, a **referral** by your **PCP** to a **non-participating provider**.

- The request must be from a **participating provider.**
- Requested documentation must be received by the **HMO**.
- The **HMO** will provide a **referral** within an appropriate time, not to exceed five business days.
- The **HMO** will reimburse the **non-participating provider** at the usual and customary rate or otherwise agreed upon rate, less the applicable **copayment(s)/coinsurance** and any **deductibles**. You are responsible for the **copayments/coinsurance** and any **deductibles** for such **covered services**.
- The **HMO** will not deny a **referral** before a review by a **specialist** of the same or similar specialty as the **provider** to whom a **referral** is requested.

In some instances, you will be unable to choose a **participating provider**, such as when you receive services from a **non-participating** facility-based **provider** in a **network** facility, or when you receive services from a **non-participating** laboratory or diagnostic imaging facility in connection with care provided by your **participating provider**. In these instances, your services may be covered, and you would not be responsible for any amounts beyond the **copayment/coinsurance** and any **deductibles**. If you receive a bill from an out-of-**network provider** in such circumstances, please contact the **HMO**.

If you elect to use out-of-**network providers** for **non-emergency care** for services and supplies available from **participating providers**, **benefits** will not be covered.

Balance billing is prohibited for **emergency care** ground ambulance transportation services from **non-participating providers** if the services would be covered with a **participating provider**; state-level protections for ground ambulance services will remain in effect for as long as they are upheld or mandated by Texas Law.

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**.

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. However, upon discharge, you must return to the care of your **PCP** or have your **PCP** coordinate care that may be **medically necessary**.

Provider Communication

The **HMO** will not prohibit, attempt to prohibit, or discourage any **provider** from discussing or communicating to you, or your authorized representative information or opinions regarding your health care, the **health benefit plan**, the **provider's** contract with the **HMO** has terminated, or that the **provider** will no longer be providing services under the **HMO**.

Your Responsibilities

- You shall complete and submit to the **HMO** an application, forms or statements the **HMO** requests.
- You agree that all information contained in the application, form, and statement submitted to the **HMO** regarding enrollment under this Certificate is true, correct, and complete to the best of your knowledge and belief.
- You shall notify the **HMO** immediately of any change of address for you or any of your covered **dependents**.
- You understand that the **HMO** is acting in reliance upon all information you provide to **HMO**.
- By electing coverage pursuant to this Certificate, or accepting **benefits** hereunder, you represent that all information provided is true and accurate and agree to all terms, conditions, and provisions under this Certificate.

- You are subject to, and shall abide by, the rules and regulations of each **provider** from whom you receive **benefits**.

Refusal to Accept Treatment

You may refuse to accept procedures or treatments offered by a **participating provider**. A **participating provider** may regard the refusal as a discontinuance of the **provider**-patient relationship and as obstructing proper medical care.

A **participating provider** should use their best efforts to provide all necessary and appropriate **professional services** in-keeping with your wishes, as long as it can be done consistent with a **participating provider's** judgment as to the requirements of proper medical practice.

If you refuse to follow a recommended treatment or procedure, and the **participating provider** informs you of their belief that no professionally acceptable alternative exists, neither the **HMO** nor any **participating provider** will have any further responsibility to provide care for the condition under treatment.

Continuity of Care

In the event you are under the care of a **participating provider** and the **provider** stops participating in the **HMO's network**, (for reasons other than a failure to meet applicable quality standards, including, but not limited to, medical incompetence, professional behavior, or fraud), we will continue coverage for that **provider's covered services** if all of the following conditions are met:

- You are undergoing a course of treatment for a **serious and complex condition**.
- You are undergoing institutional or inpatient care.
- You are scheduled to undergo non-elective surgery from the **provider** (including receipt of post-operative care from the **provider** with respect to the surgery.
- You are pregnant or undergoing a course of treatment for the pregnancy.
- You are terminally ill.
- The **provider** submits a request to the **HMO** to continue coverage of your care identifying the condition you are being treated for; and if necessary, specifies that the **provider** reasonably believes discontinuing treatment could cause you harm.

The **provider** agrees to continue accepting the same reimbursement that applied when participating in the **HMO's network**, and not request payment from you for any amounts you would not be responsible for if the **provider** were still participating in the **HMO's network**.

In addition to the **GLOSSARY** section of this Certificate, the following definition applies:

Serious and Complex Condition means:

- Acute illness: Serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, you are currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition).
- Chronic illness or condition: Requires specialized medical care over a prolonged period of time

and is life-threatening, degenerative, disabling, or potentially disabling or congenital.

The continuity of coverage under this subsection will continue until the treatment is complete but will 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 pregnant and past the thirteenth (13^{th}) week of pregnancy at the time the **provider's** termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery.

Please Note: You have the right to appeal any decision made for a request for benefits under this subsection as explained under the **CLAIM FILING AND APPEALS PROCEDURES** section of this Certificate.

Federal Balance Billing and Other Protections

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

Protections from Unexpected Costs for Medical Services from Non-Participating Providers

Your Certificate contains provisions related to protection from surprise balance billing under Texas law. Federal law provides additional financial protections for you when you receive some types of care from **providers** who do not participate in your **network**. If you receive the types of care listed below, your in-**network** cost-sharing levels will apply to any in-**network deductible** and **out-of-pocket maximums**. Additionally, for services below that are governed by federal law (instead of state law), your cost-share amount may be calculated on an amount that generally represents the median payment rate that Blue Cross Blue Shield of Texas (BCBSTX) has negotiated with **participating providers** for similar services in the area:

- **Emergency care** from facilities or **providers** who do not participate in your **network**.
- Care furnished by **non-participating providers** during your visit to a participating facility.
- Air ambulance services from **non-participating providers** if the services would be covered with a **participating provider**.

Non-participating providers may not bill you for more than your **copayments/coinsurance** and any **deductibles** for these types of services. There are limited instances when a **non-participating provider** of the care listed above may send you a bill for up to the amount of that **provider's** billed charges.

Please Note: You are only responsible for payment of the **non-participating provider's** billed charges if, in advance of receiving services, you signed a written notice form that complies with applicable state and/or federal law.

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

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

Premium Payment

On or before the **premium** due date, the **group** or its designated agent shall remit to the **HMO** on behalf of each **subscriber** and **dependents** the amount specified in the **group agreement**.

Failure to Make Payments

Only if the **HMO** receives your payment, you will be entitled to health services covered under this Certificate for the **contract month** the payment is received. If any required payment is not received by the **premium** due date of the **contract month**, then you will be terminated at the end of the **grace period** of the **contract month**. You will be responsible for the cost of services provided to you during the **grace period** of the **contract month** if **premium** payments are not made by **group.**

Change in Premium Rates

The **HMO** reserves the right to establish a revised schedule of **premium** payments on each anniversary date of this Certificate upon sixty (60) days written notice to **group**. If a change in this Certificate is required by law or regulation which increases the **HMO's** risk under this Certificate, the **HMO** reserves the right to change the schedule of **premium** payments upon sixty (60) days written notice to **group**.

Member Complaint Procedure

If you have a **complaint** concerning the **HMO** and/or a **participating provider** please follow the process described under **CLAIM FILING AND APPEALS PROCEDURES.**

Member Claims Refund

You are not expected to make payments, other than required **copayments**/**coinsurance** and any **deductibles**, for any **benefits** provided under this Certificate. However, if you make a payment, you may send the **HMO** a claim for reimbursement. The instructions for a claim for reimbursement are in the chart below. Please visit the website at www.bcbstx.com or call customer service at the toll-free number on the back of your **identification card** to obtain a medical claim form or a prescription reimbursement claim form.

Claim For Reimbursement	Requirement	Deadline
Notice of **Claim** (Written proof of a payment to the **HMO**)	You must notify the **HMO** within 90 days from after a covered expense was incurred.	If you do not notify the **HMO** within 90 days, you must show that it was not reasonably possible to give notice and that notice was given as soon as reasonably possible. A **claim** may not be given later than 1 year after a covered expense was incurred, except for **prescription drug claims** which must be given within 90 days of the date of purchase. Written proof of a payment to the **HMO** within one (1) year of occurrence.
Receipt of your written notice	The **HMO** will acknowledge your claim and begin any necessary investigation.	Within 15 days
Additional information from you	The **HMO** may request additional information from you to complete your **claim.**	Within 15 business days of receipt of a completed **claim**. However, the **HMO** may notify you why additional time is needed to investigate your claim.
Completed **claim** and additional time		Within 45 days after the additional time notification is given to you the **HMO** will give a decision.
The **HMO** notifies you that the **HMO** will pay a claim or part of a claim		Within 5 business days

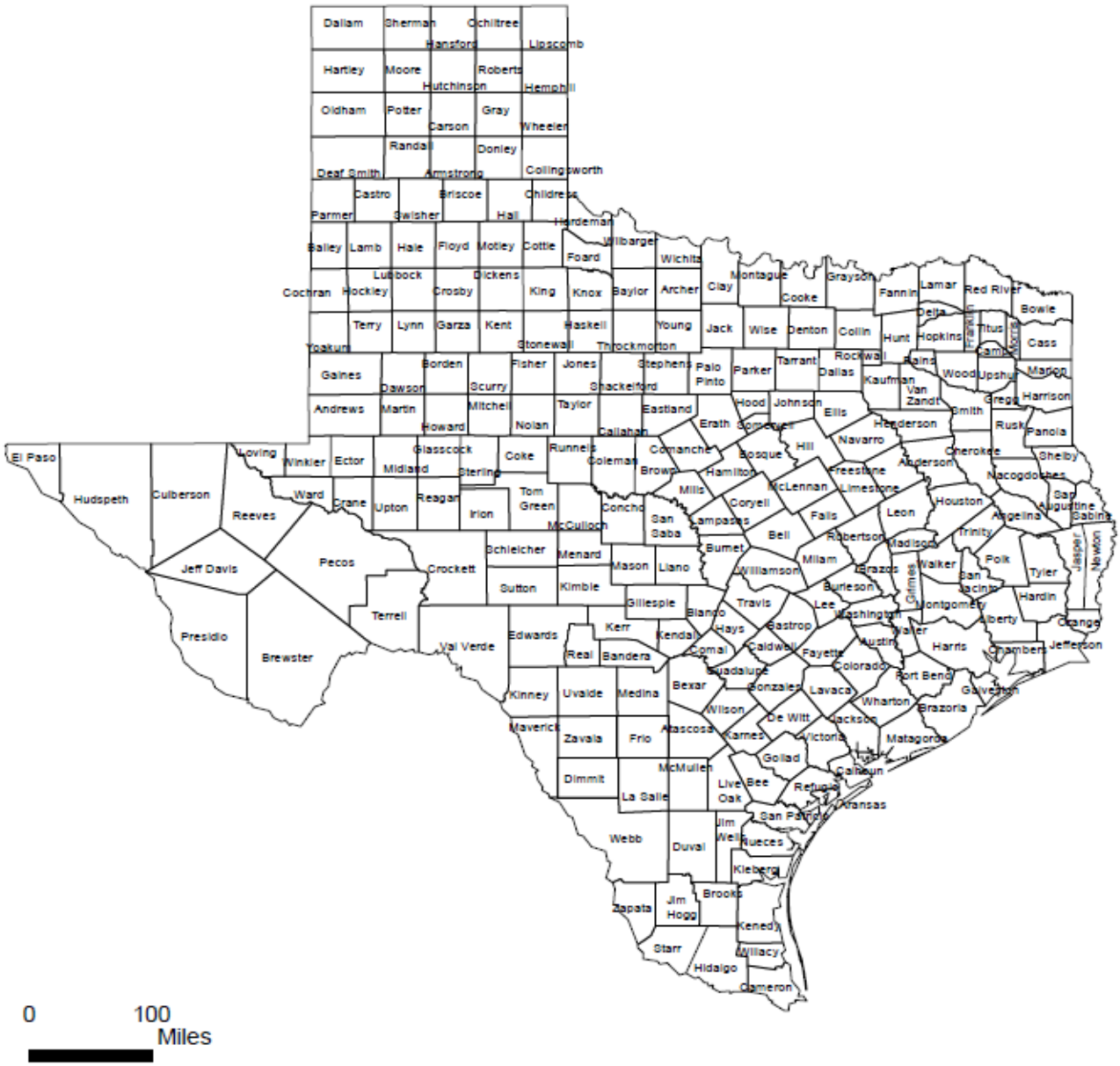
Claim or Benefit Reconsideration

If a claim or a request for **benefits** is partly or completely denied by the **HMO**, you will receive a written explanation of the reason for the denial and are entitled to a full review. If you wish to request a review or have questions regarding the explanation of **benefits**, please call or write customer service at the toll-free telephone number or address on the back of your **identification card**. If you are not satisfied with the information received, you may request an appeal of the decision or file a **complaint** by following the process under the **CLAIM FILING AND APPEALS PROCEDURES** section.

Service Area

Service Area

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



Service Area Plan

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

COVERED SERVICES

This section describes **covered services** for which your **plan** pays **benefits** for you and your eligible **dependents. Covered services** must also meet the criteria for **medical necessity**. Some **covered services** may also **require prior authorization,** which requires the **provider** get approval from your **plan** for certain types of **covered services**. Please refer to the **UTILIZATION MANAGEMENT** section. It is your responsibility to ensure that **prior authorization** is obtained or those services may carry a cost share penalty or denial of payment. Refer to the **UTILIZATION MANAGEMENT** section or contact customer service by calling the number on the back of your **identification card** or access Blue Access for Members℠ (BAM) for additional information including which services may require **prior authorization**.

Requirements

All **covered services**, unless otherwise specifically described:

- May require **prior authorization**.
- Must be **medically necessary**.
- Must be provided by a **health care professional** who is a **participating provider**.
  (1) Who is licensed, certified, or registered by an appropriate agency of the state of Texas.
  (2) Whose professional credential is recognized and accepted by an appropriate agency of the United States.
  (3) Who is certified as a **provider** under the TRICARE military health system.
  (4) An individual acting under the supervision of a **health care professional** described under item 1.
- Are subject to the **copayments**/**coinsurance** and any **deductibles** shown under the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** section.
- May have limitations, restrictions, or exclusions described under the **MEDICAL LIMITATIONS AND EXCLUSIONS** section.
- Must be performed, prescribed, directed, or authorized in advance by the **PCP** and/or the **HMO**

Some **covered services** may not be listed in this Certificate. For assistance determining if a service will be covered you may call the toll-free telephone number on the back of your **identification card.**

Covered Services (appear alphabetically)

Acquired Brain Injury

Covered services include:

- Cognitive communication therapy
- Cognitive rehabilitation therapy
- Neurobehavioral testing
- Neurobehavioral treatment
- Neurocognitive therapy and rehabilitation
- Neurofeedback therapy
- Neurophysiological testing
- Neurophysiological treatment
- Neuropsychological testing

- Neuropsychological treatment
- Psychophysiological testing
- Psychophysiological treatment
- Remediation
- Post-acute transition services and community reintegration services (if necessary as a result of and related to an **acquired brain injury**), including:
    - Outpatient day treatment services, or
    - Any other post-acute care treatment services.

To ensure that appropriate post-acute care treatment is provided, the **HMO** includes coverage for periodic reevaluation for a **member** who:

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

Treatment of **acquired brain injury** will be covered the same as any other physical condition.

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

- Congenital
- Hereditary
- Degenerative

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

- Cognition
- Physical functioning
- Psychosocial behavior
- Sensory processing

Allergy Care

Covered services include:

Allergy testing and treatment provided or arranged by a **PCP**.

The following are **not covered services**:

- Services or supplies provided primarily for:
    - Allergen specific IgG measurement
    - **Clinical ecology** or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists.
    - **Environmental sensitivity**
    - Inpatient allergy testing or treatment.
    - Management and treatment of Idiopathic Environmental Intolerance (IEI), including laboratory or other diagnostic tests to affirm the diagnosis of IEI.

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).
- Skin irritation by Rinkel method.
- Subcutaneous provocative and neutralization testing (injecting the patient with allergen).
- Sublingual provocative testing (droplets of allergenic extracts are placed in mouth).
- Urine auto injection (injecting one's own urine into the tissue of the body).

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.

Ambulance Services

Covered services include:

- **Emergency care**, as defined, by means of ground ambulance services or air ambulance services to the nearest **hospital** equipped and staffed for treatment of a **member's** condition.
- Non-**emergency care** by means of ground ambulance services or air ambulance services when **medically necessary** and one of the following conditions is met:
    - Authorized by a **PCP**
    - Authorized by the **HMO**, to or from a facility equipped and staffed for treatment of a **member's** condition.

Non-Emergent air ambulance transportation is only covered when terrain, distance, your physical condition, or other circumstances require the use of air ambulance services rather than ground ambulance services.

Ambulance services 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. A **member's** condition must be such that any other form of transportation would be medically contraindicated.

The following are **not covered services**:

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

Autism Spectrum Disorder

Covered services include:

- Habilitative or rehabilitative treatments
- Psychiatric care, including diagnostic services.
- Psychological assessments and treatments
- Screenings at 18 and 24 months
- Therapeutic care, including behavioral, speech, occupational and physical therapies that provide treatment in the following areas:

- Applied behavior analysis (ABA) intervention and modification.
- Cognitive functioning
- Drugs or nutritional supplements used to address symptoms of **autism spectrum disorder**
- Motor planning
- Pragmatic, receptive, and expressive language
- Self-care and feeding
- Sensory processing

- Generally recognized services prescribed in relation to **autism spectrum disorder** by a **PCP** in as part of a treatment plan recommended by that **physician** are available.

Benefits for **autism spectrum disorder** will not apply towards any visit maximum.

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.

Bariatric Surgery

Covered services that require **prior authorization** include:

- Bariatric surgery

Behavioral Health

Mental Health Treatment

Covered services that require **prior authorization** include:

- Intensive outpatient program
- Office visits with a **physician**, **behavioral health administrator**, psychiatrist, psychologist, social worker, or licensed professional counselor.
- Outpatient diagnostic evaluation, treatment, and crisis intervention.
- Partial hospitalization treatment
- The treatment of mental health conditions provided by:
  - A **hospital**
  - **Crisis stabilization unit or facility**
  - Psychiatric **hospital**
  - **Residential treatment center**
  - **Residential treatment center** of children and adolescents
  - Electro-convulsive therapy (ECT)
  - Psychological testing

Mental health treatment must be authorized by the **HMO** or its designated **behavioral health administrator** and provided by a **participating provider,** which includes a **participating** facility.

Covered services are subject to the same limitations as treatment of physical illness. Services must be provided based on an individual treatment plan with specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.

The following are **not covered services**:

- **Behavioral health** services provided at behavioral modification facilities, boot camps, emotional group academies, military schools, therapeutic boarding schools, wilderness programs, halfway houses or group homes.
- Inpatient mental health services that are provided:
  - 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 **members** to non-**participating providers** for **covered services** not available from participating providers as outlined in the **HOW THE PLAN WORKS** section.
  - For the following diagnosed conditions:
    - Alzheimer's disease
    - Chronic organic brain syndrome
    - Educational testing, or any other testing required by a school system, psychiatric therapy on court order or as a condition of parole or probation.
    - Intractable personality disorders
    - Intellectual disabilities

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

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

Crisis stabilization unit or facility means an institution which is appropriately licensed and accredited as a **crisis stabilization unit or facility** for the provision of mental health treatment services to persons who are displaying a moderate to severe acute demonstrable psychiatric crisis.

Mental Health and Substance Use Disorder Services

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

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

The following are **not covered services**:

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

Behavioral Health Note: 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. We will not impose quantitative or nonquantitative treatment limitations on **benefits** for **behavioral health** services that are generally more restrictive than treatment limitations imposed on coverage of benefits for medical or surgical services.

Residential Treatment Center means a facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a level of security, supervision, and structure medically necessary to meet the needs of patients served or to be served by such facility.

Residential treatment centers must be licensed by the appropriate state and local authority as a **residential treatment facility** or its equivalent under the laws or regulations of such locality and/or must be accredited by a national accrediting body as a **residential treatment center** or its equivalent. Accepted accrediting bodies are The Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), Accreditation Association for Ambulatory Healthcare (AAAHC), Council on Accreditation of Services for Families and Children Inc. (COA), or National Integrated Accreditation of Healthcare Organizations (NIAHOSM). This includes any specialized licensing that may be applicable given the services to be provided or population to be served.

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

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

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

Biomarker Testing

Covered services include:

- Appropriate management
- **Biomarker testing** for the purpose of any of the following:
  - Diagnosis
  - Treatment

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

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

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

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

Biomarker means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to the specific therapeutic intervention. Includes gene mutations and protein expression.

Biomarker Testing means the analysis of a patient's tissue, blood, or other biospecimen for the presence of a **biomarker**. The term includes single-analyte tests, multiplex panel tests and whole genome sequencing.

Clinical Trials

Covered services include:

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

Services must be provided or arranged by a **PCP**.

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

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

Related services are:

- Hospitalization required to perform the **non-covered service**.

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

The following are not **covered services**:

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

Clinician-Administered Drugs

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

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

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

Cochlear Implant

Please see the **Hearing Implant** section.

Cosmetic, Reconstructive or Plastic Surgery

Covered services, which may require **prior authorization**, are limited to the following:

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

Coverage will be the same as for treatment of any other physical illness generally, only when prescribed or arranged by a **PCP**.

The following are **not covered services**:

- Services or supplies for cosmetic, reconstructive, or plastic surgery, including breast augmentation (enlargement) surgery, even when **medically necessary**, except as described in this section.

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

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.

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.

Dental and Oral Surgical Procedures

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

- Limited oral surgical procedures when prescribed by a **PCP** and performed in a **participating provider's** office or in an inpatient or outpatient setting.
- **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.

The following are covered oral surgical procedures:

- Removal of complete bony impacted teeth.
- Treatment for **accidental injury,** 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.
- Treatment or correction of a non-dental physiological condition which has resulted in severe functional impairment.
- Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

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

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

The following are **not covered services**:

- General dental services

- Non-surgical or non-diagnostic services, or supplies, for treatment or related services to the temporomandibular (jaw) joint or jaw-related neuromuscular conditions, with:
    - 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.
    - Dental restorations
    - Devices
    - Oral appliances, splints or orthotics
    - Orthodontics
    - Prosthetics
    - Physical therapy

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.

Diabetic Equipment, Supplies and Self-Management

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

- Diabetes self-management training in an inpatient or outpatient setting which enables you to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications.
- Medical nutrition therapy relating to diet, caloric intake and diabetes management.
- Visits for re-education and refresher training.

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

Equipment:

- Insulin pumps (both external and implantable) and insulin pump supplies including:
    - Adhesive supplies
    - Batteries
    - Durable and disposable devices used to assist with insulin injection.
    - Infusion sets
    - Infusion cartridges
    - Other disposable supplies
    - Skin preparation items
- Podiatric appliances, including up to two pairs of therapeutic footwear per **benefit period** to prevent complications of diabetes.

Supplies:

- Biohazard disposable containers
- Glucagon emergency kits
- Glucose meter solution
- Injection aids

- Insulin and insulin analogs
- Insulin infusion devices
- Insulin syringes
- Lancets and lancet devices
- Prescriptive and nonprescriptive oral agents for controlling blood sugar levels.
- Test strips for glucose monitors.
- Visual reading and urine test strips and tablets that test for glucose, ketones, and protein.

Covered services also include:

- New or improved treatment, equipment or supplies that become available, and are:
  - Approved by the U.S. Food and Drug Administration (FDA).
  - **Medically necessary** and appropriate
- Prescribed by your **physician** or other **provider.**
- Repairs and necessary maintenance of **insulin** pumps if not covered by 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.

When diabetes equipment and supplies are obtained, you may have to pay the full amount of their bill and submit a reimbursement claim form to the **HMO** with itemized receipts. Visit the website at www.bcbstx.com to obtain a medical claim form.

Diagnostic Mammograms and Other Breast Imaging

Covered services include:

- Magnetic resonance imaging
- Mammography
- Ultrasound imaging

Diagnostic imaging is designed to evaluate:

- A subjective or objective abnormality detected by a **physician** or patient in a breast.
- An abnormality seen by a **physician** on a screening mammogram.
- An abnormality previously found by a **physician** as probably benign in a breast for which follow-up imaging is recommended by a **physician**.
- An individual with a personal history of breast cancer or dense breast tissue.

Diagnostic imaging and mammograms are covered to the same extent as screening mammograms as described under the **COVERED SERVICES** and **PREVENTIVE CARE** sections**.**

Diagnostic Services

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

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

The following are covered diagnostic and diagnostic imaging service examples:

- Bone scan
- Cardiac stress test
- Electrocardiogram
- Laboratory and pathology
- Myelogram
- Nuclear medicine
- PET, CT, MRI, and other electronic medical procedures
- Radiology and x-ray
- Sleep Studies
- Ultrasounds

Services must be ordered, authorized, or arranged by a **PCP** and provided through a **participating** facility.

Durable Medical Equipment (DME)

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

- The rental and/or purchase of **durable medical equipment** through a **participating DME provider** with a written prescription for your therapeutic use. We will determine whether the **DME** is rented or purchased and retains the option to recover the **DME** upon cancellation or termination of your coverage. Rental equipment is not to exceed the total cost of the equipment.

The following are covered equipment examples:

- Bedside commode
- Wheelchair, cane, crutches, walker, ventilator, oxygen tank
- **Hospital** bed

The following are examples of non-covered equipment:

- Bathing devices
- Convenience items
- Exercise equipment
- Home spirometers or telespirometers
- Leotards and other clothing type items
- Non-hospital beds
- Room or central environmental conditioning devices
- Supplies that are usually stocked in the home for general use, including but not limited to Band-Aids, thermometers, lubricating jelly, etc.
- Transportation equipment, including, but not limited to, customized vehicles (cars, vans, etc.), car seats, etc.

DME is only covered at initial placement and when standard replacements are needed due to physical growth of **members** under 18 years of age and must be consistent with the **Medicare DME** Manual.

Durable Medical Equipment 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.

Emergency Services

Covered services include:

- Emergency medical care when you receive **covered services** that meet the definition of **emergency care**.
- We will pay for a medical screening examination or other evaluation 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.
- You must notify your **PCP** within forty-eight (48) hours after receiving **emergency care**, or as soon as possible without being medically harmful to you.

Emergency Care

Emergency care services (that meet the definition of **emergency care**) from a **participating** or non-**participating hospital** emergency department, within or out of the **service area**, will be covered. **Emergency care** services are subject to a **copayment**/**coinsurance** and any **deductibles**, unless you are admitted as an inpatient from the emergency room, in which case you pay the inpatient **hospital** amount. You are not responsible for any amounts beyond the **copayment**/**coinsurance** and any **deductibles** shown under the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** section.

If post stabilization care is required in a non-**participating hospital** (after receiving **emergency care** in a **hospital** emergency facility or **participating** comparable facility), has been treated and stabilized, the treating **provider** may contact us, but **prior authorization** is not required. For the purposes of this paragraph, "comparable facility" includes the following:

- Any stationary or mobile facility including, but not limited to, level V trauma facilities and Rural Health Clinics, that have licensed or certified personnel and equipment to provide advanced cardiac life support.
- For purposes of **emergency care** related to mental illness, a mental health facility provides 24-hour residential and psychiatric services and 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.
    - A facility operated by a community center or other entity the Texas Department of State Health Services designates to provide mental health services.
    - A **hospital** in which the diagnosis, treatment, and care for persons with mental illness is provided, and licensed by the Texas Department of State Health Services.
    - A **hospital** operated by a federal agency.

Regardless of other provisions under this Certificate to the contrary, for **emergency care** provided by **participating** or non-**participating providers**, we will fully reimburse **providers** at its usual and customary rate, or an agreed-upon rate, not to exceed billed charges. This amount is calculated excluding any in-**network copayment**/**coinsurance** and any **deductibles** imposed with respect to a **member**.

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

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

Please Note: If **out-of-area emergency care** was received because you, your spouse, child, or unborn child's health was in danger. You may be entitled to protection from balance billing. If You have questions about whether your claim was processed as **emergency care**, or questions about a balance bill, please call the toll-free telephone number on the back of your **identification card**.

Out-of-Area Services

Only **emergency care** services as described above are covered. Continuing or follow-up treatment for **emergency care** is limited to the care required before you are able to return to the **service area** without medically harmful consequences. **Emergency care** services for **out-of-area services** are subject to the **copayment**/**coinsurance** and any **deductibles** as described under the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** section.

Family Planning Services

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

- Diagnostic counseling, consultations, and planning services for family planning.
- Insertion or removal of an intrauterine device (IUD), including the cost of the device.
- Diaphragm or cervical cap fitting, including the cost of the device.
- Insertion or removal of a birth control device implanted under the skin, including the cost of the device.
- Injectable contraceptive drugs, including the cost of the drug.
- Voluntary sterilizations, including, but not limited to, vasectomy and tubal ligation.

The following are **not covered services**:

- Sterilization reversal
- Treatment of sexual dysfunction including medications, penile prostheses, and other surgery, and vascular or plethysmographic studies that are used only for diagnosing impotence.

Please Note: Some **benefits** for family planning are available under the **PREVENTIVE CARE** section.

Fertility Preservation Services

Benefits for **fertility preservation services** will be provided when a **medically necessary** treatment may directly or indirectly cause **iatrogenic infertility**.

Covered services include standard procedures to preserve fertility consistent with:

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

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

- Surgery
- Chemotherapy
- Radiation

Fertility Preservation Services means the collection and preservation of sperm, unfertilized oocytes, and ovarian tissue; and does not include the storage of such unfertilized genetic materials.

Iatrogenic Infertility means an impairment of fertility, including medical treatments that the American Society of Clinical Oncology or the American Society for Reproductive Medicine has established, caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment affecting reproductive organs or processes.

Gender Transition Procedure or Treatment

Covered services include:

- Coverage for related adverse consequences and side effects.
- Necessary annual testing and screening.
- Coverage for procedures to manage, reverse, reconstruct from, or recover from the **gender transition**.

Hearing and Speech Services

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

- Inpatient and outpatient care and treatment for the loss or impairment of hearing and/or speech that is treated the same as any other physical illness.

Benefits for **autism spectrum disorder** will not apply towards, and are not subject to, any hearing and speech services visit maximums.

Hearing Aids

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

- Any related services necessary to access, select, and adjust or fit a **hearing aid**.

- Habilitation and rehabilitation services
- Prescribed electronic **hearing aids** installed via a prescription written during a covered hearing exam.

The following are **not covered services**:

- Batteries or cords unless needed at the time of the initial placement of the **hearing aid** device(s).
- Functional defect of **hearing aids.**
- Replacement of a **hearing aid** that is lost, stolen or broken.
- Replacement parts or repairs for a **hearing aid**.

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

Hearing Implants

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

- One cochlear implant including an external speech processor and controller, per impaired ear.
- Fitting and dispensing services
- Habilitation and rehabilitation services
- The provision of ear molds as necessary to maintain optimal fit.
- Treatment related to the maintenance of your cochlear implants.

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

Home Health Care

Covered services include the following when prescribed by a **PCP** and authorized by the **HMO**:

- Care in the home by health care professionals who are **participating providers.**
- Private duty nursing when related to **home health care** and determined to be **medically necessary** and ordered or authorized by a **PCP.**

Visits include but are not limited to:

- Home health aide services while you are receiving covered nursing or therapy services.
- Physical, occupational, speech, and respiratory therapy services by licensed therapists.
- **Professional services** of a registered nurse (RN) or licensed practical nurse (LPN).

The following are **not covered services**:

- Food or home delivered meals
- Homemaker services
- Maintenance therapy
- Services or supplies for long-term or **custodial care.**
- Transportation services

Home Health Care means healthcare services provided to a patient who is at home due to a sickness or injury requiring services from a skilled and licensed professional on an intermittent or part time basis.

Hospice Care

Covered services include:

- Care provided by:
  - **Hospital**
  - Skilled nursing facility
  - Duly licensed **hospice care** agency
- Counseling services routinely provided by the hospice agency, including bereavement counseling.
- Inpatient, outpatient, or hospice facility agency services.
- In-home services which are part of a plan of care.
- Private duty nursing when related to **home health care** and determined to be **medically necessary** and ordered or authorized by a **PCP.**

Hospice care may be covered when:

- You have a terminal illness with a life expectancy of 6 months or less, as certified by your attending **physician**.

The following are **not covered services**:

- Home delivered meals
- Services or supplies for long-term or **custodial care.**
- Transportation services

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

For care provided in a **hospital** setting, the **benefits** described under the **Inpatient Hospital Services** section will apply.

Infertility Services

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

- Services provided in connection with a diagnosis and/or treatment of infertility. These services may include:
  - Evaluation services to determine underlying cause of infertility.
  - Planning services
  - Treatment for problems of fertility and infertility, subject to the exclusions under the **MEDICAL LIMITATIONS AND EXCLUSIONS** section. Once the infertility workup and testing have been completed, subsequent workups and testing will require approval of the **HMO** medical director.

The following are **not covered services**:

- 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.
- In vitro fertilization and fertility drugs.

Inpatient Hospital Services

Inpatient **hospital services**, except **emergency care** and treatment of breast cancer, must be **medically necessary** and authorized by your **PCP**.

Covered services that require **prior authorization** include:

- Inpatient care received in a **hospital** setting including:
  - Bed, board and general nursing care when you are in a semi-private room, an intensive care unit or private room.
  - Short-term rehabilitation therapy services
  - Special duty and private duty nursing
  - Special diets and meals

- Ancillary services such as:
  - Anesthesia supplies and services provided by an employee of the **hospital** or other professional **provider**.
  - Lab work, x-ray, and other diagnostic services.
  - Operating, delivery, and treatment rooms.
  - Therapy service
  - Whole blood and blood plasma, blood processing, and administration.
- Drugs, medications, biologicals, and their administration
- Treatment of breast cancer (with no **prior authorization** required) for a minimum of:
  - 48 hours following a mastectomy.
  - 24 hours following a lymph node dissection.

A shorter or longer period of inpatient care may be approved by the **HMO** if **medically necessary.**

The following is not a **covered service**:

- Private rooms unless **medically necessary** and authorized by the **HMO**. If a semi-private room is not available, the **HMO** covers a private room until a semi-private room is available.

Maternity Care

Covered services include:

- Inpatient care for the mother/birthing parent and the newborn child in a health care facility for a minimum of:

- 48 hours following an uncomplicated vaginal delivery.
- 96 hours following an uncomplicated delivery by cesarean section.

Prior authorization is not required for inpatient **maternity care**. Upon request, the length-of-stay may be extended if the **HMO** determines that an extension is **medically necessary**.

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

- Prenatal visits
- Special procedures as **medically necessary** and authorized by a **PCP** or designated OB/GYN
- Use of **hospital** delivery rooms and related facilities.

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

The following are **not covered services**:

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

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

Post-Delivery Care means postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments including:

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

Complications of Pregnancy

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

Complications of pregnancy do not include:

- False labor

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

Covered services for **complications of pregnancy** will be the same as for treatment of any other physical illness and may require **prior authorization.**

Newborn Care

Covered services for a newborn child, which may require **prior authorization** include:

- Administration of a newborn screening test, including the test kit, required by the state of Texas.
- Postnatal visits if newborn is discharged before the minimum hours of inpatient coverage have passed, the **HMO** provides coverage for **post-delivery care** for the newborn. **Post-delivery care** may be provided at the mother/birthing parent's home, or a **participating provider's** office or facility.
- Use of newborn nursery and related facilities.

A newborn child will not be required to receive health care services only from **participating providers** if born outside the **service area** due to an emergency, or born in a non-**network** facility, to a mother/birthing parent who is not a **member**. The **HMO** may require the newborn to be transferred to a **participating** facility, at the **HMO's** expense, when determined to be medically appropriate by the newborn's treating **physician**.

A separate **hospital** admission **copayment**/**coinsurance** and any **deductibles** will be required for a newborn child at the time of delivery. If a newborn child is discharged and readmitted to a **hospita**l more than five (5) days after the date of birth, a separate **hospital** admission **copayment**/**coinsurance** and any **deductibles** for such readmission will be required.

Medical Benefit Therapeutic Alternatives

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

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

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

Medical Supplies

The following medical or disposable supplies prescribed by a **physician** include, but are not limited to:

- Medical-grade compression stockings when considered medically necessary. The stockings must be individually measured and fitted to the patient.
- Ostomy supplies:
  - Pouches, face plates, and belts
  - Irrigation sleeves, bags, and ostomy irrigation catheters
  - Skin barriers
  - Deodorants, filters, lubricants, tape, appliance cleaners, adhesive and adhesive remover
  - Disposable supplies necessary for the effective use of **durable medical equipment** and diabetic supplies.
- Urinary catheters
- Wound care or dressing supplies given by a **provider** during treatment for covered health services.

The following are not covered:

- Medical supplies coverage including, but 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 does not apply to:
  - Batteries, tubing, nasal cannulas, connectors and masks except when used with **durable medical equipment.**
  - Diabetic supplies for which **benefits** are provided as described under **Diabetes Services** section.
  - Disposable supplies necessary for the effective use of **durable medical equipment** for which **benefits** are provided as described under the **Durable Medical Equipment** section.
  - Medical grade compression stockings when considered **medically necessary**.
    - The stockings must be prescribed by a **physician**, individually measured and fitted to the patient.
  - Ostomy bags and related supplies as listed above.
  - Urinary catheters, wound care or dressing supplies given by a **provider** during treatment for **covered services**.

Not all medical supplies are **covered services**, and all are subject to medical review.

Organ and Tissue Transplants

Covered services that require **prior authorization** include:

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

The following criteria must be met for coverage:

- Donated human organs or tissue or a United States Food and Drug Administration approved artificial device are used.
- The transplant procedure is not **experimental/investigational** in nature.
- The recipient is a **member**.
- You meet all of the criteria established by the **HMO** in pertinent written medical policies.
- You meet all of the protocols established by the **hospital** in which the transplant is performed.

Covered services and supplies include those provided for the:

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

The following are **not covered services**:

- Expenses related to maintenance of life of a donor for purposes of organ or tissue donation.
- Living and/or travel expenses of the recipient or a live donor.
- Purchase of the organ or tissue other than payment for **covered services** and supplies identified above.
- Organ or tissue (xenograft) obtained from another species.
- If the transplant operation, or post-transplant care, is performed in China or another country known to have participated in forced organ harvesting.
- The human organ to be transplanted was procured by a sale or donation originating in China or another country known to have participated in forced organ harvesting.
- Services or supplies related to organ and tissue transplant, or other procedures when you are the donor and the recipient is not a **member**.

Orthotic and Prosthetic Devices

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

- Initial **prosthetic appliances**, including professional fitting services related to the fitting and use of these devices (including external breast prostheses and surgical brassieres after mastectomy).
- Adjustments, repair and replacements due to wear or change in your physical condition.
- 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.
- One wig needed because of current chemotherapy or radiation treatment for cancer, subject to any maximum amount indicated in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS.**

The following are **not covered services**:

- Are for sports-related activities (e.g., knee brace to prevent injury to the knees while playing football).
- Repair or replacement due to misuse or loss.
- Orthodontic or other dental appliances or dentures
- Splints or bandages provided by a **physician** in a non-**hospital** setting or purchased over the counter for the support of strains and sprains.
- Corrective orthopedic shoes, including:
    - Arch supports
    - Braces
    - Orthotics
    - Shoe inserts designed to support the arch or effect changes in the foot or foot alignment.
    - Specially-ordered, custom-made or built-up shoes and cast shoes.
    - Splints
    - Those which are a separable part of a covered brace
    - Other foot care items.

Covered appliances and devices must be **medically necessary** and provided or arranged 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**).

Outpatient Services

Covered services that may require **prior authorization** include:

- Services provided through a **participating** medical facility without an overnight stay and are not referenced elsewhere in the **COVERED SERVICES** section.
- Services must be prescribed by a **PCP** include:
    - Dialysis treatment
    - Radiation therapy treatments
    - Surgery

Professional Services

Covered services must be provided or arranged by a **PCP** and provided by a licensed **physician**.

The **HMO** may allow other health **providers** to provide **covered services** that may be provided under applicable state law by such **providers**. Certain services may be restricted under the **MEDICAL LIMITATIONS AND EXCLUSIONS** section**.**

Covered services include:

- **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 when the above requirements are met.

- **PCP or Specialist Home Visits**
  - **Medically necessary** home visits provided by a **participating physician** when, in the judgment of the **PCP** or authorized **specialist**, the nature of the illness or injury so indicate when the requirements above are met.
- Services of a **participating physician** for the 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.**
  - Inpatient care may be directed by a **participating physician** other than your **PCP**.

Rehabilitation Services

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

- Occupational therapy
- Physical therapy
- Speech therapy

Services are covered in the following settings:

- Acute or post-acute rehabilitation center
- Assisted living
- Home Health care visits
- **Hospital** as in inpatient (inpatient rehabilitation)
- Outpatient facility
- **Provider's** office

Rehabilitation services must be **medically necessary** and help you meet or exceed your treatment goals as 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.

Retail Health Clinics

Covered services include:

- Diagnosis and treatment of uncomplicated minor conditions in situations that can be handled without a traditional **PCP** office visit, **urgent care** visit, or **emergency care** visit.

A **PCP referral** is not required to obtain **covered services**.

Retail Health Clinic means a **participating provider** that has entered into a contractual agreement with the **HMO** 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.

Skilled Nursing Facility Services

Covered services include:

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

Services must be temporary and lead to rehabilitation and an increased ability to function.

The following are not **covered services**:

- Services or supplies for long-term or **custodial care**
- Continued skilled nursing visits after a **PCP** discharges you.
- Continued skilled nursing visits after you reach the maximum **benefit period**, or period authorized by the **HMO**.

Telehealth, Teledentistry, and Telemedicine Services

Covered services that may require **prior authorization** include:

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

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

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

Telemedicine Medical Services means a health care service delivered by a **physician** licensed in Texas, or a health professional acting under the delegation and supervision of a **physician** licensed in Texas 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

Therapies for Children with Developmental Delays

Covered services for children with **developmental delays** include:

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

The therapy should follow an **individualized family service plan** submitted to us before you receive any services, and again, if the **individualized family service plan** is changed.

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

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

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

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

Urgent Care Services

Covered services include:

- Services and supplies provided 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 under the **Diagnostic Services** section may also apply.

Unless designated and recognized by the **HMO** as an **urgent care** center, neither a **hospital**, nor an emergency room will be considered as an **urgent care** center.

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.

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 telephone number on the back of your **identification card**. A **PCP referral** is not required to obtain **covered services**.

Wigs

Please see **Orthotic and Prosthetic Devices.**

PREVENTIVE CARE

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

In addition to the **covered services** in this Certificate, all preventive **covered services** will be considered **medically necessary covered services** and some may require **prior authorization.** These preventive **covered services** are to be covered at no cost to the **member**, except for certain state or federally mandated **benefits**, that may have age restrictions (example: childhood immunizations)**.**

To see a complete listing of the preventive health services available to you at no cost through a **participating provider** visit healthcare.gov/coverage/preventive-care-benefits/ or call the number on the back of your insurance **identification card.** For frequencies and any limits that may apply, contact your **physician** or visit www.bcbstx.com/provider/clinical/clinical-resources/preventive-care.

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**/**coinsurance** 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**/**coinsurance** and any **deductibles** for the office visit including the preventive health service.

The following agencies set the preventive care guidelines:

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

The above agencies’ recommendations and guidelines may be updated periodically. When updated, they will apply to your **plan.** 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 **HMO** may use reasonable medical management techniques to determine **benefits**. For more information, please contact customer service at the toll-free telephone number on your **identification card**

Preventive drugs (including both prescription and over-the-counter products) that meet the preventive recommendations outlined above and that are listed on the No-Cost Preventive **Drug list** (to be implemented in the quantities and within the time period allowed under applicable law) will be covered at no cost to the **member** when obtained from a **participating pharmacy**. Drugs on the No-Cost Preventive **Drug list** that are obtained from a **non-participating pharmacy** will not be covered under this Certificate.

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

Examples of covered preventive services included are:

- Periodic health assessments
- Immunizations
- Well-child care
- Cancer screening mammograms
- Bone density test
- Screening for colorectal cancer
- Smoking cessation counseling services
- Healthy diet counseling
- Obesity screening/counseling

Please Note: Smoking cessation medications are covered under **PHARMACY BENEFITS** with a **prescription order** from your **health care professional**.

Examples of covered immunizations included are:

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

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

Breastfeeding Support and Services

Covered services include:

- During pregnancy or after delivery when you get them from a **participating provider**:
  - Breastfeeding support services
  - Breastfeeding counseling

Breast Pump, Accessories, and Supplies

Covered services include, with a **prescription order**, either:

- Rental of **hospital** grade breast pumps (not to exceed the total cost).
- Purchase of manual or electric breast pump.

Covered services also include, with a **prescription order**:

- Breast pump supplies
- Breast milk storage supplies,

Services are not subject to **copayment/coinsurance** and any **deductibles** or benefit maximums when received from a **participating provider**.

Benefits for the purchase of an electric breast pump are limited to one per **benefit period**.

You may be required to pay the full amount and submit a reimbursement claim form along with a **prescription order** and the itemized receipts for the breast pump and supplies.

Visit www.bcbstx.com to obtain a claim form.

Cardiovascular Disease Early Detection Tests

Covered services include one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five years when performed by a laboratory that is certified by a recognized national organization:

- Computed tomography (CT) scanning measuring coronary artery calcifications
- Ultrasonography measuring carotid intima-media thickness and plaque

Tests are available to each covered **member** who is:

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

The member must have either:

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

Cardiovascular disease early detection tests may require **prior authorization,** must be authorized by a **PCP** and may be subject to **copayment/coinsurance, deductible** or dollar maximums.

Colorectal Cancer Screenings

Covered services include:

- A diagnostic medically recognized screening exam for the detection of colorectal cancer for **members** age forty-five (45) or older and who are at normal risk for developing colon cancer
- A follow-up colonoscopy if the findings are normal.

Colorectal cancer screenings may require **prior authorization,** must be authorized by a **PCP** and may be subject to **copayment/coinsurance, deductible** or dollar maximums.

Diagnostic Eye and Ear Screenings

- Preventive eye screenings for infants, children, and adolescents as required by HRSA guidelines. Eye screenings may be performed in the **PCP's** office.

- For **members** through age seventeen (17)
  - Once every twelve months
  - Performed or authorized by a **PCP**
  - Eye screenings may be performed in the **PCP's** office and do not include refractions.

- For **members** eighteen (18) and older
  - Once every two (2) years
  - Performed or authorized by a **PCP**
  - Eye screenings may be performed in the **PCP's** office and do not include refractions.

- A screening test for hearing loss for **members** from birth through age thirty (30) days and for infants, children, and adolescents as required by HRSA guidelines
- Necessary diagnostic follow-up care related to the screening test from birth through age twenty-four (24) months.

Ear and diagnostic eye screenings may require **prior authorization,** must b**e** authorized by a **PCP** and may be subject to **copayment/coinsurance, deductible** or dollar maximums.

Osteoporosis

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

- Detection of low bone mass
- To determine risk of osteoporosis and fractures associated with osteoporosis.

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

- You are postmenopausal and are not receiving estrogen replacement therapy.
- You have:
  - Vertebral abnormalities,
  - Primary hyperparathyroidism
  - A history of bone fractures.

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

Ovarian Cancer Early Detection Test

Covered services include the following early detection tests every twelve (12) months for **members** age eighteen (18) and older.

- A CA 125 blood test
- Any other test or screenings approved by the United States Food and Drug Administration for the detection of ovarian cancer.
    - Your **PCP** or any **participating** OB/GYN in your **PCP's network** of **participating providers** may administer the test.

Ovarian cancer early detection tests may require **prior authorization,** must be authorized by a **PCP** and may be subject to **copayment/coinsurance, deductible** or dollar maximums.

Prostate Cancer Screenings

Covered services include:

- A physical exam and an annual prostate-specific antigen (PSA) test (once every twelve (12) months) for the detection of prostate cancer for **members** who are at least:
    - Fifty (50) years of age and asymptomatic; or
    - At least forty (40) years of age with a family history of prostate cancer or another prostate cancer risk factor.

Women Preventive Care and Screenings

- Well-woman gynecological exam (once every twelve months)
- Early detection of cervical cancer for **members** age eighteen (18) and older
- The exam may include, but is not limited to:
    - Conventional Pap smear screening
    - Human papillomavirus (HPV)
- One screening by low-dose mammography (including digital mammography or breast tomosynthesis) for occult breast cancer every twelve (12) months for a participant thirty-five (35) years of age and older.

Your **PCP** or any **participating** OB/GYN may perform the well-woman exam.

You must 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 OB/GYN. Your **plan** allows you to self-refer to a qualified **participating provider**.

Contraceptive Services and Supplies

Covered services include:

- Female sterilization procedures and **outpatient contraceptive services** for women of reproductive capacity.
- 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 contraceptive
- Intra-uterine devices (IUD)
- Injectables
- Transdermal contraceptives
- Condoms
- Vaginal contraceptive devices
- Over-the-counter contraceptives, such as spermicide and 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 HMO with itemized receipts. Visit the website at www.bcbstx.com to obtain a claim form.

This list may change as FDA guidelines, medical management and medical policies are modified. **Please Note**: Certain prescription contraceptive medications are covered under the **PHARMACY BENEFITS** section.

Contraceptive drugs and devices not available under this **PREVENTIVE CARE SERVICES** benefit may be covered under other sections and may be subject to any applicable **copayment**/**coinsurance** and any **deductibles**.

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.

MEDICAL LIMITATIONS AND EXCLUSIONS

The following **benefits** are not covered unless specifically provided for in **COVERED SERVICES** or **PHARMACY BENEFITS**. See **COVERED SERVICES** for exclusions and limitations related to a specific service.

1. Services or supplies that are not **medically necessary**.

2. Any services or supplies determined to be **experimental/investigational** or unproven. You may contact customer service at the toll-free telephone number on the back of your **identification card** for more information about what **experimental/investigational** services or supplies may be excluded.

3. Clinical technology, services, procedures, and service paradigms designated by a temporary (CPT® Category III) code are not covered, except for certain services otherwise specified by state or federal law, or federal coverage or billing guidelines.

4. Any services or supplies provided by a person who is related to a member by blood or marriage.

5. Any services or supplies provided in connection with an occupational sickness, or an injury sustained in the scope of any employment whether or not **benefits** are, or could upon proper claim be, provided under the Workers' Compensation law.

6. Any services or supplies provided for injuries sustained either:
   - As a result of war, declared or undeclared, or any act of war.
   - While on active or reserve duty in the armed forces of any country or international authority.

7. **Benefits** you are receiving through **Medicare**, or for which you are eligible through entitlement programs of the federal, state, or local government, including, but not limited to, Medicaid and its successors.

8. Care for conditions that federal, state, or local law requires to be treated in a public facility.

9. Appearances at court hearings and other legal proceedings, and any services relating to judicial or administrative proceedings, or conducted as part of medical research

10. Any charges:
    - Resulting from the failure to keep a scheduled visit with a **participating provider**.
    - For completion of any insurance forms.
    - For the acquisition of medical records.
    - Resulting from failure to pay your cost share(s).
    - Incurred while not covered under this **plan.**
    - Special medical reports not directly related to treatment.

11. Any services or supplies that do not meet accepted standards of medical and/or dental care.

12. Any service or supplies by more than one **provider** on the same day(s) for the same **covered service**.

13. Services and supplies for the following except as listed as covered in the **COVERED SERVICES** section:
    - Dietary and nutritional services
    - Services or supplies for long-term or **custodial care**
    - Private duty nursing not related to extended care services (home health, hospice and skilled nursing facility), except when determined to be **medically necessary** and ordered or authorized by a **PCP**.
    - Any services related to a **non-covered service**.
    - Transportation services, except as described under the **Ambulance Services** section, or when approved by the **HMO.**
    - Services or supplies for dental care, except as described under the **Dental and Oral Surgical Procedures**
    - **Prosthetic appliances** or orthotic devices not described under the **Diabetes Care** or **Prosthetic Appliances and Orthotic Devices** sections.

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

15. Any services or supplies provided for, in preparation for, or in conjunction with any of the following:
    - Abortions are limited to pregnancies that, as certified by a **physician**, places the woman in danger of death.
    - Treatment of decreased blood flow to the legs with pneumatic compression device high pressure rapid inflation deflation cycle.
    - Treatment of tissue damage in any location with platelet rich plasma.
    - Supplies for smoking cessation programs and the treatment of nicotine addiction, except for prescription and over-the-counter medications for tobacco cessation and tobacco cessation counseling covered under the **PREVENTIVE CARE** section.
    - Scanning the visible front portion of the eye with computerized ophthalmic diagnostic imaging or measuring the firmness of the front of the eye with corneal hysteresis by air impulse stimulation.
    - Examinations, testing, vaccinations, or other services required by **employers**, insurers, schools, camps, courts, licensing authorities, other third parties, or for personal travel.

16. Any services or supplies provided for the following treatment modalities:
    - Acupuncture (dry needling, or trigger-point acupuncture)
    - Alternative treatments such as acupuncture, acupressure, hypnotism, and aroma therapy.
    - Massage therapy
    - Intersegmental traction
    - All types of home traction devices and equipment.

- Vertebral axial decompression sessions
- Surface electromyography (EMGs)
- Spinal manipulation under anesthesia
- Muscle testing through computerized kinesiology machines such as isostation, digital myograph, and dynatron.
- Balance testing through computerized dynamic posturography sensory organization test.

17. Testing of:
    - Blood for measurement of levels of:
        - Lipoprotein (fat/protein substances in the blood that might be ordered in people with suspected deposits in the walls of blood vessels.)
        - Small dense low-density lipoprotein
        - Lipoprotein subclass high resolution
        - Lipoprotein subclass particle numbers
        - Lipoprotein associated phospholipase A2
        - Urine for measurement of collagen cross links, which is a substance that might be ordered in people with suspected high bone turnover
        - Cervicovaginal fluid for amniotic fluid protein during pregnancy, which might be ordered in people suspected to have fluid leaking from around the baby (premature ruptured membranes).

18. Any services, supplies, or drugs received by a **member** outside the United States, except for **emergency care**.

19. Over-the-counter supplies or medicines, and prescription drugs and medications of any kind, except:
    - As provided while confined as an inpatient.
    - As provided under the **Autism Spectrum Disorder** section.
    - As provided under the **Diabetes Care** section.
    - Contraceptive devices and FDA-approved over-the-counter contraceptives for women with a written prescription from a **participating provider**.
    - If covered under the **PHARMACY BENEFITS** section.

20. Services, supplies, drugs or devices provided for reduction of obesity or weight, even if the participant has other health conditions which might be helped by a reduction of obesity or weight, except for healthy diet counseling and obesity screening/counseling as may be provided under the **PREVENTIVE CARE** section of this Certificate.

21. 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.

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

23. Any of the following:
    - 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.
    - Services or supplies furnished by an institution that is primarily a place of rest, a place for the aged, or any similar institution.
    - 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, bandages, and garter belts, ostomy bags

24. Educational testing and therapy, including the treatment of learning disabilities, **developmental delays** in speech, motor or language skills, behavioral disorders, including adolescent behavior disorders such as conduct or oppositional disorders, or services that are educational in nature or are for vocational testing or training, except as may be provided under the **Autism Spectrum Disorder** section. This exclusion does not apply to **developmental delays** if the delay is related to a treatable medical condition.

25. Mental health services except as described under the **Behavioral Health Services** section or as may be provided under the **Autism Spectrum Disorder** section.

26. Any of the following applied behavior analysis (ABA) services:
    - Services with a primary diagnosis that is not **autism spectrum disorder**
    - Services by a **provider** that is not properly credentialed
    - Activities primarily of an educational nature
    - Respite, shadow, or companion services

27. The following psychological/neuropsychological testing and psychotherapy services:
    - Educational testing
    - **Employer**/government mandated testing
    - Testing to determine eligibility for disability **benefits**.
    - Testing for legal purposes (e.g., custody/placement evaluations, forensic evaluations, and court mandated testing).
    - Testing for vocational purposes (e.g., interest inventories, work related inventories, and career development).

28. Services directed at enhancing one's personality or lifestyle:
    - Vocational or religious counseling
    - Activities primarily of an educational nature.
    - Music or dance therapy
    - Bioenergetic therapy

29. Biofeedback (except for an **acquired brain injury** diagnosis) or other behavior modification services.

30. Galvanic stimulators or TENS units

31. Female contraceptive devices, including over-the-counter contraceptive products such as spermicide, when not prescribed by a **participating provider**.

32. Services or supplies of **non-participating providers** or self-**referral** to a **participating provider**, except:
    - Emergency care
    - When authorized by the HMO or a **PCP**
    - Members may directly access an Obstetrician/Gynecologist (OB/GYN) for:
        - Well-woman exams.
        - Obstetrical care
        - Care for all active gynecological conditions
        - Diagnosis, treatment, and **referral** for any disease or condition within the scope of the professional practice of the OB/GYN.

33. This **plan** does not cover cannabis. Cannabis means all parts of the plant genus Cannabis containing delta-9-tetrahydrocannabinol (THC) as an active ingredient, whether growing or not, the seeds of the plant, the resin extracted from any part of the plant, and every cannabis-derived compound, manufacture, salt, derivative, mixture or preparation of the plant, its seeds, or its resin. Cannabis with THC as an active ingredient may be called marijuana.

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

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

36. Some laboratory services are not covered by your **plan**. The following laboratory services are not covered:
    - Vitamin B12 testing or screening for a Vitamin B12 deficiency in healthy, asymptomatic individual; homocysteine or holotranscobalamin testing to screen for, or confirm a, Vitamin B12 deficiency; or Vitamin B12 testing within three (3) months of beginning treatment for a B12 deficiency.
    - Vitamin D testing – Routine screening for Vitamin D deficiency with serum testing in asymptomatic individuals and/or during general encounters.
    - Hemoglobin A1c testing in the following situations:
        - If you have had a blood transfusion within the past 120 days.
        - If you have a condition associated with increased red blood cell turnover.
        - If you are also being measured for fructosamine.

37. Influenza Testing – Viral culture testing for influenza in an outpatient setting; outpatient influenza testing in asymptomatic patients; Serology testing for influenza under any circumstance.

38. Cardiac **biomarker**s – Measurement of cardiac **biomarkers** for the diagnosis of a heart attack if you have symptoms of acute coronary syndrome such as chest pain; or measurement of cardiac **biomarkers** if you have symptoms of acute coronary syndrome and received services in a setting that cannot perform an evaluation for a heart attack, such as an independent lab or **physician's** office.

39. Drug testing in an outpatient setting is not covered in the following situations:
    - Testing to confirm the presence and/or amount of drugs in your system is not covered when laboratory-based definitive drug testing is requested without any prior screening test results, or when laboratory-based definitive drug testing is requested for larger than seven drug classes panels.
    - Use of proprietary drug tests such as RiskviewRX Plus.
    - Specific validity testing, including, but not limited to the following tests: urine specific gravity, urine creatinine, pH, urine oxidant level, and genetic identity testing, are included in the panel test and therefore will not be covered if submitted individually if a urine panel test was also ordered at the same time.
    - Testing for any American Medical Association definitive drug class codes.
    - Same-day testing for the same drug or metabolites from two different samples (e.g., both a blood and a urine specimen).
    - Testing of samples with abnormal validity tests.
    - Drug testing for patients in a facility setting (inpatient or outpatient) are not separately covered, as they are included in the daily charge at the facility.
    - Your **plan** does not cover both qualitative (type of drug) testing and presumptive (to verify presence of drugs) testing on the same specimen.

40. Folate testing – Measurement of RBC folate is not covered. Measurement of serum folate concentration is only covered when you have been diagnosed with megaloblastic or macrocytic anemia and those conditions do not resolve after folic acid treatment.

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

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

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

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

44. Testosterone testing – The following tests are not covered:
    - Testing for serum free testosterone and/or bioavailable testosterone as primary testing (i.e., in the absence of prior serum TOTAL testosterone testing).
    - Testing for serum total testosterone, free testosterone, and/or bioavailable testosterone in asymptomatic individuals or in individuals with non-specific symptoms.
    - Testing for serum testosterone for the identification of androgen deficiency in women

- Salivary testing for testosterone.
- Measurement of serum dihydrotestosterone in individuals except in diagnosing 5-alpha reductase deficiency in individuals with ambiguous genitalia, hypospadias, or microphallus.

45. Thyroid Disease Testing is not covered in the following situations:
    - Testing for thyrotropin-releasing hormone (TRH) or thyroxine-binding globulin (TBG) for the evaluation of the cause of hyperthyroidism or hypothyroidism is not covered.
    - Testing for thyroid dysfunction during a general exam without abnormal findings for asymptomatic nonpregnant women is not covered.

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

47. The following are subject to specific limitations or exclusions under this Certificate. Please refer to the following sections under **COVERED SERVICES** for additional information:
    - Allergy Care
    - Ambulance Services
    - Behavioral Health
    - Clinical Trials
    - Dental and Oral Surgical Procedures
    - Diabetic Equipment, Supplies and Self-Management
    - Durable Medical Equipment
    - Family Planning Services
    - Hearing Aids
    - Home Health Care
    - Hospice Care
    - Infertility Services
    - Maternity Care
    - Medical Supplies
    - Organ and Tissue Transplants
    - Orthotic and Prosthetic Devices
    - Skilled Nursing Facility Services

PHARMACY BENEFITS

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

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

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

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

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

As new drugs are approved by the Food and Drug Administration (FDA), such drugs, unless the intended use is specifically excluded by the **HMO**, are eligible for **benefits** if included on the applicable **drug list**. **Copayments/coinsurance** and **out-of-pocket maximum** per **benefit period** for **covered drugs** are shown under the **PHARMACY SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** section.

Your Cost

How Copayment Amounts Apply

- You may pay lower than your copayment for a drug in the following situations:
    - The allowable amount for the drug if lower than the **copayment**.
    - The purchase price of the drug if lower than the **allowable amount**.

- If you receive a **brand name drug** when a generic equivalent is available, the **copayment** will be the total of the **generic drug copayment** and/or **coinsurance** plus the difference between the cost of the **generic drug** equivalent and the cost of the **brand name drug**.

- You will pay no more than the applicable drug **copayment** and/or **coinsurance** amounts if:

- The **prescription order** includes a valid dispensing directive prohibiting substitution of a generic equivalent (brand necessary or brand **medically necessary**) or
- If there is no generic equivalent.

Out-of-Pocket Maximums
The **out-of-pocket maximum** per **benefit period** for **pharmacy benefits** is shown under the **PHARMACY SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** section.

The **HMO** will determine when maximums have been reached for covered prescription drugs based on information provided to the **HMO** by you and **participating providers** to whom you have made **copayments**. Once you reach the maximum, you are not required to make additional **copayments** for covered prescription drugs for the remainder of the **benefit period**.

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. When the family **out-of-pocket maximum** amount is reached, you are not required to make additional **copayments** for covered prescription drugs for the remainder of the **benefit period**.

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

Most of your pharmacy covered prescription drug payments are applied to your **out-of-pocket maximum**.

The following will not accrue payment amounts toward your pharmacy out-of-pocket maximum:
- Services, supplies, or charges limited or excluded by your **plan**.
- Expenses not covered because a **benefit** maximum has been reached.
- Any covered prescription drug expense paid by your primary **plan** if you have a secondary plan for coordination of benefits.
- Penalties (if applicable) for failing to obtain **prior authorization**.
- Any **deductibles**
- Any **copayment** paid under **COVERED SERVICES.**
- Any pricing difference between the cost of brand name drugs and a generic equivalent that you pay under **PHARMACY BENEFITS.**

Member Pay the Difference
You may not be required to pay the difference in cost between the **allowable amount** of the **brand name drug** and the **allowable amount** of the **generic drug** if there is a medical reason (e.g., adverse event) you need to take the **brand name drug** and certain criteria are met. Your **provider** can submit a request to waive the difference in cost between the **allowable amount** of the **brand name drug** and **allowable amount** of the **generic drug**. In order for this request to be reviewed, your **provider** must send in a MedWatch form to the Food and Drug Administration (FDA) to let them know the issues you experienced with the generic equivalent. your **provider** must provide a copy of this form when requesting the waiver. The FDA MedWatch form is used to document adverse events, therapeutic inequivalence/failure,

product quality problems, and product use/medication error. This form is available on the FDA website. If the waiver is granted, applicable **copayment/coinsurance** and any **deductibles** will still apply.

Exceptions to this may be allowed for certain preventive medications (including prescription contraceptive medications) if your **provider** submits a request to the **HMO** indicating that the **generic drug** would be medically inappropriate, along with supporting documentation.

If the **HMO** grants the exception request, any difference between the **allowable amount** for the **brand name drug** and the **generic drug** equivalent will be waived.

How Member Payment is Determined
Prescription drug products are separated into tiers. Generally, each drug is placed into one of four drug tiers:

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

Any **deductible, copayment** and/or **coinsurance** amount for **covered drugs** on each drug tier is shown on your **PHARMACY SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS.**

Covered Drugs

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

Covered diabetic supplies include:

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

A separate **copayment/coinsurance** and any **deductibles** will apply to each fill of a prescription purchased on the same day for **insulin** and **insulin** syringes.

All supplies for the control of diabetes, will be dispensed as written unless substitution is approved by your prescribing **physician** or other **provider** who issues the written order for the supplies or equipment.

Emergency Refills of Insulin or Insulin-Related Equipment and Supplies
Covered services include emergency refills of prescription insulin or insulin-related equipment or supplies without the authorization of the prescribing **provider** in the following situations:

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

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

You are responsible for the same **copayment/coinsurance** and any **deductibles** as for nonemergency refills of diabetes equipment or supplies.

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

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

Insulin drugs obtained from a **non-participating pharmacy** or not identified as a preferred **insulin** drug may be subject to **copayment/coinsurance** and any **deductibles** or dollar maximums, if applicable.

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

Nutritional Support
Covered services include:

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

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

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

Copayments/coinsurance and any **deductibles** will not apply to certain orally administered anticancer drugs. To determine if a specific drug is included in this benefit, please contact customer service at the toll-free number on your **identification card**.

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

Select Vaccinations Obtained through Select Participating Pharmacies
Benefits for select vaccinations are shown in your **PHARMACY SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** section. These vaccinations are available through certain **participating pharmacies** that have contracted with us to provide this service.

To locate one of these **participating pharmacies** in the **pharmacy vaccine network** in your area and to determine which vaccinations are covered under this benefit, please refer to www.bcbstx.com or the toll-free number on your **identification card**.

Each **participating pharmacy** in the **pharmacy vaccine network** that has contracted with the **HMO** to provide this service may have age, scheduling, or other requirements that will apply, so you are encouraged to contact them in advance.

Childhood immunizations subject to state regulations are not available under this **pharmacy benefit**. Please refer to the **COVERED SERVICES and PREVENTIVE CARE** sections for **benefits** available for childhood immunizations.

Selecting a Pharmacy
When you need a **prescription order** filled, you should use a **participating pharmacy**. Each prescription or refill is subject to the **copayment/coinsurance** shown under the **PHARMACY SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** section.

Participating Pharmacy
When you go to a **participating pharmacy**, you must pay any **copayment** and any applicable pricing differences. You may be required to pay for limited or **non-covered services**. No claim forms are required.

Prescription Drugs Purchased Outside of the Service Area
Covered **prescription drugs** you purchase outside of the **service area**:

- Submit a completed claim form within ninety (90) days of the date of purchase.
- We will reimburse you for the **allowable amount** of the prescription drugs less the **out-of-area**

drug **copayment/coinsurance**.

Extended Prescription Drug Supply Program

Your coverage includes **benefits** for up to a 90-day supply of covered maintenance type drugs and diabetic supplies purchased from a **participating pharmacy** contracted with us to take part in our extended retail prescription drug supply program (which may only include retail or mail order **pharmacies**). See your **PHARMACY SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** for your cost information and any applicable pricing difference.

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

Day Supply

Benefits for **covered drugs** obtained from a **participating pharmacy** are provided up to the maximum day supply limit as indicated on the **PHARMACY SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**. We have the right to determine the day supply. Payment for covered drugs under this **plan** may not be paid if drugs are dispensed or delivered in a way intended to change, or having the effect of changing or circumventing, the stated maximum day supply limitation. Some drugs covered under your plan may be subject to certain supply/fill limitations pursuant to diagnoses or new-to-therapy requirements, plan design, and/or state or federal regulations. For specific drug supply/fill information, please call customer service toll-free number located on your identification card.

Mail-Order Program

The mail-order program provides delivery of covered prescription drugs directly to your home address. If you choose to use the mail-order service, refer to your **PHARMACY SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** for applicable payment levels.

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

Specialty Pharmacy Program

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

Due to special storage requirements and high cost, **specialty drugs** are not covered unless obtained through the **specialty pharmacy provider**.

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

To determine which drugs are **specialty drugs**, you should refer to your **plan's** website https://www.bcbstx.com/tx/documents/rx-drugs/specialty-drug-list-tx.pdf or by contacting customer service at the toll-free number on your **identification card**. Your cost will be the appropriate **copayment**/**coinsurance** and or **deductible** amount indicated in the **PHARMACY SCHEDULE OF COPAYMENTS AND BENEFIT LIMITATIONS**.

MedsYourWay™

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

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

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

MedsYourWay may not be available in all states or pharmacies and will be operated only to the extent permitted by law.

About Your Benefits

Covered Drug List

A list of **covered drugs** is shown on the **drug list**. The **HMO** will periodically review the list and adjust it to modify the preferred/non-preferred drug status of new and existing drugs. Changes to the **drug list** will be implemented on the next renewal date of the **group agreement** and are subject to Texas law. When there has been a pharmaceutical manufacturer's recall or other safety concern, changes to the **drug list** may occur more frequently. Changes to the **drug list** that could have an adverse financial impact to you (i.e., drug exclusion, drug moving to a higher payment tier, or drugs requiring step therapy or **prior authorization**) occur with 60-days advance notice prior to coverage renewal consistent with Texas law.

We select the drugs listed on the **drug list** based upon the recommendations of a committee, which is made up of **physicians** and pharmacists from across the country, some of whom are affiliated with us. The committee considers existing drugs approved by the FDA, as well as those newly FDA approved for

inclusion on the **drug list**. Entire drug classes are also regularly reviewed. Newly marketed drugs may not be covered until the committee has had an opportunity to evaluate them. Some of the factors committee members evaluate include:

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

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

Note: Prescription drugs that are approved by the FDA through the accelerated approval program may be considered **experimental/investigational** and may not be covered.

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

If you have a health condition that may jeopardize your life, health, or keep you from regaining maximum function, or your current drug therapy uses a **non-covered drug**, your **provider** may be able to ask for an expedited review process. We will let you, and your **provider**, know the coverage decision within 1 business day, not to exceed 72 calendar hours, after we receive your request for an expedited review.

If your request does not meet the criteria for expedited review, we will conduct a standard review according to the standard review procedures outlined.

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

Prescription Refills
You can get prescription drug refills from any **participating pharmacy**. Once every 12 months, you will be able to synchronize the start time of certain **covered drugs** used for treatment and management of a chronic illness. This ensures they are refilled on the same schedule for a given time period.

When necessary to fill a partial **prescription order** to permit synchronization, we will prorate the **copayment** and/or **coinsurance** due for **covered drugs** based on the proportion of days the reduced **prescription order** covers to the regular day supply outlined under your **PHARMACY SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** section.

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

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

The refills are allowed:

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

Prescription Contraceptives

Covered prescription contraceptives may be obtained as follows:

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

Dispensing Limits

Dispensing limits are based upon FDA dosing recommendations and nationally recognized guidelines. Coverage limits are placed on drugs in certain drug categories. Limits may include:

- Amount of covered drugs per prescription.
- Amount of covered drug in a given time period.
- Coverage only for members within a certain age range.

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

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

If you require a **prescription order** more than the dispensing limit, ask your **provider** to submit a request for a clinical review on your behalf. Your **provider** can obtain an override request form by accessing our website at www.bcbstx.com. Any relevant medical information along with the completed form should be sent to Clinical Pharmacy Programs as indicated on the form. The request will be approved or denied after evaluation of the submitted clinical information.

We have the right to determine dispensing limits. Payment for **benefits** covered under this **plan** may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or bypassing, the stated maximum amount limitation. If your dispensing limit request is denied, you will be responsible for the full cost of the prescription beyond what your coverage allows.

Multi-Category Split Fill Program

If this is your first time using select drugs in certain drug classes (e.g., drugs for cancer, multiple sclerosis, lung disorders, etc.) or if you have not filled one of these drugs within 120 days, you may only be able to receive a partial fill (14-15-day supply) of the drug for up to the first 3 months of therapy.

This is to help see how the drug is working for you. If you receive a partial fill, your **copayments** and/or **coinsurance** after your **deductible** will be adjusted to align with the amount of drug dispensed. If the drug is working for you and your **provider** wants you to continue on this drug, you may be eligible to receive up to a 30-day supply after completing up to 3 months of the partial supply. For a list of drugs that are included in this program, please visit www.bcbstx.com.

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

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

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

Although you may currently be on a drug that is part of the Step Therapy Program, your claim may need to be reviewed to see if the criteria for coverage of further treatment have been met. A documented treatment with a therapeutic alternative drug may be required for continued coverage of the targeted drug.

Step therapy may be required for a trial of a generic or pharmaceutical equivalent of a prescribed prescription drug as a condition of continued coverage of the prescribed drug only:

- Once in a **plan year**.
- If the generic or equivalent drug is added to our **drug list**.

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

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

Step Therapy Exception Requests
Your prescribing **physician** or **other provider** may submit a written request for an exception to the step therapy requirements.

- The step therapy exception request will be considered approved if we do not deny the request within 72 hours after receipt of the request.
- If your prescribing **physician** or **other provider** reasonably believes that denial of the step therapy exception request could cause you serious harm or death, submission of the request with "Urgent" noted and documenting these concerns will be considered approved if we do not deny the request within 24 hours after receipt of the request.
- If your step therapy exception request is denied, you have the right to request an expedited internal appeal and also have the right to request review by an Independent Review Organization (IRO) as explained in the **CLAIM FILING AND APPEALS PROCEDURES** section.

Prior Authorization

We require **prior authorization** before select prescription drugs to ensure that the drug is:

- Safe
- Effective
- Part of a specific treatment plan.

Certain medications may require **prior authorization** and the evaluation of additional clinical information before dispensing. A list of the drugs which require **prior authorization** is available to you and your **provider** by accessing the website at www.bcbstx.com/member/prescription-drug-plan-information/drug-lists.

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

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

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

RxRunway Transition Fill Program
This program gives you 90 days to amend current prescriptions should there be a change in your **benefits**

that impacts coverage to your current drugs due to a change in **drug list** or utilization requirements.

The 90-day window begins when the **benefit** change takes effect, during which you may obtain a 1-time refill of each of your current drugs if those drugs are not on the new **drug list** and/or require a **prior authorization** (PA)/Step Therapy (ST). You will receive a letter after the transition fill, reminding you to contact your prescriber and discuss moving to a covered drug or submitting a **prior authorization**/step therapy request.

This program does not apply to specialty drugs or to standard non-covered **benefits**, such as drugs not approved by the FDA or some drugs administered by your health care **provider**.

If you have any questions about this program, you may access the website at www.bcbstx.com or contact customer service at the toll-free number on your **identification card**.

Controlled Substance Limitations
If we determine that you may be receiving quantities of a **controlled substance** drugs not supported by FDA approved dosages or recognized safety or treatment guidelines, any coverage for additional drugs may be subject to review to assess whether **medically necessary** or appropriate. Restrictions may include but not be limited to a certain **provider** and/or **pharmacy**, quantity, and/or day supply for the prescribing and dispensing of the **controlled substance drug**. Additional **copayment/coinsurance** and any **deductible** may apply.

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

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

Pharmacy Limitations and Exclusions

Pharmacy benefits are not available for:

1. Drugs/products not included on the drug list (unless covered elsewhere under this plan, required by law or regulatory guidance), including new to market FDA approved drugs which we have not reviewed prior to coverage of the drug.

2. Non-FDA approved drugs.

3. Drugs, which by law, do not require a **prescription order**, except as indicated under **Preventive Care** in **PHARMACY BENEFITS**, from a **physician** or authorized **provider** (except **insulin, insulin** analogs, **insulin** pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and select vaccinations administered through certain **participating pharmacies** shown on your **PHARMACY SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**); and legend drugs or covered devices for which no valid **prescription order** is obtained.

4. Devices, technologies and/or **durable medical equipment (DME)** of any type (even though such devices may require a **prescription order**,) such as, but not limited to, contraceptive devices, therapeutic devices, including support garments, and other non-medicinal substances, artificial appliances, digital health technologies and/or applications, or similar devices (except disposable hypodermic needles and syringes for self-administered injections and those devices listed as diabetes supplies). **Please Note:** Coverage for female contraceptive devices and the rental or purchase) of manual or electric or **hospital** grade breast pumps is provided as indicated in the medical portion of the **plan**. However, you do have certain **DME benefits** available in the **PREVENTIVE CARE** section.

5. Pharmaceutical aids, such as excipients, found in the USP-NF (United States Pharmacopeia - National Formulary), including, but not limited to, preservatives, solvents, ointment bases, and flavoring, coloring, diluting, emulsifying, and suspending agents.

6. Administration or injection of any drugs.

7. Vitamins (except those vitamins which by law require a **prescription order** and for which there is no non-prescription alternative or as indicated in **Preventive Care** under the **PHARMACY BENEFITS**.)

8. Drugs injected, ingested, or applied in a **physician's** or authorized **provider's** office or during confinement while a patient in a **hospital**, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.

9. Any special services provided by a **pharmacy**, including counseling and delivery Select vaccinations shown under the **PHARMACY SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** section administered through certain **participating pharmacies** are an exception to this exclusion.

10. Drugs for the treatment of infertility.

11. Any prescription antiseptic or fluoride mouthwashes, mouth rinses or topical oral solutions or preparations.

12. Fluoride supplements, except as required by law.

13. Drugs required by law to be labeled: "Caution - Limited by Federal Law to Investigational Use," or experimental drugs, even though a charge is made for the drugs.

14. Drugs dispensed in quantities in excess of the day supply amounts called out in the **PHARMACY SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**, or refills of any prescriptions in excess of the number of refills specified by the **physician** or authorized **provider** or by law, or any drugs or medicines dispensed more than one (1) year after the **prescription order** date.

15. Fluids, solutions, nutrients, or drugs (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous intramuscular (in the muscle), unless approved by the FDA for self-administration, intrathecal (in the spine), or intraarticular (in the joint) injection or in the home setting. **Please Note:** this exclusion does not apply to formulas covered under the **Nutritional Support** subsection of **PHARMACY BENEFITS**. A **prescription order** from your **provider** is required.

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

17. Any drugs provided for reduction of obesity or weight, even if the participant has other health conditions which might be helped by a reduction of obesity or weight.

18. Drugs, that the use, or intended use of, would be illegal, unethical, imprudent, abusive, not medically necessary, or otherwise improper.
19. Drugs that are not considered **medically necessary** or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines.

20. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of your **identification card**.

21. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction, which is not covered under the **plan**, or for which **benefits** have been exhausted.

22. Rogaine, minoxidil or any other drugs, medications, solutions, or preparations used, or intended for use, in the treatment of hair loss, hair thinning, or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise, for cosmetic purposes.

23. Compounded drugs

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

25. **Prescription orders** if there is an over-the-counter product available with the same active ingredient(s) in the same strength, unless we determine otherwise.

26. Athletic performance enhancement drugs.

27. Bulk powders

28. Surgical supplies

29. Ostomy products

30. Diagnostic agents. This exclusion does not apply to diabetic test strips.

31. Drugs used for general anesthesia.

32. Drugs to treat sexual dysfunction.

33. Allergy serum and allergy testing materials.
    - However, you do have certain benefits available under **Allergy Care** in the **COVERED SERVICES** section.

34. Injectable drugs, except self-administered **drugs** or those approved by the FDA for self-administration.

35. Self-administered drugs dispensed or administered by a **physician** in their office.

36. **Prescription orders** which do not meet the required step therapy criteria.

37. **Prescription orders** which do not meet the required **authorization** criteria.

38. **Specialty drugs**, unless obtained through a **specialty pharmacy provider**.

39. Replacement of drugs or other items that have been lost, stolen, destroyed, or misplaced.

40. Shipping, handling, or delivery charges.

41. Non-sedating antihistamine drugs and combination drugs containing a non-sedating antihistamine and decongestant.

42. Drugs which are repackaged by anyone other than the original manufacturer (i.e., a repackager, institutional packs, clinic packs, or other custom packaging).

43. **Prescription orders** written by a member of your immediate family, or a self-prescribed

prescription order.

44. Certain drug classes where there is an over-the-counter alternative available

45. Brand name proton pump inhibitors

46. Drugs we determine to have inferior efficacy or significant safety issues.

47. Cannabis, meaning all parts of the plant genus Cannabis containing delta-9-tetrahydrocannabiol (THC) as an active ingredient, whether growing or not, the seeds of the plant, the resin extracted from any part of the plant, and every cannabis-derived compound, manufacture, salt, derivative, mixture or preparation of the plant, its seeds, or its resin. Cannabis with THC as an active ingredient may be called marijuana.

48. Drugs purchased from a **non-participating pharmacy** in the **service area**, except as provided in the **Clinician-Administered Drugs** section under **COVERED SERVICES**.

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

50. Covered drugs, devices, or other **pharmacy** services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether **benefits** are, or could upon proper claim be, provided under the Workers' Compensation law.

51. Covered drugs, devices, or other **pharmacy** services or supplies for which **benefits** are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or the laws, regulations or established procedures of any county or municipality, except any program which is a state **plan** for medical assistance (Medicaid), or any prescription drug which may be properly obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law; provided, however, that the exclusions of this section shall not be applicable to any coverage held by you for prescription drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.

52. The following are subject to specific limitations or exclusions under this Certificate. Please refer to the following sections under **covered services** for additional information:
    - Diabetic Equipment, Supplies and Self-Management
    - Infertility Services

CLAIM FILING AND APPEALS PROCEDURES

Customer Inquiries

You or an authorized representative may direct inquiries to a customer service representative by mail or by calling the toll-free telephone number on the back of your **identification card**. If an inquiry is not resolved promptly to your satisfaction, you may submit a **complaint** as described below.

How to File a Complaint with the HMO

Complainant means a party, including you, an authorized representative, **physician**, or **provider** ("you") who submits a **complaint**.

Complaint means an expression of dissatisfaction by a **complainant** either orally or in writing to the **HMO**, including, but not limited to:

- Information relied upon in making a **benefit** determination.
- **HMO** operational issue.
- Procedures related to review or appeal of an **adverse benefit determination**.
- The denial, reduction, or termination of a service for reasons not related to **medical necessity,** including an **out-of-network** denial because services provided do not meet the definition of **emergency care** as shown under the **Emergency Care Services** section in **COVERED SERVICES**.
- A **provider**
- Disenrollment decisions

A **complaint** does not include:

- A misunderstanding or giving of misinformation that has been resolved promptly.
- Dissatisfaction or disagreement with an **adverse benefit determination** (defined under the **How To Appeal an Adverse Benefit Determination** section below).

Complaint Procedure	Time Period
Submission of a **complaint**	If an inquiry is not resolved promptly to your satisfaction
HMO receives **complaint** and must notify you within:	5 days - confirming receipt of your **complaint** and provide **complaint** process and timeframes*
HMO receives **complaint** and within:	30 days • Investigate and resolve your **complaint** • Send you correspondence explaining the **HMO's** decision, including: o The medical and contractual reasons o Any benefit exclusion, limitation, or medical condition o The specialty of any **provider** consulted. o Information to resolve a claim (if needed) o Explanation of the **complaint** appeal process, including deadlines and final appeal decision
Complaints about emergencies or denial of continued **hospital** stay within	1 business day – investigated and decision given
*If you submitted an oral **complaint**, the **HMO** would also enclose a **complaint** form to be filled out and returned.	

If you dispute the **HMO's** decision regarding your **complaint**, you may have the decision reviewed as described under the **How to Appeal an HMO Complaint Decision** section. The **HMO** will not retaliate against you, the **group**, a **physician**, or **provider** for submitting a **complaint** and appealing a decision of the **HMO**.

How to Appeal an HMO Complaint Decision

If the **complaint** is not resolved to your satisfaction, the **HMO complaint** appeal process gives you the right to submit a written appeal and appear in person, by telephone, or other technological methods before a **complaint** appeal panel.

Complaint Appeal Process	Time Period
Your written appeal request	Within 5 business days (upon receipt of your appeal) the **HMO** will send you a letter confirming receipt of your appeal.
Your written appeal request	Within 30 calendar days the **HMO** will complete the appeals process.
The **HMO** will appoint persons to a **complaint** appeal panel including an equal number of **HMO** members (not **employee**s) and **providers** not involved in the disputed decision. **Providers** must have experience in the care that is in dispute and independent of any **provider** who made a prior determination. If specialty care is in dispute, a person must be a **specialist** in that field.	During the appeal process

The **HMO** will provide you: o Documentation presented to the **complaint** appeal panel by the **HMO.** o The specialization of any **providers** consulted during the investigation. o The name and affiliation of each **HMO.** representative on the **complaint** appeal panel. o The date and location of the hearing.	Within 5 business days before the scheduled meeting of the **complaint** appeal panel
You are entitled to appear before the **complaint** appeal panel appear in person, by telephone, or other technological methods, and: o Present written or oral information. o Present alternative expert testimony. o Request the presence of, and question those responsible for, making the prior. determination that resulted in the appeal. o Bring any person you wish, but only you may directly question meeting participants.	During the appeal process
Your written appeal request	Within 30 calendar days upon receipt of your written appeal request, the **HMO** will provide written notice of the final decision; and will include the reasons (medical, clinical, and contractual) used in making the final decision. The **HMO** will also include the toll-free telephone number and address of the Texas Department of Insurance (TDI)

You have the right to have an Independent Review Organization (IRO) review the denial if your denied **complaint** appeal involves services which do not meet the definition of **emergency care** (Please see **Emergency Care Services** section in **COVERED SERVICES**). The written final decision will also include the procedures to obtain a review as shown below under the **How to Appeal to an Independent Review Organization (IRO)** section.

Expedited Complaint Appeal (Emergency or Continued Hospitalization Situations)

Complaint appeals involving an ongoing emergency or denial of continued hospitalization will be investigated and decided depending on the medical or dental urgency of the case within 1 business day from the **HMO's** receipt of your request for an appeal. At your request, the **HMO** will provide (instead of a **complaint** appeal panel) a review by a **provider** who has not previously reviewed the case and is of the same or similar specialty for the medical or dental condition, procedure, or treatment on appeal. The **provider** reviewing the appeal may interview you, or your authorized representative and will decide the appeal. The **provider** may deliver an initial notice of the appeal decision orally, and then will provide a written notice no later than the 3rd day after the date of the decision.

Upon request and free of charge, you, or your authorized representative may have reasonable access to, and copies of, all documents, records, and other information related to the appeal, including:

- Information relied upon to make the decision.
- Information submitted, considered, or produced while making the decision, and whether it was relied upon.

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

How to Appeal to the Texas Department of Insurance

For general information about reporting a suspected **HMO** insurance-related violation, please call the Texas Department of Insurance (TDI) at (800) 599-SHOP, or in Austin (800)252-3439. You may report a suspected **HMO** insurance-related violation to the TDI by mail at Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030, or online at www.tdi.texas.gov.

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

- Additional information is needed.
- An on-site review is necessary.
- The **HMO, physician**, **provider,** or **complainant** did not provide all documentation necessary to complete the investigation.
- Other circumstances beyond the TDI's control occur.

How to Appeal an Adverse Benefit Determination

An **Adverse Benefit Determination** means the **HMO**, or a utilization review agent determined that the health care services you have received, or may receive are:

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

It is not part of the **complaint** process.

An **adverse benefit determination** includes a denial, reduction, or termination of a benefit, an **urgent care** claim, a benefit resulting from a utilization review, treatment previously approved being reduced or terminated, or not paying (in whole or in part) for a **benefit** or claim. An **adverse benefit determination** does not mean a denial of health care services due to the failure to request a potential or concurrent utilization review.

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

Please Note: An Independent Review Organization (IRO) is an organization independent of the **HMO** which may perform a final administrative review of an **adverse benefit determination** made by the **HMO**. You are entitled to an immediate appeal to an IRO if your request is based on the following:

- If you were receiving prescription drugs or intravenous infusions and coverage was discontinued.

- If you do not receive a timely **adverse benefit determination** decision.
- Life-threatening, **urgent care** circumstances

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

Appeal Process	Time Period
Your written request for the **HMO** to review an **adverse benefit determination**.	Within 5 business days (upon receipt of your appeal) the **HMO** will send a letter with a list of documents you must provide
Your **oral** request for the **HMO** to review an **adverse benefit determination**	Within 5 business days (upon receipt of your appeal) the **HMO** will send a letter with a list of documents you must provide, and an appeal form which must be returned to the **HMO** to proceed
Appeal is reviewed by a **provider** (in the same or similar specialty for the condition, procedure, or treatment under review) not involved in the initial **adverse benefit determination**	During the review process
Your written or oral request for the **HMO** to review an **adverse benefit determination.**	Within 30 calendar days upon receipt of a written appeal or appeal form, the **HMO** will provide written notice of the decision; and will include the reasons (medical, clinical, dental, and contractual) for the decision and the specialization of the **provider** consulted. A denial will include your right to have an IRO review and the procedures to obtain a review.

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

Expedited Appeal of Adverse Determination

(Emergencies or Continued Hospitalization Situations)

An appeal involving ongoing emergencies, denials of continued **hospital** stay, or the discontinuance of coverage of prescription drugs or intravenous infusions that you are receiving, are referred directly to an expedited appeal process for investigation and resolution. The appeal will be decided depending on the medical or dental urgency of the case within 1 working day from the date all information necessary to complete the appeal is received. An initial notice of the decision may be delivered orally following a written notice within 3 days.

Your appeal will be reviewed by a **provider** (in the same or similar specialty for the condition, procedure, or treatment under review) not involved in the initial **adverse benefit determination**. The **provider** may interview you or your authorized representative.

How to Appeal to an Independent Review Organization (IRO)

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

- Services do not meet the definition of **emergency care** (Please see the **Emergency Care Services** section of **COVERED SERVICES**).

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

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

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

You must submit the request for independent review form:

- To the **HMO**
- Within four (4) months after receipt of the **adverse benefit determination**.

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

The **HMO** will:

- Submit medical records, names of **providers**, and documentation related to the decision of the IRO.
- Comply with the decision by the IRO.
- Pay for the independent review.

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

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

If the process for appeal and review places your health in serious jeopardy, you are not prohibited from pursuing other appropriate remedies under the law, including, injunctive relief, a declaratory judgment, or other relief.

GENERAL PROVISIONS

Termination of Coverage

The group is liable for **premium** payments from the time you cease to be eligible for coverage until the end of the **contract month** in which the group notifies the **HMO** that you are no longer covered and are not eligible for coverage. The group is required to provide coverage for you until the end of the **contract month** in which the termination notice is received by the **HMO**.

Coverage of any **member** who ceases to be eligible as shown under the **WHO GETS BENEFITS** section, will terminate on the last day of the in which the **group** notifies the **HMO** that the **member** is no longer eligible for coverage. Eligibility ceases unless otherwise specified and agreed upon by the **group** and the **HMO**. This paragraph also applies to a **dependent** of **subscriber** who has lost eligibility, for whatever reason, including the death of **subscriber**.

If this Certificate is terminated for nonpayment of **premium**, your coverage will be terminated effective after the last day of the **grace period**. Only **members** for whom the stipulated payment is received by the **HMO** will be entitled to health services covered under this Certificate, and then only for the **contract month** for which payment is received. If any required payment is not received by the **premium** due date, then you will be terminated at the end of the **grace period**. You will be responsible for the cost of services provided to you during the **grace period** if **premium** payments are not made by **group**.

Your coverage is terminated upon the termination of the **group agreement**. If the **group** does not notify you of the termination of your coverage because of the termination of the **group agreement**, your coverage will not continue past the date coverage terminates.

If your coverage is terminated, **premium** payments received on your account applicable to periods after the **effective date** of termination will be refunded to the **group** within thirty (30) days, and neither the **HMO**, nor **participating providers**, will have any further liability under this Certificate. Any claims for refunds by the **group** must be made within sixty (60) days from the effective day of termination of your coverage, or otherwise such claims will be considered waived.

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

Group Termination

The **HMO** may terminate this Certificate for the **group** in the case of:

Cause	Effective Date of Termination
Nonpayment of **premium**	At the end of the **grace period**
Fraud or intentional misrepresentation of a material fact on the part of the **group**	After fifteen (15) days written notice
Non-compliance by the **group** with a material **HMO** provision relating to any **employer** contribution or **group** participation rules	According to applicable state law

No member residing or working in the **service area**	After thirty (30) days written notice
Termination of membership of the **group** in an association, but only if coverage is terminated uniformly without regard to a health status related factor of a covered individual	After thirty (30) days written notice

Renewal of Group Coverage

The **HMO** will renew this Certificate with the **group** unless the **group** was terminated under the **Termination of Coverage and/or Group Termination** sections above.

Non-Renewal of All Group Coverage

The **HMO** may not renew this Certificate if the **HMO** elects to not renew all **HMO** contracts issued to other large or small **employers**, as applicable, in the **service area**. The **HMO** must notify the **group** of such non-renewal at least one hundred eighty (180) days before the date on which coverage terminates for the **group**.

The **HMO** may elect to discontinue a particular type of coverage for all large or small **employers** only if notice is provided to each large or small **employer**, as applicable, at least ninety (90) days before the date on which coverage terminates for the **group**. The **HMO** must offer each **employer** the option to purchase other coverage offered at the time of discontinuation.

Member Termination

The **HMO** may terminate this Certificate for a **member** in the case of:

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

Renewal of Member Coverage

The **HMO** will renew your Certificate unless you were terminated under the **Termination of Coverage and/or Member Termination** sections above.

COBRA Continuation Coverage

COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985, as modified by the Tax Reform Act of 1986. This Act permits you or covered **dependents** to elect to continue your **group** coverage as follows:

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

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

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

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

- Divorce or end of **domestic partnership**.
- **Subscriber's** death
- **Subscriber's** entitlement to **Medicare benefits**.
- Ending of covered **dependent child** status under the **WHO GETS BENEFITS** section.

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

- The last day of the continued coverage whether eighteenth (18) month or thirty-sixth (36) month period.
- The first day on which timely payment of **premium** is not made subject to the **premiums** section of the **group agreement**.
- The first day on which the **group agreement** between the **group** and the **HMO** is not in full force and effect.
- The first day on which you are 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.
- The date you are entitled to **Medicare**.

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

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

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

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

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

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

State Continuation Coverage

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

- The death of **subscriber.**
- The retirement of **subscriber.**
- Divorce or end of **domestic partnership**.

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

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

- The end of the three (3) year period after the date of **subscriber's** death or retirement.
- The end of the three (3) year period after the date of the divorce or legal separation.
- The date you become eligible for similar coverage under any substantially similar coverage under another health insurance policy, **hospital**, or medical service **subscriber** contract, medical practice, or other prepayment **health benefit plan**, or by any other program.
- The end of the period for which you have paid any applicable **premiums**.

Continuation of Group Coverage Privilege
In the event your coverage has been terminated for any reason except (i) involuntary termination for cause, or (ii) discontinuance of the **group agreement**, either in its entirety or with respect to an insured

class, you shall be entitled to continuation of **group** coverage if you have been continuously insured under the Certificate or under any **group** policy providing similar **benefits** which it replaces for at least three (3) consecutive months immediately prior to the termination.

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

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

- The date on which you exhaust the maximum continuation period which is:
  - If you are not eligible for COBRA continuation coverage, nine months after the date of state continuation coverage.
  - If you are covered under COBRA continuation coverage, six additional months following any period of COBRA continuation coverage.
- The date on which failure to make timely payments would terminate coverage.
- The date on which the **group** coverage terminates in its entirety.
- The date on which you are covered for similar **benefits** by another **hospital**, surgical, medical, or major medical expense insurance policy, **hospital** or medical service **subscriber** contract, medical practice or other prepayment **health benefit plan**, or any other program.

Transfer of Residence

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

Paper Check – Automatic Clearing House/Electronic Funds Transfer
BCBSTX will not charge an additional fee to a **payee** if such person elects to receive the payment by paper check instead of by an automated clearinghouse transaction or other electronic funds transfer.

In addition to the definitions in the **GLOSSARY** section of this Certificate, the following definition is applicable to this provision:

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

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, coinsurance, and copayments**, that is covered at least in part by any **health care plan** covering the person for whom claim is made. When a **health care plan** (including this **health care plan**) provides benefits in the form of services, the reasonable cash value of each service provided is considered to be both an **allowable expense** and a benefit paid. In addition, any expense that a **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 **members** of a **group**, the separate contracts are considered parts of the same **plan** and there is no COB among those separate contracts:

- **Group**, blanket, or franchise accident and health insurance policies, excluding disability income protection coverage.
- Individual and **group** health maintenance organization evidence 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.
- **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**.
- 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 **HMO** 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 Certificate and any other **health care plan** covering you on whose behalf a claim is made are as follows:

1. The benefits of a **health care plan** that does not have a coordination of benefits provision shall in all cases be determined before the benefits of this Certificate.

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**, **member**, policyholder, **subscriber**, or retiree, is the primary plan, and the **health care plan** that covers the person as a **dependent** is the secondary **plan**. However, if the person is a **Medicare** beneficiary and, as a result of federal law, **Medicare** is secondary to the **health care plan** covering the person as a **dependent** and primary to the **health care plan** covering the person as other than a **dependent**, then the order of benefits between the two plans is reversed so that the **health care plan** covering the person as an **employee**, **member**, policyholder, **subscriber**, or retiree is the secondary **plan** and the other **health care plan** is

the primary **plan**. An example includes a retired **employee**.

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

   a. For a **dependent** child whose parents are married or are living together, whether or not they have ever been married:
      (1) The **health care plan** of the parent whose birthday falls earlier in the **calendar year** is the primary **plan**.
      (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 their own coverage as a **dependent** under a spouse's **health care plan**, paragraph **5.** below applies.

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

dependent child's parent(s) and the **dependent's** spouse.

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

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

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

   Please Note: 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 non-panel **provider**, benefits are not payable by one closed panel

health care plan, COB must not apply between that **health care plan** and other closed panel **health care plans**.

If inpatient care began when you were enrolled in a previous **health care plan**, after you make your **copayment** under this Certificate, the **HMO** will pay the difference between benefits under this Certificate and benefits under the previous contract or insurance policy for services on or after the **effective date** of this Certificate.

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

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

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

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

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

Reimbursement - Acts of Third Parties

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

1. To reimburse the **HMO** to the extent of the **allowable amount** that would have been charged to you for health care services if you were not covered under this Certificate. Such reimbursement must be made immediately upon collection of damages for **hospital** or medical expenses by you, whether by action at law, settlement, or otherwise.

2. To assign the **HMO** a right of recovery from a third party for **hospital** and medical expenses paid by the **HMO**, on your behalf, and to provide the **HMO** with any reasonable help necessary for the **HMO** to pursue a recovery. In addition, the **HMO** will be entitled to recover attorneys' fees and court costs related to its subrogation efforts only if the **HMO** aids in the collection of damages from a third party.

Alternate Service Area Access

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 of 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 the **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. **Members** may renew qualification within the **alternate service area** by submitting a request for **alternate service area** access and receiving approval from the **HMO**.

This Certificate remains in full force and effect while you are in the **alternate service area**, and you may avail yourself of **covered services** under this Certificate by returning to the **service area**. **Emergency care** in the **alternate service area** will be covered in agreement with the terms and conditions of this Certificate. Coverage for services other than **emergency care** in the **alternate service area** will be provided in accordance with the terms and conditions of the Certificate in the **alternate service area** (the "Alternate Certificate") which the **HMO** will provide to you at the time of request for **alternate service area** access. The terms and conditions of the **alternate certificate**, including the benefits offered, may be different from this Certificate 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 may be required to select a **PCP** from a list of **participating providers** for the **alternate service area**. The **HMO** will determine the date coverage begins for the **alternate service area** (either the **effective date** of **member's** eligibility or the first day of the month following the **HMO's** receipt of the request for **alternate service area** access). If approved, the **HMO** will issue written notification.

Assignment

This Certificate is not assignable by the **group** without the written consent of the **HMO**. The coverage, and any benefits under this Certificate, are not assignable by any **member** without the written consent of the **HMO**.

Cancellation

Except as otherwise provided under this Certificate, the **HMO** shall not have the right to cancel or terminate any Certificate issued to any **subscriber** while the **group agreement** remains in full force and effect, and while the **subscriber** remains in the eligible class of **employees** of the **group**, and **premiums** are paid in accordance with the terms of this Certificate.

Clerical Error

Clerical error, whether of the **group** or the **HMO**, in keeping any records pertaining to the coverage under this Certificate, will not cancel coverage otherwise valid or continue coverage already terminated.

Entire Certificate

This Certificate, any attachments, amendments, the **group agreement**, and the individual applications, if any, of the **subscriber** comprise the entire contract between the parties and as of the **effective date** replace all other contracts between the parties.

Force Majeure

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

Form or Content of Certificate

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

Gender

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

Identity Theft Protection

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

The identity theft protection services include:

- Credit monitoring
- Fraud detection
- Credit/identity repair
- Insurance to help protect your information.

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

You may accept identity theft protection services by enrolling in the program online at www.bcbstx.com, or by calling the toll-free telephone number on the back of your **identification card**.

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

Incontestability

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

Interpretation of Certificate

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

Limitation of Liability

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

Member Data Sharing

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

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

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

To do this we may:

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

appropriate Blue Cross and/or Blue Shield **plan** to offer you uninterrupted coverage through replacement coverage.

Modifications

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

Notice

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

The **HMO**, or the **group** by agreement between the **HMO** and the **group**, may send you notices under this Certificate. These notices may be delivered:

- Through the United States Postal Service at the last address known to the **HMO.**
- Electronically, if permitted by applicable law.

Patient/Provider Relationship

Participating providers maintain a **provider**-patient relationship with **members** and are solely responsible to you for all health services. If a **participating provider** cannot establish a satisfactory **provider**-patient relationship, the **participating provider** may send a written request to the **HMO** to terminate the **provider**-patient relationship, and this request may be applicable to other **providers** in the same group practice.

Refund of Benefit Payments

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

- The person to, or for whom, such benefits were paid.
- Any insurance company or **plan**.
- Any other persons, entities, or organizations, including, but not limited to, **participating providers** or **non-participating providers.**

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

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

Further, BCBSTX has the right to reduce your benefit **plans** or policy's payment to a **provider** by the

amount necessary to recover another BCBSTX **plan's** or policy's **overpayment** to the same **provider** and to pay the recovered amount to the other BCBSTX **plan** or policy.

Relationship of Parties

The relationship between the **HMO** and **participating providers** is that of an independent contractor relationship. **participating providers** are not agents or **employees** of the **HMO**. The **HMO**, or any employee of the **HMO**, is not an **employee** or agent of **participating providers**. The **HMO** is not 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 **HMO** makes no express or implied warranties or representations concerning the qualifications, continued participation, or quality of services of any **physician**, **hospital** or other **participating provider**.

Reports and Records

The **HMO** is entitled to receive a **members** information reasonably necessary to administer this Certificate from a **provider** using the applicable confidentiality requirements described below. By accepting coverage under this Certificate, the **subscriber**, and the **subscriber's dependents** covered under this Certificate, authorizes all **providers** who give services to you to:

- Disclose all facts pertaining to your care, treatment, and physical condition to the **HMO**, or a medical, dental, or mental health professional the **HMO** may engage to assist it in reviewing a treatment or claim.
- Provide reports pertaining to your care, treatment, and physical condition to the **HMO**, or a medical, dental, or mental health professional the **HMO** may engage to assist it in reviewing a treatment or claim.
- Permit copying of your records by the **HMO**.

Information contained in your medical records and information received from **physicians**, surgeons, **hospitals**, or other **health care professionals** incident to the **physician**-patient relationship or **hospital**-patient relationship, will be kept confidential in agreement with applicable law.

Rescission of Coverage

Rescission means the retroactive cancellation or discontinuance of coverage due to an act, practice, or omission that involves fraud or an intentional misrepresentation of an important fact by you, or by a person pursuing coverage on your behalf.

Rescission is not considered:

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

Rescission is subject to 30 days' prior notification and is retroactive to the **effective date**. In the event of cancellation, the **HMO** may deduct from the **premium** refund any amounts made in claim payments during this period. You may be liable for any claim payment amount greater than the total amount of **premiums** paid during the period the cancellation is affected.

At any time when the **HMO** is allowed to rescind coverage already in force or is otherwise permitted to

make retroactive changes to this Certificate, the **HMO** may at its option make an offer to revise the Certificate already in force and/or change the rating category/level. If a recission occurs, the Certificate will be reissued retroactive in the form it would have been issued had the misstated or omitted information been known at the time of application.

Please call the **HMO** at the toll-free telephone number listed on the back of your **identification card** for more information about your appeal rights concerning Rescission and/or revision. If the decision to rescind coverage is confirmed at the completion of the internal appeal process, an external review by an Independent Review Organization may be requested.

Subtitles

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

Your rights with a Health Maintenance Organization (HMO) plan

Notice from the Texas Department of Insurance

Your plan

Your HMO plan contracts with doctors, facilities, and other health care providers to treat its members. Providers that contract with your health plan are called “contracted providers” (also known as “in-network providers”). Contracted providers make up a plan’s network. Your plan will only pay for health care you get from doctors and facilities in its network.

However, there are some exceptions, including for emergencies, when you didn’t pick the doctor, and for ambulance services.

Your plan’s network

Your health plan must have enough doctors and facilities within its network to provide every service the plan covers. You shouldn’t have to travel too far or wait too long to get care. This is called “network adequacy.” If you can’t find the care you need, ask your health plan for help. You have the right to receive the care you need under your in-network benefit.

If you don’t think the network is adequate, you can file a complaint with the Texas Department of Insurance at www.tdi.texas.gov or by calling 800-252-3439.

List of doctors

You can get a directory of health care providers that are in your plan’s network.

You can get the directory online at www.bcbstx.com/find-care/find-a-doctor-or-hospital or by calling the toll-free telephone number on the back of your identification card.

If you used your health plan’s directory to pick an in-network health care provider and they turn out to be out-of-network, you might not have to pay the extra cost that out-of-network providers charge.

Bills for health care

If you got health care from a doctor that was out-of-network when you were at an in-network facility, and you didn’t pick the doctor, you won’t have to pay more than your regular copay, coinsurance, and deductible. Protections also apply if you got emergency care at an out-of-network facility or lab work or imaging in connection with in-network care.

If you get a bill for more than you’re expecting, contact your health plan. Learn more about how you’re protected from surprise medical bills at tdi.texas.gov.

NOTICES

BlueCross BlueShield of Texas

Non-Discrimination Notice

Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids or language assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, you can file a grievance with:

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
Attn: Office of Civil Rights Coordinator	TTY/TDD:	855-661-6965
300 E. Randolph St., 35th Floor	Fax:	855-661-6960
Chicago, IL 60601	Email:	civilrightscoordinator@bcbsil.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

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

US Dept of Health & Human Services	Phone: 800-368-1019
200 Independence Avenue SW	TTY/TDD: 800-537-7697
Room 509F, HHH Building	Complaint Portal:
Washington, DC 20201	ocrportal.hhs.gov/ocr/smartscreen/main.jsf
	Complaint Forms:
	hhs.gov/civil-rights/filing-a-complaint/index.html

This notice is available on our website at bcbstx.com/legal-and-privacy/non-discrimination-notice

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 855-710-6984 (TTY: 711) or speak to your provider.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-710-6984 (TTY: 711) o hable con su proveedor.
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة.

BlueCross BlueShield of Texas

中文 Chinese	注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 855-710-6984（文本电话：711）或咨询您的服务提供商。
Français French	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-710-6984 (TTY : 711) ou parlez à votre fournisseur.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 855-710-6984 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Italiano Italian	ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'855-710-6984 (tty: 711) o parla con il tuo fornitore.
한국어 Korean	주의: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-710-6984(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	SHOOH: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.
فارسي Farsi	توجه: اگر فارسي صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 855-710-6984 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.
Polski Polish	UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 855-710-6984 (TTY: 711) lub porozmawiaj ze swoim dostawcą.
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-710-6984 (TTY: 711) или обратитесь к своему поставщику услуг.
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider.
اردو Urdu	توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔855-710-6984 (711:TTY) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 855-710-6984 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

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 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

Adverse Benefit Determinations

In addition to the processes described under the **COMPLAINT AND APPEAL PROCEDURES** section of this Certificate, and in the **Plan Description and Member Handbook,** you have the right to a review by the **HMO** of any **adverse benefit determination**.

Review of Claim Determinations

Claim Determinations

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

If a Claim is Denied or Not Paid in Full

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

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

Timing of Required Notices and Extensions

There are four types of claims as defined below.

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

NOTICE

Adverse Benefit Determinations

- **Pre-service Claim** means any non-urgent request for benefits that involves services you have not yet received and requires Prior Authorization.

- **Post-Service Claim** is notification in a form acceptable to the **HMO** that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the **provider**, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the claim charge, and any other information which the **HMO** may request in connection with services rendered to you.

- **Concurrent Care Claim** means a claim occurs when you need the **HMO** to approve more services than it already has approved. Examples are extending a hospital stay or adding visits to a **provider**. The **HMO** will notify you of its determination for such a request within 24 hours after receipt of your claim for benefits.

Type of Notice (Claim) or Extension	Time Period*
Urgent Care Clinical Claim (you don't need to submit Urgent Care Clinical Claims in writing. You should call the **HMO** at the toll-free telephone number on the back of your **identification card** as soon as possible to submit an Urgent Care Clinical Claim).	
If your claim is incomplete, the **HMO** must notify you within:	24 hours
If you are notified that your claim is incomplete, you must provide information to complete your claim within:	48 hours after receiving notice
If the initial claim is complete (taking into consideration medical needs), within:	72 hours.
After receiving the completed claim (if the initial claim is incomplete), within:	48 hours
Pre-Service Claims	
If your claim is filed improperly, the **HMO** must notify you within:	5 days
If your claim is incomplete, the **HMO** must notify your within:	15 days
If you are notified that your claim is incomplete, you must then provide completed claim information to the **HMO** within:	45 days after receiving notice
If the initial claim is completed, within:	15 days. The **HMO** may extend this period one time for up to 15 days providing the **HMO** both (1) determines that such an extension is necessary dur to matters beyond its control and (2) notifies You prior to the expiration of the initial 15-day period of the reasons requiring the extension of time and the date by which the **HMO** expects to give a decision.
After receiving the completed claim (if the initial claim is incomplete), within:	30 days
If post-stabilization care is required after an emergency, within:	One hour after claim is received
Post-Service Claims	
If your claim is incomplete, you will be notified within:	30 days after claim is received

NOTICE

Adverse Benefit Determinations

If you are notified that your claim is incomplete, you must then provide completed claim information within:	45 days after receiving notice
If the initial claim is complete, within:	30 days. The **HMO** may extend this period one time for up to 15 days providing the **HMO** both (1) determines that such an extension is necessary due to matters beyond its control and (2) notifies you prior to the expiration of the initial 30-day period of the reasons requiring the extension of time and the date by which the **HMO** expects to give a decision.
After receiving the completed claim (if the initial claim is incomplete), within:	45 days
Concurrent Care Claim	
We will notify you of our determination for such a request within:	24 hours after receipt of your claim for benefits

*The **HMO** must notify you of the claim determination (whether adverse or not):

Please Note: If the **HMO** is going to discontinue coverage of prescription drugs or intravenous infusions that You are receiving, the **HMO** will notify You at least 30 days before the date coverage will be discontinued. This notice explains Your rights to an expedited appeal and immediate review by an Independent Review Organization.

Claim Appeal Procedures and Definitions

Adverse Benefit Determination means the **HMO's** determination that the health care services you have received, or may receive are:

- Experimental/ investigational
- Not medically necessary or appropriate

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

Final Internal Adverse Benefit Determination means an **adverse benefit determination** that has been confirmed by the HMO after completion of its internal review/appeal process.

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

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

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

NOTICE

Adverse Benefit Determinations

Expedited Clinical Appeals

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

How to Appeal to an Adverse Benefit Determination

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

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

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

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

Please Note: the HMO will honor telephone requests for information; however, such inquiries will not start a request for review.

The review of the **HMO's** decision will take place as follows:

Appeal Process	Time Period
You may present evidence and testimony in support of your claim.	Within 180 calendar days or during the review process

NOTICE

Adverse Benefit Determinations

You may review your claim file and relevant documents. You may submit written issues, comments, and additional medical information.	Within 180 calendar days or during the review process
The **HMO** will give you any new or additional information it uses to review your claim before the date a final decision on the appeal is made. The **HMO** may extend the time for its final decision to provide you with a reasonable opportunity to respond	Within 180 calendar days or during the review process
The review and decision of your appeal will be made by personnel not involved in making the initial adverse decision.	During the review process
If the initial adverse decision was based on a medical result, the review will be made by individuals associated or contracted with the **HMO**, and/or by external advisors, who were not involved in the initial **adverse benefit determination**.	During the review process
The **HMO** will not consider the initial **adverse benefit determination**.	During the review process
Non-Urgent Concurrent or Pre-Service appeal, within	30 days upon receipt of the appeal
Post-Service appeal, within	60 days upon receipt of the appeal

Before you may bring any action to recover benefits, you must complete the appeal process, raise all issues with respect to a claim, and file an appeal or appeals, and the appeals must be finally decided by the **HMO**.

If you have a claim for benefits which is denied or ignored, in whole or in part, and your health **plan** is governed by the Employee Retirement Income Security Act (ERISA), you have the right to bring civil action under 502(a) of ERISA.

If You Need Assistance

If you have any questions about claims procedures or review procedures, please call the **HMO** at 1-877-299-2377. The Customer Service helpline is available from 8:00 A.M. to 8:00 P.M. Monday through Friday, or write to us at:

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

Notice of Appeal Determination

The **HMO** will provide an oral and written notice of its appeal determination to you, and, if your appeal is a clinical appeal, to the **provider** who recommended the services involved in the appeal.

The written notice to you includes:

- The reasons for the determination, including the guidelines used in denying the claim and a discussion of the decision, benefit plan provisions, contractual, administrative, or procedure basis.
- The identification of the claim, date of service, **provider**, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used – subject to privacy laws and other restrictions, if any. Upon request, diagnosis/treatment codes with their meanings and the standards used.
- An explanation of the **HMO's** external review processes (and how to initiate an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) following a final denial on external appeal.
- If available, and upon request, a document in non-English language(s) showing how to access the language services provided by the **HMO**, including a written notice of claim denials and certain other benefit information.
- The right to request, without any cost to you, reasonable access to, and copies of, all documents, records, and other information related to the claim for benefits.
- Any internal rule, guideline, procedure, or other similar reasons relied upon in the determination, and instructions on getting a copy of these, upon request, without any cost to you.
- An explanation of the scientific or clinical decision relied upon in the determination, or instructions on getting a copy of the explanation, upon request, without any cost to you.
- Health Insurance Consumer Assistance or Ombudsman contact information (as appropriate).

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

If you need assistance with the internal claims and appeals or the external review processes, 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 may contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

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

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

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

How to Appeal a Final Adverse Determination to an Independent Review Organization (IRO)

An independent review is a review made by an organization independent of the **HMO**. This is called an independent review organization (IRO).

NOTICE

Adverse Benefit Determinations

IRO Procedures and Definitions

External Review Criteria

External Review is available for Adverse Benefit Determinations and Final Internal Adverse Benefit Determinations.

An Adverse Benefit Determination means the cancellation and determination that a covered service has been reviewed and determined to be, or does not meet requirements for:

- Experimental/ investigational
- Medically necessity, appropriateness, health care setting, level of care, or effectiveness
- Whether you are entitled to a reasonable alternative standard for a reward under a wellness program
- Compliance with the non-measurable treatment limitation provisions of the Mental Health Parity and Addiction Equity Act

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

A **final internal adverse benefit determination** means an **adverse benefit determination** that the **HMO** confirmed after completing its internal review/appeal process.

Standard External Review

You, or your authorized representative, may request a standard external review or expedited external review of an **adverse benefit determination** or **final internal adverse benefit determination** by an IRO.

Appeal Process	Time Period
STANDARD EXTERNAL REVIEW	
You receive notice of an **adverse benefit determination** or **final internal adverse benefit determination** and must file your request for a standard external review, within	4 months
Preliminary review: The **HMO** receives your external review request and completes a review to determine whether: • You were covered under the plan at the time the service was provided • The **adverse benefit determination** or the **final adverse internal benefit determination** does not relate to your failure to meet the requirements for eligibility under the plan • You have completed the **HMO's** internal appeal process (unless you are not required to complete the internal appeals process • You have provided the information and forms required to process an external review	5 business days upon receipt
You will be notified if your request is eligible or if further information or documents are needed. If your claim is not	1 business day

eligible for external review, we will outline the reasons why in the notice.	
Referral to IRO	
The **HMO** will assign an eligible request to an IRO.	
EXPEDITED EXTERNAL REVIEW	
You may request an expedited external review with the **HMO** at the time you receive: • An **adverse benefit determination**, if it involved your medical condition and the timeframe for an expedited internal appeal would seriously jeopardize your life, health, or your ability to regain maximum function • A **final internal adverse benefit determination** involved your medical condition and the timeframe for a standard external review would seriously jeopardize your life, health, or your ability to regain maximum function, or it 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.	
Preliminary Review: The **HMO** determines if your request meets the requirements in the Preliminary Review (above) and will send you a notice of its eligibility determination	Immediately
Referral to IRO	
The **HMO** will assign an eligible request to an IRO and provide all necessary documents and information considered in making the **adverse benefit determination** or **final internal adverse benefit determination.**	

Please Note: The IRO assigned will be accredited by URAC or by a similar nationally-recognized accrediting organization. The HMO will make sure the IRO is unbiased and independent. The HMO must contract with at lease 3 IROs for assignments and rotate among them (or include other independent, unbiased methods for selection of IROs, such as random selection). Additionally, 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. Use of legal experts where appropriate to make coverage determinations
b. Timely notification to you, or your authorized representative, in writing, of the eligibility and acceptance for external review. This notice will include information that you may submit in writing within 10 business days additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

c. Within five business days after the date of assignment of the IRO, the **HMO** must provide the IRO documents and information considered in the **adverse benefit determination** or **final internal adverse benefit determination**. Failure by the **HMO** to timely provide the documents and information must not delay the external review. If the **HMO** fails to timely provide the documents and information, the IRO may terminate the external review and decide to reverse the **adverse benefit determination** or **final internal adverse benefit determination**. Within one business day after making the decision, the IRO must notify the **HMO** and you or your authorized representative.

d. Upon receipt of any information you, or your authorized representative submit, within one business day the IRO must forward the information to the **HMO**. Upon receipt of the information, the **HMO** may reconsider the **adverse benefit determination** or Final Internal **adverse benefit determination** that is the subject of the external review. Reconsideration by the HMO must not delay the external review. The external review may be terminated because of the reconsideration only if the **HMO** decides, upon completion of its reconsideration, to reverse the **adverse benefit determination** or Final Internal **adverse benefit determination** and provide coverage or payment. Within one business day after making such a decision, the **HMO** must provide written notice of its decision to you and the IRO. The IRO must terminate the external review upon receipt of the notice from the **HMO**.

e. Review the information and documents timely received. In reaching a decision, the IRO will review the claim from the beginning and not be bound by any decisions or conclusions reached during the **HMO's** internal claims and appeals process. In addition to the documents and information provided, the IRO to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

   (1) Your medical records

   (2) The attending health care professional's recommendation

   (3) Reports from appropriate health care professionals and other documents submitted by the **HMO**, you, or your treating provider

   (4) The terms of your plan to ensure the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law

   (5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national, or professional medical societies, boards, and associations

   (6) Any applicable clinical review criteria developed and used by the **HMO**, unless the criteria are inconsistent with the terms of the plan or with applicable law

   (7) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

f. Written notice of the final external review decision must be provided within forty-five days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the **HMO** and you or your authorized representative.

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

   (1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial)

(2) The date the IRO received the assignment to conduct the external review and the date of the IRO decision

(3) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision

(4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision

(5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the **HMO**, you, or your authorized representative

(6) A statement that judicial review may be available to you or your authorized representative

(7) Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

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

Reversal of plan's decision

Upon receipt of a notice of a final external review decision reversing the **adverse benefit determination** or Final Internal Adverse Benefit Determination, the **HMO** must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

In addition to the information contained in the table above:

The 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 a Standard Review. In reaching a decision, the IRO must review claim from the beginning and is not bound by any decisions or conclusions reached during the **HMO**'s internal claims and appeals process.

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 within 72 hours after the IRO receives your request. If the notice is oral, a written notice will be given within 48 hours of the oral notice. The IRO must provide written confirmation of the decision to the **HMO**, you, or your authorized representative.

Exhaustion

For a standard internal review, you have the right to request an external review after the internal review process has been completed and you have received the final **internal adverse benefit determination**. For an expedited internal review, you may request an external review at the same time as the request for an expedited internal review. The IRO will determine whether your request is appropriate for an expedited external review or if the expedited internal review process must be completed before an external review may be requested.

NOTICE

Adverse Benefit Determinations

You will be considered to have exhausted the internal review process and may request an external review if:

- The **HMO** waives the internal review process
- The **HMO** fails to comply with the internal claims and appeals process other than a minor failure

If you have exhausted the internal review process due to the **HMO**'s failure to comply with the internal claims and appeals process, other than a minor failure, you have the right to pursue any available remedies under 502(a) of ERISA or under State law.

The internal review process will not be deemed exhausted based on small violations that do not cause, and are not likely to cause, prejudice or harm to you; as long as the **HMO** shows that the violation was for good cause or due to matters beyond its control, and that the violation occurred in the context of an ongoing, good faith exchange of information between you and the **HMO**.

An external review may not be requested for an **adverse benefit determination** involving a claim for benefits for a health care service that you have already received until the internal review process has been exhausted.

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your HMO contract with Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation.

Mastectomy or Lymph Node Dissection

Minimum Inpatient Stay: If due to treatment of breast cancer, any person covered by this Plan has either a mastectomy or a lymph node dissection, this Plan will provide coverage for inpatient care for a minimum of:

(a) 48 hours following a mastectomy
(b) 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the covered person receiving the treatment and the attending physician determine that a shorter period of inpatient care is appropriate.

Prohibitions: We may not (a) Deny any covered person eligibility, continued eligibility, or fail to renew this Plan solely to avoid providing the minimum inpatient hours; (b) Provide money payments or rebates to encourage any covered person to accept less than the minimum inpatient hours; (c) Reduce or limit the amount paid to the attending physician, or otherwise penalize the physician, because the physician required a covered person to receive the minimum inpatient hours; or (d) Provide financial or other incentives to the attending physician to encourage the physician to provide care that is less than the minimum hours.

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy - Enrollment

Coverage and/or benefits are provided to each covered person for reconstructive surgery after mastectomy, including:

(a) All stages of the reconstruction of the breast upon which the mastectomy was performed;
(b) Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
(c) Prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy.

The coverage and/or benefits must be provided in a manner determined to be appropriate in consultation with the covered person and the attending physician.

Deductibles, coinsurance, and copayment amounts will be the same as those applied to other similarly covered medical services as shown under the Schedule of Copayments and Benefit Limits.

Prohibitions: We may not (a) offer the covered person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above; (b) condition, limit, or deny any covered person's eligibility or continued eligibility to enroll in the plan, or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above; or (c) reduce or limit the amount paid to the physician or provider, nor otherwise penalize, or provide a financial incentive to induce the physician or provider to provide care to a covered person in a manner inconsistent with the coverage and/or benefits shown above.

NOTICE OF CERTAIN MANDATORY BENEFITS

Examinations for Detection of Prostate Cancer

Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include:

(a) A physical examination for the detection of prostate cancer; and
(b) A prostate-specific antigen test for each covered male who is:
    (1) At least 50 years of age; or
    (2) At least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

Inpatient Stay following Birth of a Child

For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

(a) 48 hours following an uncomplicated vaginal delivery, and
(b) 96 hours following an uncomplicated delivery by cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to (a) give birth in a hospital or other health care facility or (b) remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours has expired, we will provide coverage for post-delivery care. Post-delivery care includes parent education, assistance, and training in breast-feeding and bottle-feeding, and the performance of any necessary and appropriate clinical tests. Care will be provided by a physician, registered nurse, or other appropriate licensed health care provider, and the mother will have the option of receiving the care at her home, the health care provider's office or a health care facility.

Since we provide in-home post-delivery care, we are not required to provide the minimum number of hours outlined above unless (a) the mother's or child's physician determines the inpatient care is medically necessary, or (b) the mother requests the inpatient stay.

Prohibitions. We may not (a) modify the terms of this coverage based on any covered person requesting less than the minimum coverage required; (b) offer the mother/birthing parent financial incentives or other compensation for waiver of the minimum number of hours required; (c) refuse to accept a physician's recommendation for a specified period of inpatient care made in consultation with the mother/birthing parent, if the period recommended by the physician, does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians; (d) reduce payments or reimbursements below the usual and customary rate; or (e) penalize a physician for recommending inpatient care for the mother/birthing parent and/or the newborn child.

NOTICE OF CERTAIN MANDATORY BENEFITS

Coverage for Tests for Detection of Colorectal Cancer

Benefits are provided, for each person enrolled in the plan who is 50 years of age or older, and at normal risk for developing colon cancer, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include the covered person's choice of: (a) a fecal occult blood test performed annually, and a flexible sigmoidoscopy performed every five years, or (b) a colonoscopy performed every 10 years.

Coverage of Tests for Detection of Human Papillomavirus, Ovarian Cancer, and Cervical Cancer

Coverage is provided for each woman enrolled in the plan who is 18 years of age or older for expenses incurred for an annual, medically recognized diagnostic examination for the early detection of ovarian and cervical cancer. Coverage required under this section includes a CA 125 blood test and, at a minimum, a conventional Pap smear screening, or a screening using liquid-based cytology methods, as approved by the FDA, alone, or in combination with, a test approved by the FDA for the detection of the human papillomavirus.

Treatment of Acquired Brain Injury

Your health benefit plan coverage for an acquired brain injury includes the following services:

(a) Cognitive rehabilitation therapy;
(b) Cognitive communication therapy;
(c) Neurocognitive therapy and rehabilitation;
(d) Neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing and treatment;
(e) Neurofeedback therapy, remediation;
(f) Post-acute transition services and community reintegration services, including outpatient day treatment services or other post-acute care treatment services; and
(g) Reasonable expenses related to periodic reevaluation of the care of an individual covered under the plan who has incurred an acquired brain injury, has been unresponsive to treatment, and becomes responsive to treatment at a later date, at which time the cognitive rehabilitation services would be a covered benefit.

The fact that an acquired brain injury does not result in hospitalization or acute care treatment does not affect the right of the insured or the enrollee to receive the preceding treatments or services commensurate with their condition. Post-acute care treatment or services may be obtained in any facility where such services may legally be provided, including acute or post-acute rehabilitation hospitals and assisted living facilities regulated under the Health and Safety Code.

If any person covered by this plan has questions concerning the information above, please call Blue Cross and Blue Shield of Texas at 1-877-299-2377 or write us at P.O. Box 660044, Dallas, Texas 75266-0044.

NOTICE

INTER-PLAN ARRANGEMENTS NOTICE

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

Inter-Plan Arrangements

Out-of-Area Services

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation (herein called "**HMO**") has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter- Plan Arrangements." These Inter- Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you obtain healthcare services outside of our Service Area, the claims for these services may be processed through one of these Inter-Plan Arrangements.

Typically, when accessing care outside our Service Area, you will obtain care from healthcare **providers** that have a contractual agreement (i.e., are "**participating providers**") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from **non**-**participating 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 we serve. Any other services will not be covered when processed through any Inter-Plan Arrangements, unless authorized by your **Primary Care physician/Practitioner ("PCP")/HMO**.

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 what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its **participating** healthcare **providers**.

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 the **covered services** provided to you, so there are no claim forms for you to fill out. You will be responsible for the **member copayment** amount indicated in the Certificate of Coverage, Schedule of **copayments** and Benefit Limits.

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 receive **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 covered charges for the **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 also take into account adjustments to correct for over-or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied after a claim has already been paid.

Federal or state laws or regulations may require a surcharge, tax, or other fee that applies to insured accounts. If applicable, the **HMO** will include any such surcharge, tax, or other fee as part of the claim charge passed on to you. If federal law or any state laws mandate other liability calculation methods, including a surcharge, the **HMO** 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**, services received from a **non-participating provider** outside of our **service area** will not be covered.

For **emergency care** and **urgent care** services received from **non-participating providers** within the state of Texas, please refer to the "**Emergency Services**" section of this Certificate.

For **emergency care** and **urgent care** services that are provided outside of the **service area** 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 Blue Cross Blue Shield Global Core when accessing **covered services**. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands in certain ways. For instance, although Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional **providers**, the network is not served by a Host Blue. As such, when you receive care from **providers** outside the 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 United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands, you should call the service center at

1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, will arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

In most cases, if you contact the service center for assistance, hospitals 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 Blue Cross and Blue Shield of Texas to obtain Prior Authorization for non- emergency inpatient services.

Outpatient Services

Physicians, urgent care centers and other outpatient **providers** located outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands 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 and 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 **HMO**, the service center, or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the Blue Cross Blue Shield Global Core service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

HANDBOOK

Blue Cross and Blue Shield of Texas

(herein called “BCBSTX” or “HMO”)
BLUE CROSS AND BLUE SHIELD OF TEXAS
A DIVISION OF HEALTH CARE SERVICE CORPORATION
1001 E. Lookout Drive
Richardson, TX 75082

This plan is offered by the following organization, which operates under Chapter 843 of the Texas Insurance Code

Plan Description and Member Handbook

This Plan Description and Member Handbook summarizes your benefits and rights and responsibilities under this health care plan. You can find complete information about this health care plan in the Certificate of Coverage (COC) you will receive after your enrollment. This document may be delivered to you electronically. Any notices included with this document may be sent to you electronically by the HMO, or Group by agreement between the HMO and Group. Paper copies are available upon request.

Your satisfaction with your new health care program is very important to us. If you would like additional information about your plan, a Customer Service representative will be happy to help you. Please call Customer Service (Monday through Friday from 7:30 a.m. to 6:00 p.m. CST) at toll-free telephone number 1-877-299-2377. You may also write HMO at: HMO Customer Service P.O. Box 660044 Dallas, Texas 75266-0044.

Thank you for considering us for your health care coverage.

TABLE OF CONTENTS

Medically Necessary Covered Services and Benefits

The COC contains specific information regarding your health care benefits, amounts you may owe, limitations, and exclusions. You will receive the COC upon enrollment. Please take the time to review the COC, Benefit Highlights and any attachments to get the most from your health care coverage.

During enrollment, you will select a primary care physician/practitioner (PCP) for yourself and one for each of your covered dependents. A PCP provides most of your health care needs and may be a family or general practitioner, advanced practice nurse, physician assistant, internist, pediatrician, or obstetrician-gynecologist (OB/GYN). (Please see the "Receiving Care**"** section below for more information about PCPs.)

Your copayment, coinsurance, or deductible amount is determined by the plan chosen. Consumer Choice plans do not include all state-mandated health insurance benefits and may include deductibles and benefit limits that are not included in other plans.

Hospitalization

If you need to be hospitalized, your PCP, or participating OB/GYN, can arrange for your care at a local participating hospital and make the necessary arrangements (including referrals) and keep you informed. The HMO will review a referral request and within 24 hours issue a determination indicating whether the proposed services have obtained prior authorization. You may have to pay a copayment, coinsurance, or deductible depending upon your plan.

During an inpatient stay at a participating hospital, skilled nursing facility, or other participating facility, a physician other than your PCP may manage 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.

In non-emergency situations, first call your PCP as special rules apply in emergency situations or in cases where you are out of the area (Please see the "Emergency Care" section below.)

Other Medical Services

In addition to PCPs, specialists, and hospitals, the network includes other health care professionals for diagnostic testing, laboratory services, or other health care services. Your PCP or participating OB/GYN will coordinate your care or refer you to an appropriate provider. You may have to pay a copayment, coinsurance, or deductible depending upon your plan.

Preventive Care

Preventive care is a key part of your plan, which emphasizes staying healthy by covering:

- Well-child care, including immunizations.
- Hearing loss screenings through 24 months.
- Periodic health assessments
- Eye and ear screenings
- Annual well-woman exams, including, but not limited to, a conventional pap smear.

- Annual screening mammograms for members aged 35 and over.
- Bone mass measurement for osteoporosis.
- Prostate cancer screening for members at least age 50, or at least age 40 with a family history of prostate cancer.
- Colorectal cancer exams, preventive services, and lab tests that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF") for members 45 years of age and older.
- Depending on your plan, any other evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Task Force ("USPSTF") or as required by state law.

Behavioral Health Care

Your mental health benefits include outpatient, and depending on your plan, inpatient visits for crisis intervention and evaluation. Please refer to the COC for additional information. To access mental health services, please call behavioral health at the toll-free telephone number on the back of your ID card.

Benefits and coverage for behavioral health services are provided the same as the medical plan. The HMO will not impose limitations for behavioral health services that are more restrictive than treatment limitations.

Prescription Drugs

Depending on the plan, you may have prescription drug coverage. To find out which prescription drugs are covered under a plan, please review the applicable drug list at https://www.bcbstx.com.

REMEMBER:

- Your PCP, or participating OB/GYN, will arrange for specialty care or hospitalization.
- Preventive care is an important part of staying healthy. These services can be provided or arranged by your PCP.
- A copayment, coinsurance, or deductible may apply when obtaining services provided or arranged by your PCP.
- You won't have to file claims for services received from participating providers.

Emergency Care, After Hours Care, and Urgent Care

Medical Emergencies

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

In the case of a pregnant woman, serious jeopardy to the health of the fetus.

- Placing the patient's health in serious jeopardy.

- Serious impairment of a bodily function.
- Serious dysfunction of any bodily organ or part.
- Serious disfigurement.

Please seek care immediately in a medical emergency and present your ID card to the hospital emergency room or comparable facility. You or a family member should call your PCP within 48 hours, or as soon as possible, after receiving emergency care. This call is important so that your PCP can coordinate or provide any follow-up care required as a result of a medical emergency.

If post stabilization care is required after an emergency care condition has been treated and stabilized, the treating provider will contact the HMO for approval or denial of treatment within one hour upon receiving the request.

After Hours Care
HMO participating providers have systems in place to respond to your needs when their business offices are closed. These systems may include the use of an answering service or a recorded telephone message informing patients how to access further care.

Urgent Care Services
Services and supplies provided 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.

Retail Health Clinics
Covered services include:

- Diagnosis and treatment of uncomplicated minor conditions in situations that can be handled without a traditional PCP office visit, urgent care visit, or emergency care visit.

A PCP referral is not required to obtain covered services.

Out-of-Area Services and Benefits

Emergency Services Outside the Service Area
If you experience a medical emergency while traveling outside our service area, go to the nearest emergency or urgent care facility.

Urgent Care Outside the Service Area
When you are traveling outside of Texas and you need urgent care that cannot be postponed until you return home, the BlueCard® Program gives you the ability to obtain health care services through a Blue Cross and Blue Shield affiliated physician or hospital outside of Texas.

Follow these easy steps:

1. Locate a participating provider by calling BlueCard Access at 1-800-810-BLUE (2583) or visit the BlueCard Doctor and Hospital Finder website (www.bcbs.com).
2. Call your PCP for referrals and for care requiring prior authorization.
3. Schedule an appointment directly with the provider.
4. Present your ID card.
5. Pay any applicable copayments, coinsurance, or deductible.
6. Discuss follow-up care with your PCP.

Away From Home Care® Program

If you (or a covered dependent) will be temporarily residing outside of Texas, in a participating location, for at least 90 days, you may be eligible to obtain covered services from a Blue Cross and Blue Shield Association affiliated HMO. Under the Away From Home Care (AFHC) Program, you retain your coverage under the HMO.

To apply, call the home plan AFHC Coordinator at 1-888-522-2396 before you leave your service area, who will locate the HMO near your (or your dependent's) temporary location and process your request.

When you arrive at your new location, call the Host HMO AFHC Program Coordinator and receive information about the host HMO, including a list of physicians and benefits you are entitled to. The benefits available and requirements for accessing services outside of Texas may not be identical to those under your current HMO plan. When returning to the home plan service area, use the home plan PCP and receive home plan benefits.

Out-Of-Network Facility Based Providers and Diagnostic Imaging and Lab Providers

In some instances, you may not have the ability to choose a participating provider, such as when you receive services from a non-participating facility-based provider in a participating facility, or when you receive services from a non-participating laboratory or diagnostic imaging facility in connection with care provided by your participating provider. In these instances, your services may be covered, and you would not be responsible for any amounts beyond the copayment and any applicable coinsurance or deductibles. If you receive a bill from a non-participating provider in such circumstances, please call HMO. If you elect to use non-participating providers for non-emergency care services and supplies available from participating providers, benefits will not be covered.

Your Financial Responsibilities

BCBSTX requires a premium from you (or your employer) as a condition of coverage. A copayment and any applicable coinsurance or deductible may be due at the time a participating provider provides service. Certain copayment amounts and any applicable coinsurance or deductible and the corresponding types of services are listed on your ID card. For a complete list, please refer to the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** in your COC. The copayment and any other coinsurance or deductible amount is determined by your plan. Consumer Choice plans do not include all state mandated health insurance benefits, which means these plans may include deductibles and benefit limits that are not included on other plans. Also, you will have to pay for services not covered by HMO.

HMO network physicians and providers have agreed to look only to the HMO, and not to its members, for payment of covered services. Usually, you are expected to pay nothing more than a copayment and any applicable coinsurance or deductible to participating providers. You should not receive a bill for services received from participating providers. If this occurs, call Customer Service to help determine if the service is a covered benefit and/or to correct the problem.

Limitations and Exclusions

The COC contains specific information including limitations and exclusions. If prescription drugs are covered, the COC will include prescription drug benefit exclusions and limitations. The Benefit Highlights also include a summary of limitation and exclusions.

Prior Authorization Requirements, Referral Procedures, and Other Review Requirements

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

Prior authorization requires the provider to get approval from the HMO before you are admitted to the hospital or for certain types of covered services. Renewal of an existing prior authorization issued by the HMO may be requested by a provider up to 60 days prior to the expiration of an existing prior authorization.

Emergency care services do not require prior authorization. Non-emergency requests for inpatient admissions require prior authorization by are reviewed by registered nurses who utilize a system of clinical protocols and criteria to determine the following:

- Medical necessity of the requested care.
- Appropriateness of the location and level of care.
- Appropriateness of the length of stay.
- Assignment of the next anticipated review point.

Concurrent Review

The HMO supports the review of requests for continued services including inpatient hospital admissions. A concurrent review means you, your provider, or other authorized representative submits a request to extend care beyond the approved time limit. The HMO will provide a decision within the timeframes described under the Review of Claim Determinations section.

Retrospective Review

The HMO conducts reviews after services have been provided to the patient. Retrospective review includes a medical necessity evaluation of the care/service provided to a member, and of physician compliance to the Utilization/Case Management Program requirements.

Case Management Review

The Case Management Department facilitates a collaborative process to access, plan, implement, coordinate, monitor, evaluate options, and/or service to meet a member's health care needs through communication and available resources to promote appropriate, cost-effective outcomes.

Continuity of Care

If you receive notice that your provider is no longer participating with the HMO, it is important to understand that there are special circumstances that allow the provider to continue treatment for a limited time. Except for reasons of medical competence or professional behavior, termination does not release the HMO from the obligation to reimburse a provider who is treating you if you have a disability, acute condition, life-threatening illness, or a pregnancy which has passed the 13th week.

If your provider reasonably believes that discontinuing the care that they are providing may cause harm to you, the **provider** must identify the special circumstances to the HMO, and request that you be allowed to continue treatment. Continuity of treatment may last (i) for up to 90 days from the provider's termination date, (ii) for up to nine months in the case of a member who at the time of provider termination has been diagnosed with a terminal illness, or (iii) for a member who at the time of the termination is past the 13th week of pregnancy, through the delivery of the child, immediate postpartum care, and the follow-up checkup within the first six weeks of delivery.

Complaint Procedure: Appeal of Adverse Determination; Independent Review Organization Process; and Non-Retaliation

Claim or Benefit Reconsideration

If a claim or request for benefits is partially or completely denied, you will receive a written explanation of the reason for the denial and be entitled to a full review. If you wish to request a review or have a question regarding the explanation of benefits, please call customer service at the toll-free telephone number on the back of your ID card. If you are still not satisfied, you may request an appeal of the decision or file a complaint. You may obtain a review of the denial by following the procedures set forth below and more fully in the Claim Filing and Appeals Procedures section in the COC.

Complaints

There may be times when you find that you do not agree with a particular HMO policy, procedure, or benefit decision, or you are not satisfied with some aspect of the treatment by a participating provider. We encourage you to communicate your dissatisfaction promptly and directly to the source of the problem.

The goal of customer service is to prevent small problems from becoming large issues. To express a complaint regarding any aspect of the HMO program, please call or write customer service.

If an inquiry is not resolved promptly to your satisfaction, it will be handled according to the complaint procedure described below.

Complaint Procedure
Complainant means a party, including you, an authorized representative, physician, or provider ("you") who submits a complaint.

Complaint means an expression of dissatisfaction by a complainant either orally or in writing to the HMO, including, but not limited to:

- Information relied upon in making a benefit determination.
- HMO operational issue.
- Procedures related to review or appeal of an adverse determination.
- The denial, reduction, or termination of a service for reasons not related to medical necessity, including an out-of-network denial because services provided do not meet the definition of emergency care as shown under the COC Emergency Services section.
- A provider
- Disenrollment decisions.

A Complaint does not include:

- A misunderstanding or giving of misinformation that has been resolved promptly.
- Dissatisfaction or disagreement with an adverse determination (defined under the COC How to Appeal an Adverse Determination section.)

Complaint Procedure	Time Period
Submission of a complaint	If an inquiry is not resolved promptly to your satisfaction
HMO receives complaint and must notify you within:	5 days – confirming receipt of your complaint and provide complaint process and timeframes*
HMO receives Complaint and within:	30 days • Investigate and resolve your complaint • Send you correspondence explaining the HMO's decision, including: 1. The medical and contractual reasons 2. Any benefit exclusion, limitation, or medical condition 3. The specialty of any provider consulted 4. Information to resolve a claim (if needed) 5. Explanation of the complaint appeal process, including deadlines and final appeal decision
Complaints about emergencies or denial of continued Hospital stay within	1 business day – investigated and decision given

*If you submitted an oral complaint, the HMO will also enclose a Complaint form to be filled out and returned.

If the complaint is not resolved to your satisfaction, you have the right to dispute the resolution by following the complaint appeals process. A full description of the complaint appeals process will accompany the complaint resolution.

The HMO is prohibited from retaliating against an individual who has filed a complaint against or appealed a decision of the HMO. Also, we are prohibited from retaliating against a physician or provider because the physician or provider has, on your behalf, reasonably filed a complaint against or appealed a decision of the HMO.

Complaint Appeals to the HMO

If the complaint is not resolved to your satisfaction, the HMO complaint appeal process gives you the right to submit a written appeal and appear in person, by telephone, or other technological methods before a complaint appeal panel.

Complaint Appeal Process	Time Period
Your written appeal request	Within 5 business days (upon receipt of Your appeal) the HMO will send you a letter confirming receipt of your appeal.
Your written appeal request	Within 30 calendar days the HMO will complete the appeals process.
The HMO will appoint persons to a complaint appeal panel including an equal number of HMO members (not employees) and providers not involved in the disputed decision. Providers must have experience in the care that is in dispute and independent of any provider who made a prior determination. If specialty care is in dispute, a person must be a Specialist in that field.	During the appeals process
The HMO will provide you: • Documentation presented to the complaint appeal panel by the HMO. • The specialization of any providers consulted during the investigation. • The name and affiliation of each HMO. representative on the complaint appeal panel. • The date and location of the hearing.	Within 5 business days before the scheduled meeting of the complaint appeal panel
You are entitled to appear before the complaint appeal panel appear in person, by telephone, or other technological methods, and: • Present written or oral information. • Present alternative expert testimony. • Request the presence of, and question those responsible for, making the prior determination that resulted in the appeal. • Bring any person a you wish, but only you may directly question meeting participants.	During the appeal process
Your written appeal request	Within 30 calendar days upon receipt of your written appeal request, the HMO will provide written notice of the final decision; and will include the reasons (medical, clinical, and contractual) used in making the final decision. The HMO will also include the toll-free telephone number and address of the Texas Department of Insurance (TDI)

You have the right to have an Independent Review Organization (IRO) review the denial if your denied complaint appeal involves services which do not meet the definition of emergency care (Please see COC Emergency Services section). The written final decision will also include the procedures to obtain a review as shown in the COC How to Appeal to an Independent Review Organization (IRO) section.

How to Appeal to the Texas Department of Insurance

For general information about reporting a suspected HMO insurance-related violation, please call the Texas Department of Insurance (TDI) at (800) 599-SHOP, or in Austin (800) 252-3439. You may report a

suspected HMO insurance-related violation to the TDI by mail at Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030, or online at www.tdi.texas.gov.

The Texas Department of Insurance will investigate complaints against the HMO within sixty (60) days after receiving the complaint. The time necessary to complete an investigation may be extended if:

- Additional information is needed.
- An on-site review is necessary.
- Complainant, the HMO, or the physician or provider does not provide all documentation necessary to complete the investigation.
- Other circumstances beyond the control of the Texas Department of Insurance occur.

Appeal of Adverse Determinations

Adverse determination is not part of the Complaint process. It means the HMO, or a utilization review agent determined that the health care services you have received, or may receive are:

- Experimental/ investigational
- Not medically necessary or appropriate.

An adverse determination includes a denial, reduction, or termination of a benefit, an urgent care claim, a benefit resulting from a utilization review, treatment previously approved being reduced or terminated, or not paying (in whole or in part) for a benefit or claim. An adverse determination does not mean a denial of health care services due to the failure to request a potential or concurrent utilization review.

Please Note: An Independent Review Organization (IRO) is an organization independent of the HMO which may perform a final administrative review of an adverse determination made by the HMO. You are entitled to an immediate appeal to an IRO if your request is based on the following:

- Life-threatening, urgent care circumstances.
- If you were receiving prescription drugs or intravenous infusions and coverage was discontinued.
- If you do not receive a timely adverse benefit determination decision.

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

Appeal Process	Time Period
Your written request for the HMO to review an adverse determination.	Within 5 business days (upon receipt of your appeal) the HMO will send a letter with a list of documents you must provide.
Your **oral** request for the HMO to review an adverse determination.	Within 5 business days (upon receipt of your appeal) the HMO will send a letter with a list of documents you must provide, and an appeal form which must be returned to the HMO to proceed.
Appeal is reviewed by a provider (in the same or similar specialty for the condition, procedure, or treatment under review) not involved in the initial adverse determination.	During the review process.

Your written or oral request for the HMO to review an adverse determination.	Within 30 calendar days upon receipt of a written appeal or appeal form, the HMO will provide written notice of the decision; and will include the reasons (medical, clinical, dental, and contractual) for the decision and the specialization of the health care provider consulted. A denial will include your right to have an IRO review and the procedures to obtain a review.

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

Expedited Appeal of Adverse Determination Procedures

An appeal involving ongoing emergencies, denials of continued hospital stay, or the discontinuance of coverage of prescription drugs or intravenous infusions that you are receiving, are referred directly to an expedited appeal process for investigation and resolution. The appeal will be decided depending on the medical or dental urgency of the case within 1 working day from the date all information necessary to complete the appeal is received. An initial notice of the decision may be delivered orally following a written notice within 3 days.

Your appeal will be reviewed by a provider (in the same or similar specialty for the condition, procedure, or treatment under review) not involved in the initial adverse determination. The provider may interview you or your authorized representative.

Appeals Process to Independent Review Organization

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

- Services do not meet the definition of emergency care (Please see COC emergency services section).
- Life-threatening, urgent care circumstances.
- If you were receiving prescription drugs or intravenous infusions and coverage was discontinued.

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

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

You must submit the request for independent review form:

- To the HMO.
- Within four (4) months after receipt of the adverse determination.

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

The HMO will:

- Submit medical records, names of providers, and documentation related to the decision of the IRO.
- Comply with the decision by the IRO.
- Pay for the independent review.

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

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

If the process for appeal and review places your health in serious jeopardy, you are not prohibited from pursuing other appropriate remedies under the law, including, injunctive relief, a declaratory judgment, or other relief.

Network Providers

To find out more about the HMO's contracting providers, please refer to the website at www.bcbstx.com for the Provider Finder®, an Internet-based provider directory. It has important information about the locations and availability of providers, restrictions on accessibility, referrals to specialists, and information about limited provider networks. You may also request a hard copy or electronic copy of the provider directory, which is updated quarterly, by calling customer service. The directories can also be found at www.bcbstx.com. Upon admission to an inpatient facility, (e.g. hospital or skilled nursing facility), a participating physician other than your primary care physician/practitioner may direct and oversee your care.

Your PCP will be the one you call when you need medical advice, when you are sick, and when you need preventive care such as immunizations. Your PCP may also be part of a "network" or association of medical professionals and facilities that work together to provide health care services in a timely, efficient, and cost-effective manner. That means when you choose your PCP, you are also choosing a network, and in most instances, you are not allowed to receive services from any physician or health care professional, including your obstetrician-gynecologist (OB/GYN), that is not also part of your PCP's network. You will not be able to select any physician or health care professional outside of your PCP's network, even though that physician or health care provider is listed with your health plan. If you see any physician or provider outside of that network, even if the name of such physician or provider is listed in the provider directory, the cost of such services will not be covered under your health plan.

Your PCP will play a key role in the delivery of your health care. The network to which your PCP belongs will provide or arrange for all your care, so make sure that your PCP's network includes the specialists and hospitals that you prefer.

If your PCP changes networks, you will be notified and will receive an updated ID card. You and your covered dependents may select the same or a different provider network, and the same or a different PCP within the network.

Direct Access for Obstetrician/Gynecologist (OB/GYN) Care

Your HMO plan provides direct access to participating OB/GYNs for gynecologic and obstetric conditions, including annual well-woman exams and maternity care, without first obtaining a referral from a PCP or calling HMO.

Your PCP, or participating OB/GYN, will establish a referral for you for any required obstetric/gynecologic specialty care.

You must go to an OB/GYN who is within the same provider network as your PCP. It is not required that you select an OB/GYN; you may choose to receive your OB/GYN services from your PCP.

If you need help in locating a participating OB/GYN in your area, please refer to the online provider directory at www.bcbstx.com, or call Customer Service at the toll-free telephone number on the back of your ID card for assistance.

Service Area

For a map of the HMO service area, please refer to the website at www.bcbstx.com for the Provider Finder or request a hard or electronic copy by calling customer service.

General Information

Identification (ID) Card

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

REMEMBER:

- The COC contains specific information about your health care benefits. Please take the time to review them carefully and contact customer service if you have questions about your plan.
- Your provider directory gives you a complete listing of participating providers in your area. Please contact customer service if you need assistance in locating a PCP in your area.
- Take your ID card with you when you seek care. It has important information your provider needs to know.

RECEIVING CARE

Your Primary Care Physician/Practitioner (PCP)

We encourage you to make an appointment with your PCP before you need health care so that you can establish yourself as a patient. One of the advantages of establishing a physician/patient relationship with your PCP is that your PCP becomes familiar with you and your medical history, which helps make sure you receive the care that is right for you.

It is very important to visit or contact your PCP first when seeking medical care. Your PCP will either treat you or refer you for specialty care. Your PCP will also coordinate any required hospital admissions.

REMEMBER:
Always see your PCP first when you need health care. Services received from any provider without a referral from your PCP will not be covered, except in emergency situations or for OB/GYN services provided by a participating OB/GYN in your network, as described below.

Changing PCPs

Changing your PCP is easy. Simply use the online provider directory at www.bcbstx.com, refer to your provider directory, or call customer service for assistance in selecting a new PCP in your area. Sometimes a PCP may not be accepting new patients. When selecting a new PCP, you may call customer service or the PCP's office and ask about availability. If the PCP is unavailable, Provider Finder or customer service can help you find another physician in your area.

Once you've made your decision, either call customer service, or complete a change form and submit it to: Membership Department, P.O. Box 660044, Dallas, Texas 75266-0044. You may also request the transfer of your medical records from your previous PCP to the newly selected physician.

PCP changes become effective the first day of the month following the HMO's receipt and approval of your request. You will receive an updated ID card that shows your new PCP's name and telephone number. If you need health care but have not received your new ID card with your new PCP's name, please call customer service to verify that your request has been processed. You may also go to the website at www.bcbstx.com and print a temporary ID card under the Blue Access for Members section.

Making Appointments

You may make appointments for periodic health assessments at a time convenient for you.

If the nature of an illness warrants an urgent appointment, your PCP can generally fit you into their schedule within a reasonable period of time. If your PCP cannot fit you in, they may direct you to a designated back-up physician. If you need assistance, you may call customer service at the telephone number on the back of your ID card.

If you need to change or cancel an appointment, be sure to call your PCP as soon as you can. When you visit your PCP's office for covered services, you will pay only a copayment and any other applicable coinsurance or deductibles for the office visit. There are no claims to file. If you need the care of a specialist, your PCP will refer you and will handle any prior authorization requirements for you.

REMEMBER:

- Have your health care provided or arranged by your PCP.
- For obstetric or gynecologic conditions, you may directly access a participating OB/GYN (in the same provider network as your PCP).
- Contact customer service for assistance in changing your PCP.
- It is important to schedule an appointment with your PCP as soon as you can. Contact customer service if your PCP cannot fit you in.

Additional Information

Status Changes

Your records are very important to us. Incorrect records can delay membership verification or medical care, create problems in continuing coverage for a dependent, and possibly cost you money. To keep your coverage up to date, see your employer for specific instructions about submitting forms to notify us of any changes. Completed forms must be received by the HMO within 31 days from the date of any change listed below:

- Change of dependency status of a child.
- Court-ordered dependents
- Loss of other health coverage.
- Marriage
- Divorce
- Death
- Change of address.
- Change of telephone number.

Completed forms must be received by the HMO within 60 days from the date of any change listed below:

- Birth of a child.
- Adoption or becoming a party in a suit for adoption, or legal guardianship.

Coverage will be automatic for a subscriber or a subscriber's spouse's newborn child for the first sixty (60) days following the date of birth. Coverage will continue beyond the sixty (60) days only if the child is an eligible dependent and you notify the HMO (verbally or in writing) or submit an enrollment application/change form to the HMO timely and make, or agree to make, any additional premium payments.

Duplication of Coverage and Coordination of Benefits

If you or your dependents are covered by more than one health benefit plan, you may have duplicate coverage. Each covered dependent will then have "primary" and "secondary" coverage. At the time of enrollment, you were asked to provide information about your other health benefit plan. Please notify customer service of any change in your duplicate coverage.

Injuries and sometimes illnesses may be covered by other types of insurance such as auto, homeowners,

or workers' compensation. Please call customer service in cases such as these for information on what steps to take.

It is important that you provide this information to us to allow coordination of payment of your claims to ensure that claims are not paid twice. This helps keep your health care costs down.

Continuation of Benefits

Under the Consolidated Omnibus Budget Reconciliation Act (federal legislation called COBRA), many employers offer a continuation of group coverage if you become ineligible for group membership. Ask your employer if this coverage is available to you. You may also be able to continue your coverage under State Continuation guidelines, as explained in your COC.

REMEMBER:

- Notify us within 31 days of a change to your eligibility.
- Be sure to indicate any other health coverage you have or contact customer service with this information.
- You may be eligible to continue your membership. Please review the guidelines above to see if you are eligible.

New Medical Technology

The HMO keeps abreast of medical breakthroughs, experimental treatments, and newly approved medication. The medical policy department evaluates new technologies, medical procedures, drugs, and devices for potential inclusion in the benefit packages we offer. Clinical literature and accepted medical practice standards are assessed thoroughly with ongoing reviews and determinations made by our Medical Policy Group.

Your Rights and Responsibilities

You have certain rights and responsibilities when receiving health care services and should expect the best possible care available. We have provided the following information, so you can be an informed customer and active participant in your plan.

Your Rights

You have the right to:

- Select or change your PCP and know the qualifications, titles, and responsibilities of the professionals responsible for your health care.
- Receive prompt and appropriate treatment for physical or emotional disorders and participate with your providers in decisions regarding your care.
- Be treated with dignity, compassion, and respect for your privacy.
- Have a candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
- Have all medical and other information held confidential unless disclosure is required by law or authorized in writing by you.

- Be provided with information about:
  - The HMO
  - Health care benefits
  - Copayments, copayment limitations, and/or other charges.
  - Service access
  - Changes and/or termination in benefits and participating providers.
  - Exclusions and limitations
- Express opinions, concerns, and complaints in a constructive manner or appeal regarding any aspect of the HMO.
- Receive timely resolution of complaints or appeals through Customer Service and the complaint procedure.
- Have access to review by an Independent Review Organization (IRO).
- Refuse treatment and be informed of the medical consequences that may be a result of your decision.
- Make recommendations regarding your HMO rights and responsibilities policies.

Your Responsibilities

You have the responsibility to:

- Meet all eligibility requirements.
- Identify yourself by presenting your ID card and pay the copayment and any other applicable amount due at the time of service for network benefits.
- Establish a physician/patient relationship with your PCP and seek your PCP's medical advice/referral for network services prior to receiving medical care, unless it is an emergency situation or services are performed by your HMO participating OB/GYN.
- Understand the medications you are taking and receive proper instructions on how to take them.
- Communicate complete and accurate medical information to providers.
- Call in advance to schedule appointments with network providers and notify them prior to canceling or rescheduling appointments.
- Ask questions, follow instructions, and guidelines given by providers to achieve and maintain good health.
- Discuss disagreements and/or misunderstandings regarding treatment from providers.
- Notify your PCP or the HMO within 48 hours or as soon as reasonably possible after receiving emergency care services.
- Provide, to the extent possible, information that the HMO needs in order to administer your benefit plan, including changes in your family status, address and telephone numbers.
- Read the COC for information about HMO benefits, limitations, and exclusions.
- Understand your health conditions and participate to the degree possible in the development of treatment goals mutually agreed upon between you and your provider.

Confidentiality and Access to Records

We are required by federal and state law to maintain the privacy of your protected health information. "Protected health information" (PHI) is information about you that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services. With limited exceptions, your medical records may not be disclosed to others, including your employer, without your written consent. You, or an individual acting on your behalf, may request medical records for the purpose of providing care or resolving disputes related to coverage, reimbursement, or complaints.

Routine consent signed at the time of enrollment permits us to release information for purposes of quality assessment and measurement, treatment, coordination of care, accreditation, billing, and other uses. Identifiable information is minimized and protected from inappropriate disclosure. Information provided to employer groups is aggregated to protect the identification of any individual.

You have a right to specifically approve the release of information beyond the uses identified in the routine consent that you sign upon enrollment and, at other times, as needed for worker's compensation claims, auto insurance claims, marketing, or data used for research studies.

You may give us written authorization to use your PHI, or to disclose it, to another person only for the purpose you designate. PHI may not be disclosed to your spouse or family without written authorization from you or an authorized representative. Information regarding children under 18 years of age may be released to a parent or legal guardian. If an adult is incapacitated, a legally appointed guardian may act on their behalf. Unless you give us written authorization, we cannot use or disclose your PHI for any reason except those described in the HIPAA Notice.

Participating providers must comply with applicable HIPAA laws, professional standards, and policies regarding the confidential treatment of medical information, including security measures to control access to confidential information maintained in computer systems. Access to electronic files containing information is to be protected and restricted to employees who have a business-related need to know. Oral, written, and electronic personal health information across the organization will be kept confidential in accordance with applicable law.

Blue Cross Blue Shield of Texas understands the importance of confidentiality and respects your right to privacy. A summary of our privacy practices is available on the BCBSTX website at www.bcbstx.com, or you may call customer service at the telephone number on the back of your ID card to obtain a paper copy.

Customer Service

Questions

If you have questions about your benefits, customer service representatives are available to help you at the toll-free telephone number on the back of your ID card. Customer service can also help if you want to change your PCP. They will have an up-to-date list of participating providers in your area.

Customer service can also assist you with special communications needs. If your first language is not English, you can ask to speak to a bilingual staff member (English or Spanish). Some written materials (including this Plan Description and Member Handbook) are available in Spanish. Members may also ask for access to a telephone-based translation service to assist with other languages.

BCBSTX provides TDD/TYY services and language assistance for incoming callers for deaf, hard-of-hearing, and speech-disabled members. Members can utilize their TeleTypewriter (TTY) or Telecommunication Device (TDD) to access a teletype operator.

If you are not satisfied with service you have received, the HMO has a formal complaint process you can follow to advise us of issues related to quality of care or service. We monitor the care you receive and follow through on all complaints and inquiries, because your satisfaction is important to us.

Your rights with a Health Maintenance Organization (HMO) plan

Notice from the Texas Department of Insurance

Your plan

Your HMO plan contracts with doctors, facilities, and other health care providers to treat its members. Providers that contract with your health plan are called “contracted providers” (also known as “in-network providers”). Contracted providers make up a plan’s network. Your plan will only pay for health care you get from doctors and facilities in its network.

However, there are some exceptions, including for emergencies, when you didn’t pick the doctor, and for ambulance services.

Your plan’s network

Your health plan must have enough doctors and facilities within its network to provide every service the plan covers. You shouldn’t have to travel too far or wait too long to get care. This is called “network adequacy.” If you can’t find the care you need, ask your health plan for help. You have the right to receive the care you need under your in-network benefit.

If you don’t think the network is adequate, you can file a complaint with the Texas Department of Insurance at www.tdi.texas.gov or by calling 800-252-3439.

List of doctors

You can get a directory of health care providers that are in your plan’s network.

You can get the directory online at www.bcbstx.com/find-care/find-a-doctor-or-hospital or by calling the toll-free telephone number on the back of your identification card.

If you used your health plan’s directory to pick an in-network health care provider and they turn out to be out-of-network, you might not have to pay the extra cost that out-of-network providers charge.

Bills for health care

If you got health care from a doctor that was out-of-network when you were at an in-network facility, and you didn’t pick the doctor, you won’t have to pay more than your regular copay, coinsurance, and deductible. Protections also apply if you got emergency care at an out-of-network facility or lab work or imaging in connection with in-network care.

If you get a bill for more than you’re expecting, contact your health plan. Learn more about how you’re protected from surprise medical bills at tdi.texas.gov.

NOTICE

OUT-OF-NETWORK PHYSICIANS AND PROVIDERS

A health maintenance organization (HMO) plan does not provide benefits for services you receive from out-of-network physicians or providers, with specific exceptions as described in your Certificate of Coverage and below.

- You have the right to an adequate network of in-network physicians and providers (known as *network physicians and providers*).
- If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance at: www.tdi.texas.gov/consumer/complfrm.html.
- If your HMO approves a referral for out-of-network services because no network physician or provider is available, or if you have received out-of-network emergency care, the HMO must, in most cases, resolve the out-of-network physician's or provider's bill so that you only have to pay any applicable in-network copayment, coinsurance, and deductible amounts.
- You may obtain a current directory of network physicians and providers at the following website: https://www.bcbstx.com/find-a-doctor-or-hospital or by calling 1-877-299-2377 for assistance in finding available network physicians and providers. If you relied upon materially inaccurate directory information, you may be entitled to have a claim by an out-of-network physician or provider paid as if it were from a network physician or provider, if you present a copy of the inaccurate directory information to the HMO, dated not more than 30 days before you received the service.

AMENDMENTS

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

This is an Amendment to your Plan Description and Member Handbook. It is to be attached to, and becomes part of, the Plan Description and Member Handbook. This amendment may be delivered to you electronically, but a paper copy of this Amendment is available upon request.

The **Plan Description and Member Handbook, Network Providers section** is amended to add the following information:

The following demographics describe the network as of July 2025, that your Texas HMO Plan provides access to for the provision of Covered Services.

Network	Enrollees	Specialty	Participating Providers	Access
Blue Essentials Network	58,252	Internal Medicine	4,787	Yes
		Family/Gen. Practice	15,897	Yes
		Pediatrics	23,636	Yes
		Obstetrics and Gynecology	3,812	Yes
		Anesthesiology	11,530	Yes
		Psychiatry	2,061	Yes
		General Surgery	3,341	Yes
		Acute Care Hospitals	547	Yes

For additional information regarding network adequacy, please call the customer service toll-free telephone number shown on the back of your Identification Card or visit the website at https://www.bcbstx.com.

Changes in state or federal law or regulations, or interpretations thereof, may change the terms and conditions of coverage. Except as changed by this Amendment, all terms, conditions, limitations, and

exclusions of the Member Handbook and Plan Description to which this Amendment is attached, will remain in full force and effect.

Blue Cross and Blue Shield of Texas (BCBSTX)

By: James Springfield
President, Blue Cross and Blue Shield of Texas

BlueCross BlueShield of Texas

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