This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbstx.com/member/policy-forms/ or by calling 1-800-521-2227.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For Network and Out-of-Network **$500** Individual/**$1,500** Family. Preventive care, copays, and prescription drugs do not apply to the Network deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. For Network **$2,000** Individual/**$6,000** Family. For Out-of-Network **$4,000** Individual/**$12,000** Family.	The **out-of-pocket** limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, deductible, balance-billed charges, pharmacy/drugs, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. See www.bcbstx.com or call **1-800-810-2583** for a list of Network Providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the health plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- The plan may encourage you to use Network **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit	30% coinsurance	---none---
	Specialist visit	$15 copay/visit	30% coinsurance	
	Other practitioner office visit	$15 copay/visit	30% coinsurance	
	Preventive care/screening/immunization	No Charge	30% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	30% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbstx.com/member/rx_drugs.html	Generic drugs	$15 copay/prescription	20% coinsurance plus copay	Copay amounts are per 30-day supply for retail and mail order.
	Preferred brand drugs	$30 copay/prescription	20% coinsurance plus copay	
	Non-preferred brand drugs	$45 copay/prescription	20% coinsurance plus copay	
	Specialty drugs	$15/$30/$45 copay/prescription	20% coinsurance plus copay	Copay amounts are per 30-day supply for retail only, no mail order.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	---none---
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room services	20% coinsurance after $100 copay/visit	20% coinsurance after $100 copay/visit	Copay amount waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	---none---
	Urgent care	$40 copay/visit	30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required and there is a $250 penalty if Out-of-Network is not preauthorized.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/behavioral health outpatient services	20% coinsurance	40% coinsurance	$15 copay per office visit in lieu of coinsurance for Network, and 30% coinsurance for Out-of-Network office visit. Coverage is limited to 25 visits per calendar year. Certain services must be preauthorized; refer to benefit booklet for details.
	Mental/behavioral health inpatient services	20% coinsurance	40% coinsurance	Preauthorization is required. Coverage is limited to 10 days per calendar year.
	Substance use disorder outpatient services	20% coinsurance	40% coinsurance	$15 copay per office visit in lieu of coinsurance for Network, and 30% coinsurance for Out-of-Network office visit. Certain services must be preauthorized; refer to benefit booklet for details.
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	Preauthorization is required. Three separate series of treatments for each covered individual.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	$15 copay/visit	30% coinsurance	Copay applies to first prenatal visit (per pregnancy).
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	Preauthorization is only required if extension of minimum length of stay is requested.
If you need help recovering or have other special health needs	Home health care	No Charge	30% coinsurance	Preauthorization is required. Limited to 60 visits per calendar year.
	Rehabilitation services	20% coinsurance	40% coinsurance	Limited to combined 35 visits per year, including Chiropractic.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	No Charge	30% coinsurance	Preauthorization is required. Limited to 25 days per calendar year.
	Durable medical equipment	20% coinsurance	40% coinsurance	---none---
	Hospice service	No Charge	30% coinsurance	Preauthorization is required.
If your child needs dental or eye care	Eye exam	$15 copay/visit	30% coinsurance	---none---
	Glasses	Not Covered	Not Covered	
	Dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Long term care
- Private duty nursing
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Hearing aids
- Infertility treatment (Invitro and artificial insemination are not covered unless shown in your plan document)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care (Only covered in connection with diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-800-521-2227. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit www.bcbstx.com, or contact U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-521-2227.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-521-2227.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-521-2227.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-521-2227.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About These Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under the plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,900
- **Patient pays** $1,640

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$40
Coinsurance	$900
Limits or exclusions	$200
Total	**$1,640**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,920
- **Patient pays** $1,480

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$500
Copays	$700
Coinsurance	$200
Limits or exclusions	$80
Total	**$1,480**

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Your Health Care Benefits Program

Group #114897

Managed Health Care
Pharmacy Benefits

BlueCross BlueShield of Texas

CERTIFICATE OF COVERAGE

Blue Cross and Blue Shield of Texas
(herein called "BCBSTX" or "Carrier")

Hereby certifies that it has issued a Group **Managed Health Care and Pharmacy Benefits** Contract (herein called the "Plan") for the Employees of the Employer named on this Benefit Booklet. Subject to the provisions of the Plan, each Employee (Subscriber) to whom a Blue Cross and Blue Shield Identification Card is issued, together with his eligible Dependents for whom application is initially made and accepted, shall have coverage under the Plan, beginning on the Effective Date shown on the Identification Card, if the Employer makes timely payment of total premium due to the Carrier. Issuance of this Benefit Booklet by BCBSTX does not waive the eligibility and Effective Date provisions stated in the Plan.

President of Blue Cross and Blue Shield of Texas

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

The Schedule(s) of Coverage specify benefits for:

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

Pharmacy Benefit coverage

NOTICE OF SEPARATE AVAILABLE COVERAGE

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

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

IMPORTANT NOTICE

To obtain information or make a complaint:

- You may call Blue Cross and Blue Shield of Texas's toll-free telephone number for information or to make a complaint at:

1-800-521-2227

- You may also write to Blue Cross and Blue Shield of Texas at:

P. O. Box 660044
Dallas, Texas 75266-0044

- You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

- You may write the Texas Department of Insurance at:

P. O. Box 149104
Austin, Texas 78714-9104
Fax: (512) 475-1771
Web: http://www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.state.tx.us

- **PREMIUM OR CLAIM DISPUTES:** Should you have a dispute concerning your premium or about a claim, you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

- **ATTACH THIS NOTICE TO YOUR POLICY:** This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

- Usted puede llamar al numero de telefono gratis de Blue Cross and Blue Shield of Texas's para informacion o para someter una queja al:

1-800-521-2227

- Usted tambien puede escribir a Blue Cross and Blue Shield of Texas al:

P. O. Box 660044
Dallas, Texas 75266-0044

- Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

- Puede escribir al Departamento de Seguros de Texas:

P. O. Box 149104
Austin, Texas 78714-9104
Fax: (512) 475-1771
Web: http://www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.state.tx.us

- **DISPUTAS SOBRE PRIMAS O RECLAMOS:** Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el la compania primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

- **UNA ESTE AVISO A SU POLIZA:** Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

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BlueCross BlueShield of Texas

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

Plan RS03 — ***BlueChoice Network***

Overall Payment Provisions	***In-Network Benefits***	***Out-of-Network Benefits***
Deductibles		
• Calendar Year Deductible *Combined In and Out-of-Network* *Applies to all Eligible Expenses*	*$500 Individual / $1,500 Family*	
Coinsurance Stop-Loss Amounts	*$2,000 Individual / $6,000 Family*	*$4,000 Individual / $12,000 Family*
Copayment Amount Required		
Physician office visit/consultation	*$15.00 Copayment Amount*	
Urgent Care center visit	*$40.00 Copayment Amount*	
Outpatient Hospital emergency room/treatment room visit	*$100.00 outpatient Hospital emergency room/treatment room visit Copayment Amount*	*$100.00 outpatient Hospital emergency room/treatment room visit Copayment Amount*
Maximum Lifetime Benefits		
Per Participant	*$5,000,000**	
Inpatient Hospital Expenses		
Inpatient Hospital Expenses		
All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	*80% of Allowable Amount after Calendar Year Deductible*	60% *of Allowable Amount after Calendar Year Deductible*
Penalty for failure to Preauthorize services	*None*	*$250*
Medical/Surgical Expenses		
Physician office visit/consultation, including lab and x-ray	*100% of Allowable Amount after $15.00 Copayment Amount*	*70% of Allowable Amount after Calendar Year Deductible*
Lab & x-ray in other outpatient facilities, excluding Certain Diagnostic Procedures	*100% of Allowable Amount*	*70% of Allowable Amount after Calendar Year Deductible*
Inpatient visits and Certain Diagnostic Procedures	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Home Infusion Therapy	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Physician surgical services performed in any setting	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Extended Care Expenses	***In-Network Benefits***	***Out-of-Network Benefits***
	100% of Allowable Amount	*70% of Allowable Amount*

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

Schedule of Coverage

BlueCross BlueShield of Texas

Skilled Nursing Facility	*$10,000 Calendar Year maximum**	
Home Health Care	*60 visits per Calendar Year**	
Hospice Care	*$20,000 lifetime maximum**	

Special Provisions Expenses

Behavioral Health Services

Treatment of Chemical Dependency

Preauthorization is required

Inpatient treatment must be provided in a Chemical Dependency Treatment Center	*Three separate series of treatments for each covered individual per lifetime**	
All other outpatient treatment	*Covered as any other sickness*	*Covered as any other sickness*
Serious Mental Illness Preauthorization is required	*Benefits determined on the same basis as for Mental Health Care*	*Benefits determined on the same basis as for Mental Health Care*

Mental Health Care *includes treatment for Serious Mental Illness*

Preauthorization is required

Inpatient Services		
Hospital services (facility)	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Behavioral Health Practitioner services	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Outpatient Services		
Behavioral Health Practitioner expenses (office setting)	*100% of Allowable Amount after $15.00 Copayment Amount*	*70% of Allowable Amount after Calendar Year Deductible*
Other outpatient services	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
All Inpatient and Outpatient benefits for Serious Mental Illness and Mental Health Care are limited to:		
Calendar Year Maximum	*$5,000**	
Lifetime maximum	*$10,000**	

Emergency Room/Treatment Room

Accidental Injury & Emergency Care within first 48 hours (including Accidental Injury & Emergency Care for Behavioral Health Services)	
Facility charges	*80% of Allowable Amount after $100.00 outpatient Hospital emergency room/treatment room Copayment Amount (waived if admitted, and Inpatient Hospital Expenses will apply)*
Physician charges	*80% of Allowable Amount after Calendar Year Deductible*
Non-Emergency Care (including Non-Emergency Care for Behavioral Health Services)	

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

Facility charges	*80% of Allowable Amount after $100.00 outpatient Hospital emergency room/treatment room Copayment Amount (waived if admitted, and Inpatient Hospital Expenses will apply)*	*60% of Allowable Amount after $100.00 outpatient Hospital emergency room/treatment room Copayment Amount (waived if admitted, and Inpatient Hospital Expenses will apply) and after Calendar Year Deductible*
Physician charges	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Urgent Care Services		
Urgent Care center visit, including lab & x-ray services (excluding Certain Diagnostic Procedures)	*100% of Allowable Amount after $40.00 Copayment Amount*	*70% of Allowable Amount after Calendar Year Deductible*
Services received during an Urgent Care visit - Certain Diagnostic Procedures	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Ground and Air Ambulance Services	*80% of Allowable Amount after Calendar Year Deductible*	
Preventive Care		
Routine well baby care exams, routine lab and x-ray, annual vision exams, annual hearing exams and immunizations. Note: Deductibles will not be applicable to immunizations of a Dependent child 7 years of age or younger	*100% of Allowable Amount after $15.00 Copayment Amount for Physician office visit*	*70% of Allowable Amount after Calendar Year Deductible*
Routine annual physical exam which includes but is not limited to diagnostic examination for early detection of cervical cancer (Pap smear) for female Participants age 18 and over	*100% of Allowable Amount after $15.00 Copayment Amount*	*70% of Allowable Amount after Calendar Year Deductible*
Annual screening by low-dose mammography for the presence of occult breast cancer for female participants age 35 and older	*100% of Allowable Amount after $15.00 Copayment Amount*	*70% of Allowable Amount after Calendar Year Deductible*
Outpatient facility or imaging centers	*100% of Allowable Amount*	*70% of Allowable Amount after Calendar Year Deductible*
Bone mass measurement for the detection of low bone mass to determine risk of osteoporosis and fractures associated with osteoporosis for Qualified Individuals (refer to your booklet for details)	*100% of Allowable Amount after $15.00 Copayment Amount*	*70% of Allowable Amount after Calendar Year Deductible*
Outpatient facility or imaging centers	*100% of Allowable Amount*	*70% of Allowable Amount after Calendar Year Deductible*
Routine annual physical exam For male Participants who are at least 50 years of age and asymptomatic or at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor:	*100% of Allowable Amount after $15.00 Copayment Amount*	*70% of Allowable Amount after Calendar Year Deductible*
Diagnostic examination for the detection of prostate cancer and	*100% of Allowable Amount after $15.00 Copayment Amount*	*70% of Allowable Amount after Calendar Year Deductible*

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

Prostate-specific antigen test used for the detection of prostate cancer	*100% of Allowable Amount after $15.00 Copayment Amount*	*70% of Allowable Amount after Calendar Year Deductible*
One of the following early detection tests for cardiovascular disease will be covered for a Participant who meets the age requirements and is a diabetic or has been determined to have a risk of developing coronary heart disease:	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
• Computed tomography (CT) scanning measuring artery calcification. • Ultrasonography measuring carotoid intim-media thickness and plaque.	*Maximum benefit of $200 for one test every 5 years**	

Speech and Hearing Services

Services to restore loss of or correct an impaired speech or hearing function with hearing aids	*Covered as any other sickness*	*Covered as any other sickness*
Hearing Aids	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Hearing Aids maximum	*Hearing Aids are subject to a $1,000 maximum amount each 36-Month period**	

Physical Medicine Services

Physical Medicine Services (includes, but is not limited to physical, occupational, and manipulative therapy)	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Calendar Year maximum	*$1,500 maximum benefit each Calendar Year**	

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

Schedule of Coverage

BlueCross BlueShield of Texas

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

Pharmacy Benefits	***Participating Pharmacy***	***Non–Participating Pharmacy (member files claims)***
Retail Pharmacy		
One Copayment Amount per 30–day supply, up to a 90–day supply	*$15.00 Copayment Amount – Generic Drugs* *$30.00 Copayment Amount* – Preferred Brand Name Drug* *$45.00 Copayment Amount* – Non–Preferred Brand Name Drug*	*80% of Allowable Amount minus Copayment Amount**
Mail–Order Program		
One Copayment Amount per 30–day supply, up to a 90–day supply	*$15.00 Copayment Amount – Generic Drugs* *$30.00 Copayment Amount* – Preferred Brand Name Drug* *$45.00 Copayment Amount* – Non–Preferred Brand Name Drug*	*XXXXXXXXXXXXXXXXXXXXX*
Specialty Drugs	***Specialty Pharmacy Provider***	***Other Pharmacy***
Available In–Network through Specialty Pharmacy Program One Copayment Amount per 30–day supply – limited to a 30–day supply	*$15.00 Copayment Amount* – Generic Specialty Drugs* *$30.00 Copayment Amount* – Preferred Brand Name Specialty Drug* *$45.00 Copayment Amount* – Non–Preferred Brand Name Specialty Drug*	*80% of Allowable Amount minus Copayment Amount**
Vaccinations obtained through Pharmacies	***Participating Pharmacy***	***Non–Participating Pharmacy (member files claims)***
	Flu vaccine – $15 Copayment Amount	*80% of Allowable Amount less any applicable Copayment Amount*

Diabetes Supplies are available under the Pharmacy Benefits portion of your Plan. All provisions of this portion of the Plan will apply including any Deductibles, Copayment Amounts, and any pricing differences.

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

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

Preferred Drug List 1 applies.

Pharmacy Network A applies.

INTRODUCTION

This Plan is offered by your Employer as one of the benefits of your employment. The benefits provided are intended to assist you with many of your health care expenses for Medically Necessary services and supplies. There are provisions throughout this Benefit Booklet that affect your health care coverage. It is important that you read the Benefit Booklet carefully so you will be aware of the benefits and requirements of this Plan. In the event of any conflict between any components of this Plan, the *Small Employer Benefit Program Application* prevails.

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

The terms "you" and "your" as used in this Benefit Booklet refer to the Employee. Use of the masculine pronoun "his," "he," or "him" will be considered to include the feminine unless the context clearly indicates otherwise.

Managed Health Care – In–Network Benefits

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

To receive In–Network Benefits for Mental Health Care, Serious Mental Illness, or treatment of Chemical Dependency, all care should be preauthorized by calling the toll–free Mental Health Helpline indicated on your Identification Card and in this Benefit Booklet. Services and supplies for Mental Health Care, Serious Mental Illness, or treatment of Chemical Dependency must be provided by Network Providers that have specifically contracted with BCBSTX to furnish services and supplies for those types of conditions to be considered for In–Network Benefits.

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

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

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

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

Managed Health Care – Out–of–Network Benefits

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

You will be responsible for…

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

Pharmacy Benefits

Benefits are provided for those Covered Drugs as explained in the **PHARMACY BENEFITS** section and shown on your Schedule of Coverage in this Benefit Booklet. The amount of your payment under the Plan depends on whether:

- the Prescription Order is filled at a Participating Pharmacy, or at a non-Participating Pharmacy, or through the Mail-Order Program; or
- the Prescription Order is filled by a provider contracting with BCBSTX;
- a Generic Drug is dispensed; or
- a Preferred or Non-Preferred Brand Name Drug is dispensed.
- a specialty drug is dispensed;

Important Contact Information

Resource	Contact Information	Accessible Hours
Customer Service Helpline	**1-800-521-2227**	**Monday – Friday 8:00 a.m. – 8:00 p.m.**
Website	**www.bcbstx.com**	**24 hours a day 7 days a week**
Medical Preauthorization Helpline	**1-800-441-9188**	**Monday – Friday 7:30 a.m. – 6:00 p.m.**
Mental Health/Chemical Dependency Preauthorization Helpline	**1-800-528-7264**	**24 hours a day 7 days a week**

Customer Service Helpline

Customer Service Representatives can:

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

BCBSTX Website

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

Mental Health/Chemical Dependency Preauthorization Helpline

To satisfy Preauthorization requirements for Participants seeking treatment for Behavioral Health Services, you, your Behavioral Health Practitioner, or a family member may call the Mental Health/Chemical Dependency Preauthorization Helpline at any time, day or night.

Medical Preauthorization Helpline

To satisfy all medical preauthorization requirements for inpatient Hospital Admissions, Extended Care Expenses, or Home Infusion Therapy, call the Medical Preauthorization Helpline.

WHO GETS BENEFITS

Eligibility Requirements for Coverage

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

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

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

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

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

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

Effective Dates of Coverage

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

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

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

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

1. Are eligible on the Contract Date and the application is received by the Carrier prior to or within 31 days following such date, your coverage will become effective on the Contract Date.

2. Enroll for coverage for yourself or for yourself and your Dependents during an Open Enrollment Period, coverage shall become effective on the Contract Anniversary.

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

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

Effective Dates – Late Enrollee
If your application is not received within 31 days from the Eligibility Date, you will be considered a Late Enrollee. You will become eligible to apply for coverage during your Employer's next Open Enrollment Period. Your coverage will become effective on the Contract Anniversary. If you are a Late Enrollee, you may be subject to a 12-month Preexisting Condition limitation beginning on the Contract Anniversary.

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

1. The Employee or Dependent were covered under a Health Benefit Plan, self-funded Health Benefit Plan, or had other health insurance coverage at the time this coverage was previously offered; and

2. Coverage was declined under this Plan in writing, on the basis of coverage under another Health Benefit Plan or self-funded Health Benefit Plan; and

3. There is a loss of coverage under such prior Health Benefit Plan or self-funded Health Benefit Plan as a result of:

    a. Under Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended, or the applicable continuation provision of the *Texas Insurance Code* have been exhausted; or

    b. Cessation of Dependent status (such as divorce or attaining the maximum age to be eligible as a dependent child under the Plan), termination of employment, a reduction in the number of hours of employment, or employer contributions toward such coverage were terminated; or

    c. Termination of the other plan's coverage, a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits, a situation in which the other plan no longer offers any benefits to the class of similarly situated individuals that include you or your Dependent, or, in the case of coverage offered through an HMO, you or your Dependent no longer reside, live, or work in the service area of that HMO and no other benefit option is available; and

4. You request to enroll no later than 31 days after the date coverage ends under the prior Health Benefit Plan or self-funded Health Benefit Plan or, in the event of the attainment of a lifetime limit on all benefits, the request to enroll is made not later than 31 days after a claim is denied due to the attainment of a lifetime limit on all benefits. Coverage will become effective the first day of the calendar month following receipt of the application by the Carrier.

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

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

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

Dependent Enrollment Period

1. ***Special Enrollment Period for Newborn Children***
   Coverage of a newborn child will be automatic for the first 31 days following the birth of your newborn child or your Dependent daughter's newborn child. For coverage to continue beyond this time, you or your Dependent daughter must notify the Carrier within 31 days of birth and pay any required premium within that 31-day period or a period consistent with the next billing cycle. Coverage will become effective on the date of birth. If the Carrier is notified after that 31-day period, the newborn child's coverage will become effective on the Contract Anniversary following the Employer's next Open Enrollment Period.

2. ***Special Enrollment Period for Adopted Children or Children Involved in a Suit for Adoption***
   Coverage of an adopted child or child involved in a suit for adoption will be automatic for the first 31 days following the adoption or date on which a suit for adoption is sought. For coverage to continue beyond this time, the Carrier must receive all necessary forms and the required premium within the 31-day period or a period consistent with the next billing cycle. Coverage will become effective on the date of adoption or date on which a suit for adoption is sought. If you notify the Carrier after that 31-day period, the child's coverage will become effective on the Contract Anniversary following the Employer's next Open Enrollment Period.

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

4. ***Court Ordered Coverage for a Spouse***
   If a court has ordered you, the Employee, to provide coverage for a spouse, enrollment must be received within 31 days after issuance of the court order. Coverage will become effective on the first day of the

month following the date the application for coverage is received and the required premium is paid within the 31-day period. If application is not made within the initial 31 days, your spouse's coverage will become effective on the Contract Anniversary following your Employer's next Open Enrollment Period.

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

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

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

Other Employee Enrollment Period

1. As a special enrollment period event, if you acquire a Dependent through birth, adoption, or through suit for adoption, and you previously declined coverage for reasons other than under ***Loss of Other Health Insurance Coverage***, as described above, you may apply for coverage for yourself, your spouse or Domestic Partner, and a newborn child, adopted child, or child involved in a suit for adoption. If the application is received within 31 days of the birth, adoption, or suit for adoption, coverage for the child, you, or your spouse or Domestic Partner will become effective on the date of the birth, adoption, or date suit for adoption is sought.

   If you marry or enter into a domestic partnership and you previously declined coverage for reasons other than under ***Loss of Other Health Insurance Coverage*** as described above, you may apply for coverage for yourself and your spouse or Domestic Partner. If the application is received within 31 days of the marriage or establishment of a domestic partnership, coverage for you and your spouse or Domestic Partner will become effective on the first day of the month following receipt of the application by the Carrier.

2. If you are required to provide coverage for a child as described in ***Court Ordered Dependent Children*** above, and you previously declined coverage for reasons other than under ***Loss of Other Health Insurance Coverage***, you may apply for coverage for yourself. If the application is received within 31 days of the date your Employer receives notification of the court order, coverage for you will become effective on the date your Employer receives notification of the court order.

Employee Application/Change Form

Use this form to...

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

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

Changes In Your Family

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

- If you are adding a Dependent due to marriage or establishment of a domestic partnership, adoption, or a child being involved in a suit for which an adoption of the child is sought, or your Employer receives a court order to provide health coverage for a Participant's child or your spouse, you must submit an *Employee Application/Change Form* and the coverage of the Dependent will become effective as described in ***Dependent Enrollment Period***.
- When you divorce or terminate a domestic partnership, your child reaches the age indicated in the definition of Dependent, or a Participant in your family dies, coverage under the Plan terminates in accordance with the **Termination of Coverage** provisions selected by your Employer.

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

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

Allowable Amount

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

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

Case Management

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

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

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

Continuity of Care

In the event a Participant is under the care of a Network Provider at the time such Provider stops participating in the Network and at the time of the Network Provider's termination, the Participant has *special circumstances* such as a (1) disability, (2) acute condition, (3) life-threatening illness, or (4) is past the 24th week of pregnancy and is receiving treatment in accordance with the dictates of medical prudence, BCBSTX will continue providing coverage for that Provider's services at the In-Network Benefit level.

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

The continuity of coverage under this subsection will not extend for more than ninety (90) days, or more than nine (9) months if the Participant has been diagnosed with a terminal illness, beyond the date the Provider's termination from the Network takes effect. However, for Participants past the 24th 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.

Freedom of Choice

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

Identification Card

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

- ***Your Subscriber identification number***. This unique identification number is preceded by a three character alpha prefix that identifies Blue Cross and Blue Shield of Texas as your Carrier.
- ***Your group number***. This is the number assigned to identify your Employer's Health Benefit Plan with BCBSTX.
- ***Any Copayment Amounts that may apply to your coverage.***
- ***Important telephone numbers***.

Always remember to carry your Identification Card with you and present it to your Providers or Participating Pharmacies when receiving health care services or supplies.

Please remember that any time a change in your family takes place it may be necessary for a new Identification Card to be issued to you (refer to the **WHO GETS BENEFITS** section for instructions when changes are made). Upon receipt of the change in information, the Carrier will provide a new Identification Card.

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

1. The unauthorized, fraudulent, improper, or abusive use of Identification Cards issued to you and your covered Dependents will include, but not be limited to, the following actions, when intentional:

   a. Use of the Identification Card prior to your Effective Date;
   b. Use of the Identification Card after your date of termination of coverage under the Plan;

c. Obtaining prescription drugs or other benefits for persons not covered under the Plan;
d. Obtaining prescription drugs or other benefits that are not covered under the Plan;
e. Obtaining Covered Drugs for resale or for use by any person other than the person for whom the Prescription Order is written, even though the person is otherwise covered under the Plan;
f. Obtaining Covered Drugs without a Prescription Order or through the use of a forged or altered Prescription Order;
g. Obtaining quantities of prescription drugs in excess of Medically Necessary or prudent standards of use or in circumvention of the quantity limitations of the Plan;
h. Obtaining prescription drugs using Prescription Orders for the same drugs from multiple Providers;
i. Obtaining prescription drugs from multiple Pharmacies through use of the same Prescription Order.

2. The fraudulent or intentionally unauthorized, abusive, or other improper use of Identification Cards by any Participant can result in, but is not limited to, the following sanctions being applied to all Participants covered under your coverage:

a. Denial of benefits;
b. Cancellation of coverage under the Plan for **all** Participants under your coverage;
c. Limitation on the use of the Identification Card to one designated Physician, Other Provider, or Participating Pharmacy of your choice;
d. Recoupment from you or any of your covered Dependents of any benefit payments made;
e. Pre-approval of drug purchases and medical services for all Participants receiving benefits under your coverage;
f. Notice to proper authorities of potential violations of law or professional ethics.

Medical Necessity

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

ParPlan

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

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

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

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

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

Preexisting Conditions Provision

Benefits for Eligible Expenses incurred for treatment of a Preexisting Condition will not be available during the twelve-month period following the Participant's initial Effective Date, or if a Waiting Period applies, the first day of the Waiting Period (typically the date you are hired).

The Preexisting Condition exclusion **will not apply** to:

1. A newborn child who is added as described in ***Dependent Enrollment Period*** within the first 31 days after the date of birth; or

2. A child who is adopted or involved in a suit for adoption before attaining the limiting age shown in the definition of Dependent and who applies, as described in ***Dependent Enrollment Period***, for coverage under this Contract; or

3. A court ordered Dependent of a covered Employee who applies for coverage as described in ***Dependent Enrollment Period***; or

4. An individual who was continuously covered for an aggregate period of twelve months under Creditable Coverage that was in effect up to a date not more than 63 days before the Effective Date of coverage under the Health Benefit Plan, excluding any Waiting Periods.

The Carrier will credit the time you were covered under Creditable Coverage if the previous coverage was in effect under a Health Benefit Plan or self-funded Health Benefit Plan at any time during the twelve months prior to the Effective Date of coverage under this Plan. If the previous coverage was issued under a Health Benefit Plan, any waiting period that applied before that coverage became effective also will be credited against the Preexisting Condition exclusion.

Pregnancy, conditions resulting from domestic violence, and genetic information without a diagnosis of a specific condition shall not be considered a Preexisting Condition. All other terms, provisions, limitations, and exclusions will apply to all Participants even if any Preexisting Condition exclusion is not applicable for the reasons set out above.

Specialty Care Providers

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

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

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

Use of Non-Contracting Providers

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

charges for services, supplies and procedures limited or not covered under the Plan and any applicable Deductibles, Coinsurance Amounts, and Copayment Amounts.

PREAUTHORIZATION REQUIREMENTS

Preauthorization Requirements

Preauthorization establishes in advance the Medical Necessity or Experimental/Investigational nature of certain care and services covered under this Plan. It ensures that the Preauthorized care and services described below will not be denied on the basis of Medical Necessity or Experimental/Investigational. However, Preauthorization does not guarantee payment of benefits. Actual availability of benefits is always subject to other requirements of the Plan, such as Preexisting Conditions, limitations and exclusions, payment of premium, and eligibility at the time care and services are provided.

The following types of services require Preauthorization:

- All inpatient Hospital Admissions,
- Extended Care Expense,
- Home Infusion Therapy,
- All inpatient treatment of Chemical Dependency, Serious Mental Illness, and Mental Health Care,
- If you transfer to another facility or to or from a specialty unit within the facility.
- The following outpatient treatment of Chemical Dependency, Serious Mental Illness, and Mental Health Care:
  - Psychological testing;
  - Neuropsychological testing;
  - Electroconvulsive therapy;
  - Intensive Outpatient Program.

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

You are responsible for satisfying Preauthorization requirements. This means that you must ensure that you, your family member, your Physician, Behavioral Health Practitioner or Provider of services must comply with the guidelines below. Failure to Preauthorize services will require additional steps and/or benefit reductions as described in the paragraph entitled *Failure to Preauthorize*.

Preauthorization for Inpatient Hospital Admissions
In the case of an elective inpatient Hospital Admission, the call for Preauthorization should be made at least two working days before you are admitted unless it would delay Emergency Care. In an emergency, Preauthorization should take place within two working days after admission, or as soon thereafter as reasonably possible.

To satisfy Preauthorization requirements, on business days between 7:30 a.m. and 6:00 p.m. Central Time, you, your Physician, Provider of services, or a family member should call one of the Customer Service toll-free numbers listed on the back of your Identification Card. After working hours or on weekends, please call the **Medical Preauthorization Helpline** toll-free number listed on the back of your Identification Card. Your call will be recorded and returned the next working day. A benefits management nurse will follow up with your Provider's office. All timelines for Preauthorization requirements are provided in keeping with applicable state and federal regulations.

In-Network Benefits will be available if you use a Network Provider or Network Specialty Care Provider. If you elect to use Out-of-Network Providers for services and supplies available In-Network, Out-of-Network Benefits will be paid. In-Network and Out-of-Network Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied.

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

When an inpatient Hospital Admission is Preauthorized, a length-of-stay is assigned. If you require a longer stay than was first Preauthorized, your Provider may seek an extension for the additional days. Benefits will not be available for room and board charges for medically unnecessary days.

Preauthorization not Required for Maternity Care and Treatment of Breast Cancer Unless Extension of Minimum Length of Stay Requested
Your Plan is required to provide a minimum length of stay in a Hospital facility for the following:

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

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

Preauthorization for Extended Care Expense and Home Infusion Therapy
Preauthorization for Extended Care Expense and Home Infusion Therapy may be obtained by having the agency or facility providing the services contact BCBSTX to request Preauthorization. The request should be made:

- Prior to initiating Extended Care Expense or Home Infusion Therapy;
- When an extension of the initially Preauthorized service is required; and
- When the treatment plan is altered.

BCBSTX will review the information submitted prior to the start of Extended Care Expense or Home Infusion Therapy and will send a letter to you and the agency or facility confirming Preauthorization or denying benefits. If Extended Care Expense or Home Infusion Therapy is to take place in less than one week, the agency or facility should call the BCBSTX **Medical Preauthorization Helpline** telephone number indicated in this Benefit Booklet or shown on your Identification Card.

If BCBSTX has given notification that benefits for the treatment plan requested will be denied based on information submitted, claims will be denied.

Preauthorization for Chemical Dependency, Serious Mental Illness, and Mental Health Care
In order to receive maximum benefits, all inpatient treatment for Chemical Dependency, Serious Mental Illness, and Mental Health Care must be Preauthorized by the Plan. Preauthorization is also required for

certain outpatient services. Outpatient services requiring Preauthorization include psychological testing, neuropsychological testing, Intensive Outpatient Programs and electroconvulsive therapy. Preauthorization is not required for therapy visits to a Physician, Behavioral Health Practitioner and/or Professional Other Provider.

To satisfy Preauthorization requirements, you, a family member, or your Behavioral Health Practitioner must call the **Mental Health/Chemical Dependency Preauthorization Helpline** toll-free number indicated in this Benefit Booklet or shown on your Identification Card. The **Mental Health/Chemical Dependency Preauthorization Helpline** is available 24 hours a day, 7 days a week. All timelines for Preauthorization requirements are provided in keeping with applicable state and federal regulations**.**

In-Network Benefits will be available if you use a Network Provider or Network Specialty Care Provider. If you elect to use Out-of-Network Providers for services and supplies available In-Network, Out-of-Network Benefits will be paid. In-Network and Out-of-Network Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied.

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

When treatment or service is Preauthorized, a length-of-stay or length of service is assigned. If you require a longer stay or length of service than was first Preauthorized, your Behavioral Health Practitioner may seek an extension for the additional days or visits. Benefits will not be available for medically unnecessary treatment or services.

Failure to Preauthorize

If Preauthorization for inpatient Hospital Admissions, Extended Care Expense, Home Infusion Therapy, all inpatient and the above specified outpatient treatment of Chemical Dependency, Serious Mental Illness and Mental Health Care is not obtained:

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

  The penalty charge will be deducted from any benefit payment which may be due for the Covered Services.

If an inpatient Hospital Admission, Extended Care Expense, Home Infusion Therapy, any treatment of Chemical Dependency, Serious Mental Illness, and Mental Health Care or extension for any treatment or service described above is not Preauthorized and it is determined that the treatment, service, or extension was not Medically Necessary or Experimental/Investigational, benefits will be reduced or denied.

CLAIM FILING AND APPEALS PROCEDURES

CLAIM FILING PROCEDURES

Filing of Claims Required

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

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

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

Who Files Claims

Providers that contract with BCBSTX and some other health care Providers (such as *ParPlan* Providers) will submit your claims directly to BCBSTX for services provided to you or any of your covered Dependents. At the time services are provided, inquire if they will file claim forms for you. To assist Providers in filing your claims, you should carry your Identification Card with you.

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

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

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

Participant-filed claims

- Medical Claims

  If your Provider does not submit your claims, you will need to submit them to BCBSTX using a Subscriber-filed claim form provided by BCBSTX. Your Employer should have a supply of claim forms or you can obtain copies from the BCBSTX website. Follow the instructions on the reverse side of the form to complete the claim. Remember to file each Participant's expenses separately because any Deductibles, maximum benefits, and other provisions are applied to each Participant separately. Include itemized bills from the health care Providers, labs, etc., printed on their letterhead and showing the services performed, dates of service, charges, and name of the Participant involved.

- Prescription Drug Claims

  When you receive Covered Drugs dispensed from a Non-Participating Pharmacy, a *Prescription Reimbursement Claim Form* must be submitted. This form can be obtained from the Carrier or your Employer. This claim form, accompanied by an itemized bill obtained from the Pharmacy showing the prescription services you received, should be mailed to the address shown below or on the claim form.

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

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

VISIT THE BCBSTX WEBSITE FOR SUBSCRIBER CLAIM FORMS AND OTHER USEFUL INFORMATION
www.bcbstx.com

Where to Mail Completed Claim Forms

Medical Claims

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

Prescription Drug Claims

Blue Cross and Blue Shield of Texas
c/o Prime Therapeutics LLC
P. O. Box 14624
Lexington, KY 40512-4624

Mail Order Program

Blue Cross and Blue Shield of Texas
c/o PrimeMail Pharmacy
P. O. Box 650041
Dallas, Texas 75265-0041

Who Receives Payment

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

Except as provided in the section **Assignment and Payment of Benefits,** rights and benefits under the Plan are not assignable, either before or after services and supplies are provided.

Benefit Payments to a Managing Conservator
Benefits for services provided to your minor Dependent child may be paid to a third party if:

- the third party is named in a court order as managing or possessory conservator of the child; and
- BCBSTX has not already paid any portion of the claim.

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

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

An *Explanation of Benefits* summary is sent to you so you will know what has been paid.

When to Submit Claims

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

Receipt of Claims by BCBSTX

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

REVIEW OF CLAIM DETERMINATIONS

Claim Determinations

When BCBSTX receives a properly submitted claim, it has authority and discretion under the Plan to interpret and determine benefits in accordance with the Plan provisions. BCBSTX will render an initial decision to pay or deny a claim within 30 days of receipt of the claim. If BCBSTX requires further information in order to process the claim, we will request it within that 30-day period.

You have the right to seek and obtain a full and fair review by BCBSTX of any determination of a claim, any determination of a request for preauthorization, or any other determination made by BCBSTX of your benefits under the Plan.

If a Claim Is Denied or Not Paid in Full
On occasion, BCBSTX may deny all or part of your claim. There are a number of reasons why this may happen. We suggest that you first read the *Explanation of Benefits* summary prepared by BCBSTX; then review this Benefit Booklet to see whether you understand the reason for the determination. If you have additional information that you believe could change the decision, send it to BCBSTX and request a review of the decision. Include your full name, group and subscriber numbers with the request.

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

- The reasons for denial;
- A reference to the health care plan provisions on which the denial is based;
- A description of additional information which may be necessary to complete the claim and an explanation of why such information is necessary; and
- An explanation of how you may have the claim reviewed by BCBSTX if you do not agree with the denial.

Right to Review Claim Determinations
If you believe BCBSTX incorrectly denied all or part of your benefits, you may have your claim reviewed. BCBSTX will review its decision in accordance with the following procedure:

- Within 180 days after you receive notice of a denial or partial denial, write to BCBSTX's Administrative Office. BCBSTX will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

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

- You may also designate a representative to act for you in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative.
- BCBSTX will honor telephone requests for information, however, such inquiries will not constitute a request for review.
- You and your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of a denial or partial denial. BCBSTX will give you a written decision within 60 days after it receives your request for review.
- If you have any questions about the claims procedures or the review procedure, write to BCBSTX's Administrative Office or call the toll-free Customer Service Helpline number shown in this Benefit Booklet or on your Identification Card.
- If you have a claim for benefits which is denied or ignored, in whole or in part, and your Plan is governed by the Employee Retirement Income Security Act (ERISA), you may file suit under 502 (a) of ERISA.

Preauthorization Appeal Procedures

If you or your Physician disagree with the determination of the preauthorization prior to or while receiving services, you may appeal that decision by contacting BCBSTX's Administrative Office.

In some instances, the resolution of the appeal process will not be completed until your inpatient admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after claim processing has taken place or upon receipt of the notification letter from BCBSTX, you may appeal that decision by having your Physician call the contact person indicated in the notification letter or by submitting a written request to:

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

Once you have requested this review, you may submit additional information and comments on your claim to BCBSTX as long as you do so within 30 days of the date you ask for a review. Also, during this 30-day period, you may review any documents relevant to your claim held by BCBSTX, if you request an appointment in writing.

Within 30 days of receiving your request to review, BCBSTX will send you its decision on the claim. In unusual situations, an additional 15 days may be needed for the review and you will be notified of this during the first 30–day period.

Interpretation of Employer's Plan Provisions

The operation and administration of the Plan require uniformity regarding the intent of the Plan and the interpretation of the Plan provisions. Your Employer has given BCBSTX full and complete authority and discretion to make decisions regarding the Plan provisions and determining questions of eligibility and benefits. Any decision by BCBSTX which is not arbitrary or capricious shall be final and conclusive, subject to any applicable Texas and federal law.

Actions Against BCBSTX

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

ELIGIBLE EXPENSES, PAYMENT OBLIGATIONS, AND BENEFITS

Eligible Expenses

The Plan provides coverage for four categories of Eligible Expenses:

- Inpatient Hospital Expenses,
- Medical-Surgical Expenses,
- Extended Care Expenses, and
- Special Provisions Expenses

Wherever Schedule of Coverage is mentioned, please refer to the Schedule(s) in this Benefit Booklet. Your benefits are calculated on a Calendar Year benefit period basis unless otherwise stated. At the end of a Calendar Year, a new benefit period starts for each Participant.

Copayment Amounts

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

A Copayment Amount will be required for most Physician office visits, including lab and x-ray. If the services provided by your Physician require a return office visit (lab services for instance) on a different day, a new Copayment Amount will be required. A Copayment Amount will be required for the initial office visit for Maternity Care, but will not be required for subsequent visits.

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

- surgery performed in the Physician's office;
- physical therapy billed separately from an office visit;
- occupational modalities in conjunction with physical therapy;
- allergy injections billed separately from an office visit;
- any services requiring Preauthorization;
- Certain Diagnostic Procedures;
- outpatient treatment therapies or services such as radiation therapy, chemotherapy, and renal dialysis.

A Copayment Amount will be required for each visit to an Urgent Care center, including lab and x-ray. If the services provided require a return visit (lab services for instance) on a different day, a new Copayment Amount will be required. The following services are not payable under this Copayment Amount provision but instead are considered Medical-Surgical Expense shown on your Schedule of Coverage:

- surgery performed in the Urgent Care center;
- physical therapy billed separately from an Urgent Care visit;
- occupational modalities in conjunction with physical therapy;
- allergy injections billed separately from an Urgent Care visit;
- any services requiring Preauthorization;
- Certain Diagnostic Procedures;
- outpatient treatment therapies or services such as radiation therapy, chemotherapy, and renal dialysis.

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

Deductibles

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

Upfront Deductible: If an "Upfront Deductible" is shown under "Deductibles" on your Schedule of Coverage, the Upfront Deductible is a combined In and Out-of-Network annual Deductible that must be satisfied by each individual before any benefits under the plan are available. This Deductible will be applied to all categories of Eligible Expenses before certain benefits are available under the Plan.

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

The following are exceptions to the Deductibles described above:

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

Coinsurance Stop-Loss Amount

Most of your Eligible Expense payment obligations, including Copayment Amounts, are considered Coinsurance Amounts and are applied to the Coinsurance Stop-Loss Amount maximum.

Your Coinsurance Stop-Loss Amount will **not** include:

- Services, supplies, or charges limited or excluded by the Plan;
- Expenses not covered because a benefit maximum has been reached;
- Any Eligible Expenses paid by the Primary Plan when BCBSTX is the Secondary Plan for purposes of coordination of benefits;
- Any Deductibles;
- Penalties applied for failure to obtain Preauthorization;
- Any Copayment Amounts paid under the Pharmacy Benefits;
- Any remaining unpaid Medical-Surgical Expense in excess of the benefits provided for Covered Drugs if "Pharmacy Benefits" is shown on your Schedule of Coverage.

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

Family Coinsurance Stop-Loss Amount
When the Coinsurance Amount for the In-Network or Out-of-Network Benefits level for all Participants under your coverage in a Calendar Year equals the "family" "Coinsurance Stop-Loss Amount" shown on your Schedule of Coverage for that level, the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by all family Participants for the remainder of that Calendar Year for that level. No Participant will be required to contribute more than the individual Coinsurance Amount to the family Coinsurance Stop-Loss Amount.

The following are exceptions to the Coinsurance Stop-Loss Amounts described above:

There are separate Coinsurance Stop-Loss Amounts for In-Network Benefits and Out-of-Network Benefits.

Eligible Expenses applied toward satisfying the "individual" and "family" Out-of-Network Coinsurance Stop-Loss Amount maximum will apply toward both the In-Network and Out-of-Network Coinsurance Stop-Loss Amount. *However*, Eligible Expenses applied toward satisfying the "individual" and "family" In-Network Coinsurance Stop-Loss Amount maximum **will not** apply toward satisfying the Out-of-Network Coinsurance Stop-Loss Maximum amount.

Copayment Amounts for In-Network Benefits and Out-of-Network Benefits will continue to be required after the benefit percentages become 100%.

Copayment Amounts for Urgent Care visits for In-Network Benefits will continue to be required after the benefit percentages become 100%.

Annual Maximum Benefits (if shown on your Schedule of Coverage)

The total amount of benefits available to any one Participant for all combined categories of Eligible Expenses for a Calendar Year shall not exceed the "Annual Maximum Benefits" amount, if any, shown on your Schedule of Coverage. This Annual Maximum Benefit amount includes all payments made by BCBSTX under any benefit provision of the Plan.

At the end of a Calendar Year, a new benefit period starts for each Participant. Any unused amounts from the previous year do not accumulate. All totals from previous years do accumulate toward the Maximum Lifetime Benefits amount.

Maximum Lifetime Benefits

The total amount of benefits available to any one Participant under the Plan shall not exceed the "Maximum Lifetime Benefits" amount shown on your Schedule of Coverage.

This Maximum Lifetime Benefits amount includes all payments made by BCBSTX under any medical benefit provisions of the Plan including payments toward any other benefit maximums under the Plan.

Changes In Benefits

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

Inpatient Hospital Expenses

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

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

Services and supplies provided by an Out-of-Network Provider will receive In-Network Benefits when those services and supplies are not available from a Network Provider provided BCBSTX acknowledges your visit to an Out-of-Network Provider **prior** to the visit. Otherwise, Out-of-Network Benefits will be paid and the claim will have to be resubmitted for review and adjustment, if appropriate.

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

Medical–Surgical Expenses

The Plan provides coverage for Medical–Surgical Expense for you and your covered Dependents. Some services require preauthorization. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for more information.

Copayment Amounts must be paid to your Network Physician or other Network Provider at the time you receive services.

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

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

Medical–Surgical Expense shall include:

1. Services of Physicians and Professional Other Providers.

2. Consultation services of a Physician and Professional Other Provider.

3. Services of a certified registered nurse–anesthetist (CRNA).

4. Diagnostic x–ray and laboratory procedures.

5. Radiation therapy.

6. Dietary formulas necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.

7. Amino–acid based elemental formulas, regardless of the formula delivery method, used for the diagnosis and treatment of:

   a. Immunoglobulin E and non–immunoglobulin E mediated allergies to multiple food proteins;
   b. Severe food protein–induced enterocolitis syndromes;
   c. Eosinophilic disorders, as evidenced by the results of biopsy; and
   d. Disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

   A Prescription Order from your Health Care Practitioner is required.

8. Rental of durable medical equipment required for therapeutic use unless purchase of such equipment is required by BCBSTX. The term "durable medical equipment (DME)" shall not include:

   a. Equipment primarily designed for alleviation of pain or provision of patient comfort; or
   b. Home air fluidized bed therapy.

   Examples of non–covered equipment include, but are not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment, and whirlpool bath equipment.

9. Professional local ground ambulance service or air ambulance service to the nearest Hospital appropriately equipped and staffed for treatment of the Participant's condition.

10. Anesthetics and its administration, when performed by someone other than the operating Physician or Professional Other Provider.

11. Oxygen and its administration provided the oxygen is actually used.

12. Blood, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for the Participant.

13. Prosthetic Appliances, including replacements necessitated by growth to maturity of the Participant.

14. Orthopedic braces (i.e., an orthopedic appliance used to support, align, or hold bodily parts in a correct position) and crutches, including rigid back, leg or neck braces, casts for treatment of any part of the legs, arms, shoulders, hips or back; special surgical and back corsets, Physician-prescribed, directed, or applied dressings, bandages, trusses, and splints which are custom designed for the purpose of assisting the function of a joint.

15. Home Infusion Therapy.

16. Services or supplies used by the Participant during an outpatient visit to a Hospital, a Therapeutic Center, or a Chemical Dependency Treatment Center, or scheduled services in the outpatient treatment room of a Hospital.

17. Certain Diagnostic Procedures.

18. Outpatient Contraceptive Services, prescription contraceptive devices, and prescription contraceptive medications. NOTE: Prescription contraceptive medications are covered under the **PHARMACY BENEFITS** portion of your Plan.

19. Foot care in connection with diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency.

20. Drugs that have not been approved by the FDA for self-administration when injected, ingested or applied in a Physician's or Professional Other Provider's office.

Extended Care Expenses

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

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

1. At the benefit percentage under "Extended Care Expenses," and

2. Up to the amount of the combined benefit maximums shown for each category of Extended Care Expense on your Schedule of Coverage.

All payments made by BCBSTX, whether under the In-Network or Out-of-Network Benefit level, will apply toward the benefit maximums under both levels of benefits.

If shown on your Schedule of Coverage, the Calendar Year Deductible will apply. Any unpaid Extended Care Expense in excess of the benefit maximums shown on your Schedule of Coverage will not be applied to any Coinsurance Stop-Loss Amount.

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

Services and supplies for Extended Care Expense:

1. For Skilled Nursing Facility:

    a. All usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
    b. Room and board and all routine services, supplies, and equipment provided by the Skilled Nursing Facility;
    c. Physical, occupational, speech, and respiratory therapy services by licensed therapists.

2. For Home Health Care:

    a. Part-time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
    b. Part-time or intermittent home health aide services which consist primarily of caring for the patient;
    c. Physical, occupational, speech, and respiratory therapy services by licensed therapists;
    d. Supplies and equipment routinely provided by the Home Health Agency.

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

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

3. For Hospice Care:

   For Home Hospice Care:

   a. Part-time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
   b. Part-time or intermittent home health aide services which consist primarily of caring for the patient;
   c. Physical, speech, and respiratory therapy services by licensed therapists;
   d. Homemaker and counseling services routinely provided by the Hospice agency, including bereavement counseling.

   For Facility Hospice Care:

   a. All usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
   b. Room and board and all routine services, supplies, and equipment provided by the Hospice facility;
   c. Physical, speech, and respiratory therapy services by licensed therapists.

Special Provisions Expenses

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

Benefits for Treatment of Complications of Pregnancy

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

Benefits for Maternity Care

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

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

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

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

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

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

- parent education,
- assistance and training in breast-feeding and bottle feeding, and
- the performance of any necessary and appropriate clinical tests.

Charges for well-baby nursery care, including the initial examination, of a newborn child during the mother's Hospital Admission for the delivery will be considered Inpatient Hospital Expense of the child and will be subject to the benefit provisions and benefit maximums as described under **Inpatient Hospital Expenses**. Benefits will also be subject to any Deductible amounts shown on your Schedule of Coverage.

Behavioral Health Services

Benefits for Treatment of Chemical Dependency

Benefits for Eligible Expenses incurred for the treatment of Chemical Dependency will be the same as for treatment of any other sickness. Your specific benefits are shown on your Schedule of Coverage. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection to determine what services require Preauthorization.

Coverage for treatment of Chemical Dependency will be limited to a maximum of three separate series of treatments for each covered individual. The Plan may use state guidelines to administer benefits for treatment of Chemical Dependency. Inpatient treatment of Chemical Dependency must be provided in a Chemical Dependency Treatment Center. Benefits for the medical management of acute life-threatening intoxication (toxicity) in a Hospital will be available on the same basis as for sickness generally as described under **Benefits for Inpatient Hospital Expenses**.

All payments made by the Plan, whether under the In-Network or Out-of-Network Benefit level, will apply towards the "Maximum Lifetime Benefits" amount indicated on your Schedule of Coverage.

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

Benefits for Mental Health Care

Benefits for Eligible Expenses incurred for the treatment of Mental Health Care are shown on your Schedule of Coverage. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection to determine what services require Preauthorization.

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

Benefits for Eligible Expenses incurred for Mental Health Care will not exceed the Calendar Year and lifetime benefit maximum amounts shown in the Schedule of Coverage for Mental Health Care. All payments made by the Plan, whether under the In-Network or Out-of-Network Benefit level, will apply towards the Calendar Year and maximum lifetime benefit amount indicated on your Schedule of Coverage for Mental Health Care.

The benefits provided for Mental Health Care will not exceed the "Maximum Lifetime Benefits" amount shown on your Schedule of Coverage.

Benefits for Emergency Care and Treatment of Accidental Injury

The Plan provides coverage for medical emergencies wherever they occur. Examples of medical emergencies are unusual or excessive bleeding, broken bones, acute abdominal or chest pain, unconsciousness, convulsions, difficult breathing, suspected heart attack, sudden persistent pain, severe or multiple injuries or burns, and poisonings.

If reasonably possible, contact your Network Physician or Behavioral Health Practitioner before going to the Hospital emergency room/treatment room. He can help you determine if you need Emergency Care or treatment of an Accidental Injury and recommend that care. If not reasonably possible, go to the nearest emergency facility, whether or not the facility is in the Network.

Whether you require hospitalization or not, you should notify your Network Physician or Behavioral Health Practitioner within 48 hours, or as soon as reasonably possible, of any emergency medical treatment so he can recommend the continuation of any necessary medical services.

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

All treatment received during the first 48 hours following the onset of a medical emergency will be eligible for In-Network Benefits. After 48 hours, In-Network Benefits will be available only if you use Network Providers. If after the first 48 hours of treatment following the onset of a medical emergency, and if you can safely be transferred to the care of a Network Provider but are treated by an Out-of-Network Provider, only Out-of-Network Benefits will be available.

Benefits for Urgent Care

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

Preventive Care Services

Benefits for Routine Exams and Immunizations

Benefits for routine exams are available for the following Preventive Care Services as indicated on your Schedule of Coverage:

- well-baby care (after newborn's initial examination and discharge from the Hospital);
- routine annual physical examination;
- annual vision examination;
- annual hearing examinations, except for benefits as provided under ***Required Benefits for Screening Tests for Hearing Impairment***;
- immunizations. (Deductibles will not be applicable to immunizations of a Dependent child age seven years of age or younger.)

Benefits are not available for Inpatient Hospital Expense or Medical-Surgical Expense for routine physical examinations performed on an inpatient basis, except for the initial examination of a newborn child.

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

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

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

Benefits for Mammography Screening

Benefits are available for a screening by low-dose mammography for the presence of occult breast cancer for a Participant 35 years of age and older, as shown on your Schedule of Coverage, except that benefits will not be available for more than one routine mammography screening each Calendar Year.

Benefits for Detection and Prevention of Osteoporosis

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

Qualified Individual means:

a. A postmenopausal woman not receiving estrogen replacement therapy;

b. An individual with:

- vertebral abnormalities,
- primary hyperparathyroidism, or
- a history of bone fractures; or

c. An individual who is:

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

Benefits for Certain Tests for Detection of Prostate Cancer

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

1. 50 years of age and asymptomatic; or

2. 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

Benefits for Early Detection Tests for Cardiovascular Disease

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

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

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

Benefits are limited as indicated on your Schedule of Coverage.

Benefits for Screening Tests for Hearing Impairment

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

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

Deductibles indicated on your Schedule of Coverage will not apply to this provision.

Benefits for Cosmetic, Reconstructive, or Plastic Surgery

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

- Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Participant; or
- Treatment provided for reconstructive surgery following cancer surgery; or
- Surgery performed on a newborn child for the treatment or correction of a congenital defect; or
- Surgery performed on a covered Dependent child (other than a newborn child) under the age of 19 for the treatment or correction of a congenital defect other than conditions of the breast; or
- Reconstruction of the breast on which mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy.

Benefits for Dental Services

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

- Covered Oral Surgery;
- Services provided to a newborn child which are necessary for treatment or correction of a congenital defect; or
- The correction of damage caused solely by external, violent Accidental Injury to healthy, un-restored natural teeth and supporting tissues and limited to treatment provided within 24 months of the initial treatment. An injury sustained as a result of biting or chewing shall not be considered an Accidental Injury.

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

Benefits for Organ and Tissue Transplants

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

(1) The transplant procedure is not Experimental/Investigational in nature; and
(2) Donated human organs or tissue or an FDA-approved artificial device are used; and
(3) The recipient is a Participant under the Plan; and
(4) The transplant procedure is preauthorized as required under the Plan; and
(5) The Participant meets all of the criteria established by BCBSTX in pertinent written medical policies; and
(6) The Participant meets all of the protocols established by the Hospital in which the transplant is performed.

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

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

Benefits will be available for:

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

Benefits for the recipient and the donor will be provided up to the recipient's "Maximum Lifetime Benefits" amount shown on the Schedule of Coverage. Once the lifetime maximum amount has been exhausted, no further benefits will be available under the Plan.

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

(1) Donor search and acceptability testing of potential live donors up to a maximum benefit amount of $15,000 per Calendar Year; and
(2) Evaluation of organs or tissues including, but not limited to, the determination of tissue matches; and
(3) Removal of organs or tissues from living or deceased donors; and
(4) Transportation and short-term storage of donated organs or tissues.

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

(1) Living and/or travel expenses of the recipient or a live donor;
(2) Expenses related to maintenance of life of a donor for purposes of organ or tissue donation;
(3) Purchase of the organ or tissue; or
(4) Organs or tissue (xenograft) obtained from another species.

e. Preauthorization is required for any organ or tissue transplant. Review the **PREAUTHORIZATION REQUIREMENTS** section in this Benefit Booklet for more specific information about preauthorization.

(1) Such specific preauthorization is required even if the patient is already a patient in a Hospital under another preauthorization authorization.

(2) At the time of preauthorization, BCBSTX will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if BCBSTX determines that an extension is Medically Necessary.

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

Benefits for Treatment of Acquired Brain Injury

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

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

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

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

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

1. has incurred an Acquired Brain Injury;
2. has been unresponsive to treatment; and
3. becomes responsive to treatment at a later date.

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

Benefits for Treatment of Autism Spectrum Disorder

Generally recognized services prescribed in relation to Autism Spectrum Disorder by the Participant's Physician or Behavioral Health Practitioner in a treatment plan recommended by that Physician or Behavioral Health Practitioner are available for a covered Dependent child from birth but who has not yet reached the age of ten.

Individuals providing treatment prescribed under that plan must be a health care practitioner:

- who is licensed, certified, or registered by an appropriate agency of the state of Texas;
- whose professional credential is recognized and accepted by an appropriate agency of the United States; or
- who is certified as a provider under the TRICARE military health system.

For purposes of this section, generally recognized services may include services such as:

- evaluation and assessment services;
- applied behavior analysis;
- behavior training and behavior management;
- speech therapy;
- occupational therapy;
- physical therapy; or
- medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder.

Benefits for Autism Spectrum Disorder will not apply towards the "Maximum Lifetime Benefits" amount or any other maximum indicated on your Schedule of Coverage.

After the Dependent child reaches the age of ten, Eligible Expenses, as otherwise covered under this Plan, will be available. All contractual provisions of this Plan will apply, including but not limited to, defined terms, limitations and exclusions, Preauthorization and benefit maximums.

Benefits for Treatment of Diabetes

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

a. *Diabetes Equipment*

(1) Blood glucose monitors (including noninvasive glucose monitors and monitors for the blind);

(2) Insulin pumps (both external and implantable) and associated appurtenances, which include:

- Insulin infusion devices,
- Batteries,
- Skin preparation items,
- Adhesive supplies,
- Infusion sets,
- Insulin cartridges,
- Durable and disposable devices to assist in the injection of insulin, and
- Other required disposable supplies; and

(3) Podiatric appliances, including up to two pairs of therapeutic footwear per Calendar Year, for the prevention of complications associated with diabetes.

b. *Diabetes Supplies*

(1) Test strips specified for use with a corresponding blood glucose monitor

(2) Lancets and lancet devices

(3) Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein

(4) Insulin and insulin analog preparations

(5) Injection aids, including devices used to assist with insulin injection and needleless systems

(6) Insulin syringes

(7) Biohazard disposable containers

(8) Prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and

(9) Glucagon emergency kits.

NOTE: *All Diabetes Supplies listed in item b above will be covered under the* **PHARMACY BENEFITS**.

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

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

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

   Initial and follow-up instruction concerning:

   (1) The physical cause and process of diabetes;

   (2) Nutrition, exercise, medications, monitoring of laboratory values and the interaction of these in the effective self-management of diabetes;

   (3) Prevention and treatment of special health problems for the diabetic patient;

   (4) Adjustment to lifestyle modifications; and

   (5) Family involvement in the care and treatment of the diabetic patient. The family will be included in certain sessions of instruction for the patient.

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

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

Benefits for Physical Medicine Services

Benefits for Medical–Surgical Expense incurred for Physical Medicine Services are available as shown on your Schedule of Coverage.

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

Benefits for Foot Orthotics

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

Benefits for Speech and Hearing Services

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

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

Benefits for Routine Patient Costs for Participants in Certain Clinical Trials

Benefits for Eligible Expenses for Routine Patient Care Costs, as defined in the Definitions Section, are provided in connection with a phase I, phase II, phase III, or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of a life–threatening disease or condition and is approved by:

- the Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
- the National Institutes of Health;
- the United States Food and Drug Administration;
- the United States Department of Defense;
- the United States Department of Veterans Affairs; or
- an institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

Benefits are not available under this section for services that are a part of the subject matter of the clinical trial and that are customarily paid for by the Research Institution conducting the clinical trial.

MEDICAL LIMITATIONS AND EXCLUSIONS

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

1. Any services or supplies which are not Medically Necessary and essential to the diagnosis or direct care and treatment of a sickness, injury, condition, disease, or bodily malfunction.

2. Any Experimental/Investigational services and supplies.

3. Any portion of a charge for a service or supply that is in excess of the Allowable Amount as determined by BCBSTX.

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

5. Any 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 any laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical assistance (Medicaid); provided, however, that this exclusion shall not be applicable to any coverage held by the Participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.

6. Any services or supplies provided for reduction mammoplasty.

7. Any services or supplies for which a Participant is not required to make payment or for which a Participant would have no legal obligation to pay in the absence of this or any similar coverage, except services or supplies for treatment of mental illness or mental retardation provided by a tax supported institution of the State of Texas.

8. Any services or supplies provided by a person who is related to the Participant by blood or marriage.

9. Any services or supplies provided for injuries sustained:

    - As a result of war, declared or undeclared, or any act of war; or
    - While on active or reserve duty in the armed forces of any country or international authority.

10. Any charges:

    - Resulting from the failure to keep a scheduled visit with a Physician or Professional Other Provider; or
    - For completion of any insurance forms; or
    - For acquisition of medical records.

11. Room and board charges incurred during a Hospital Admission for diagnostic or evaluation procedures unless the tests could not have been performed on an outpatient basis without adversely affecting the Participant's physical condition or the quality of medical care provided.

12. Any services or supplies provided before the patient is covered as a Participant hereunder or any services or supplies provided after the termination of the Participant's coverage, except as provided in ***Extension Of Benefits***.

13. Any services or supplies provided for Dietary and Nutritional Services, except as may be provided under the Plan for:

    - an inpatient nutritional assessment program provided in and by a Hospital and approved by BCBSTX; or
    - ***Benefits for Treatment of Diabetes*** as described in **Special Provisions Expenses**; or
    - ***Benefits for Autism Spectrum Disorder*** as described in **Special Provisions Expenses.**

14. Any services or supplies provided for Custodial Care.

15. Any non-surgical (dental restorations, orthodontics, or physical therapy) or non-diagnostic services or supplies (oral appliances, oral splints, oral orthotics, devices, or prosthetics) provided for the treatment of the temporomandibular joint and all adjacent or related muscles and nerves.

16. Any items of Medical-Surgical Expense incurred for dental care and treatments, Covered Oral Surgery, or dental appliances, except as provided for in the ***Benefits for Dental Services*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet.

17. Any services or supplies provided for Cosmetic, Reconstructive, or Plastic Surgery, except as provided for in the ***Benefits for Cosmetic, Reconstructive, or Plastic Surgery*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet.

18. Any services or supplies provided for:

    - Treatment of myopia and other errors of refraction, including refractive surgery; or
    - Orthoptics or visual training; or
    - Eyeglasses or contact lenses, provided that intraocular lenses shall be specific exceptions to this exclusion; or
    - Examinations for the prescription or fitting of eyeglasses or contact lenses, except as may be provided under the ***Benefits for Routine Exams and Immunizations*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet; or
    - Restoration of loss or correction to an impaired speech or hearing function, including hearing aids, except as may be provided under the ***Benefits for Speech and Hearing Services*** and ***Benefits for Autism Spectrum Disorder*** provisions in the **Special Provisions Expenses** portion of this Benefit Booklet.

19. Except as specifically included as an Eligible Expense, any Medical Social Services, bereavement counseling, vocational counseling, or Marriage and Family Therapy.

20. Any services or supplies provided for treatment of adolescent behavior disorders, including conduct disorders and opposition disorders.

21. Any occupational therapy services which do not consist of traditional physical therapy modalities and which are not part of an active multi-disciplinary physical rehabilitation program designed to restore lost or impaired body function, except as may be provided under the ***Benefits for Autism Spectrum Disorder*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet.

22. Travel or ambulance services because it is more convenient for the patient than other modes of transportation whether or not recommended by a Physician or Professional Other Provider.

23. Any services or supplies provided for reduction of obesity or weight, including surgical procedures, even if the Participant has other health conditions which might be helped by a reduction of obesity or weight.

24. Any services or supplies provided primarily for:

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

25. Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.

26. Any services or supplies provided for, in preparation for, or in conjunction with:

    - Sterilization reversal (male or female);
    - Transsexual surgery;
    - Sexual dysfunctions; and
    - In vitro fertilization; and
    - Promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct intra-peritoneal insemination, trans-uterine tubal insemination, gamete intra-fallopian transfer, pronuclear oocyte stage transfer, zygote intra-fallopian transfer, and tubal embryo transfer.

27. Any 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.

28. Any services or supplies in connection with foot care for flat feet, fallen arches, or chronic foot strain.

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

30. Services or supplies for smoking cessation programs and the treatment of nicotine addiction.

31. Any services or supplies provided for the following treatment modalities:

    - acupuncture;
    - intersegmental traction;
    - surface EMGs;
    - spinal manipulation under anesthesia; and
    - muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.

32. Benefits for any covered services or supplies furnished by a Contracting Facility for which such facility has not been specifically approved to furnish under a written contract or agreement with BCBSTX will be paid at the Out-of-Network benefit level.

33. Any items that include, but are not limited to, an orthodontic or other dental appliance; splints or bandages provided by a Physician in a non-hospital setting or purchased "over the counter" for support of strains and sprains; orthopedic shoes which are a separable part of a covered brace, specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or affect changes in the foot or foot alignment, arch supports, elastic stockings and garter belts.

    Note: This exclusion does not apply to podiatric appliances when provided as Diabetic Equipment.

34. Any benefits in excess of any specified dollar, day/visit, Calendar Year, or lifetime maximums.

35. Any services and supplies provided to a Participant incurred outside the United States if the Participant traveled to the location for the purposes of receiving medical services, supplies, or drugs.

36. Donor expenses for a Participant in connection with an organ and tissue transplant if the recipient is not covered under this Plan.

37. Replacement Prosthetic Appliances except those necessitated by growth due to maturity of the Participant.

38. Private duty nursing services, except for covered Extended Care Expense.

39. Any Covered Drugs that is provided under the Pharmacy Benefits portion of the Plan.

40. Residential level of treatment for Chemical Dependency in a Chemical Dependency Treatment Center.

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

- ***For multiple surgeries*** – The Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount *plus* a determined percentage of the Allowable Amount ***for each*** of the other covered procedures performed.
- ***For procedures, services, or supplies provided to Medicare recipients*** – The Allowable Amount will not exceed Medicare's limiting charge.
- ***For Covered Drugs as applied to Participating and non-Participating Pharmacies*** – The Allowable Amount for Participating Pharmacies and the Mail-Order Program will be based on the provisions of the contract between BCBSTX and the Participating Pharmacy or Pharmacy for the Mail-Order Program in effect on the date of service. The Allowable Amount for non-Participating Pharmacies will be based on the Participating Pharmacy contract rate.

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

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

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

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

Certain Diagnostic Procedures means:

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

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

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

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

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

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

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

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

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

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

Coinsurance Stop-Loss Amount means the cumulative dollar amount of most Eligible Expenses incurred by a Participant during a Calendar Year that exceeds benefits provided under the Plan.

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

Complications of Pregnancy means:

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

2. Non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.

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

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

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

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

every requirement contained in the definition of such institution or facility as provided in the Plan shall be deemed a Non-Contracting Facility regardless of the existence of a written contract with another Blue Cross Plan.

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

Cosmetic, Reconstructive, or Plastic Surgery means surgery that:

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

Covered Oral Surgery means maxillofacial surgical procedures limited to:

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

Creditable Coverage means coverage provided under:

1. A group health plan that is a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974;
2. Health insurance coverage consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital, or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes:
   a. group health insurance coverage;
   b. individual health insurance coverage; and
   c. short-term, limited-duration insurance;
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
4. Title XIX of the Social Security Act (Medicaid) other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines);
5. Title 10 Chapter 55, United States Code (medical and dental care for members and certain former members of the uniformed services and for their dependents);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A State health benefits risk pool;
8. A health plan offered under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefits Program);
9. A public health plan. For purposes of this section, a public health plan means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan;
10. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504 (e)); or
11. Title XXI of the Social Security Act (State Children's Health Insurance Program).

Creditable Coverage does not include:

1. Coverage only for accident (including accidental death and dismemberment);
2. Disability income coverage;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Coverage issued as a supplement to liability insurance;
5. Workers' compensation or similar coverage;
6. Automobile medical payment insurance;
7. Credit-only insurance (for example, mortgage insurance);
8. Coverage for onsite medical clinics;
9. Limited scope dental benefits, vision benefits, or long-term care benefits if they are provided under a separate policy, certificate, or contract of insurance.
10. Flexible spending accounts (FSAs) if they meet the definition of a health FSA in IRC Sec. 106(c)(2) and (a) the maximum benefit payable for the employee under the FSA for the year does not exceed two times the employee's salary reduction election under the FSA for the year; and (b) the employee has other coverage available under a group health plan of the employer for the year; and (c) the other coverage is not limited to benefits that are excepted benefits;
11. Coverage for only a specified disease or illness or Hospital indemnity or other fixed indemnity insurance;
12. Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), also known as Medigap or MedSupp insurance);
13. Coverage supplemental to the coverage provided under Chapter 55, Title 10, United States Code (also known as TRICARE supplemental programs);
14. Similar supplemental coverage provided to coverage under a group health plan.

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

Custodial Care means care comprised of services and supplies, including room and board and other institutional services, provided to a Participant primarily to assist in activities of daily living and to maintain life and/or comfort with no reasonable expectation of cure or improvement of sickness or injury. *Custodial Care* is care which is not a necessary part of medical treatment for recovery, and shall include, but not be limited to, helping a Participant walk, bathe, dress, eat, prepare special diets, and take medication.

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

Dependent means your spouse or Domestic Partner or any *child* covered under the Plan.

Child means a natural child, a stepchild, an adopted child (including a child for whom you or your spouse is a party in a suit in which the adoption of the child is sought), under twenty-six (26) years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, or any combination of those factors. A child of your child must be dependent on you for federal income tax purposes at the time of application of coverage for the child of your child is made under the Plan. A child not listed above whose primary residence is your household and to whom you are legal guardian or related by blood or marriage and who is dependent upon you for more than one-half of his support as defined by the Internal Revenue Code of the United States, is also considered a Dependent *child* under the Plan.

For purposes of this Plan, the term *Dependent* will also include those individuals who no longer meet the definition of a Dependent, but are beneficiaries under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or continued under the appropriate provisions of the *Texas Insurance Code*. Please check with your Employer or Human Resources Department to determine if Domestic Partners are eligible for COBRA in your Plan.

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

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

Domestic Partner means a person with whom you have entered into a domestic partnership in accordance with the Employer's Plan guidelines. For purposes of this Plan, Domestic Partners may be eligible beneficiaries for continuation under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Coverage shall be available under the state continuation provisions. For specific criteria or necessary forms required to establish eligibility for benefit coverage under this Plan, contact your Employer or Human Resources Department.

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

Eligible Employee means an Employee who works on a full-time basis and who usually works at least 30 hours a week. The term includes a sole proprietor, a partner, and an independent contractor, if the individual is included as an Employee under a Health Benefit Plan of a Small Employer regardless of the number of hours the sole proprietor, partner, or independent contractor works weekly, but only if the plan includes at least two other eligible employees who work on a full-time basis and who usually work at least 30 hours a week. The term does not include an Employee who:

1. Works on a part-time, temporary, seasonal, or substitute basis, or

2. Is covered under (a) another Health Benefit Plan, or (b) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974, or

3. Elects not to be covered under the Small Employer's Health Benefit Plan and is covered under (a) the Medicaid program; (b) another federal program, including the TRICARE program or Medicare program; or (c) a benefit plan established in another country.

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

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

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

Employee means an individual employed by a Small Employer.

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

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

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

Experimental/Investigational means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as *standard medical treatment* of the condition being treated or any of such items requiring Federal or other governmental agency approval not granted at the time services were provided.

Approval by a Federal agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient.

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

Standard medical treatment means the services or supplies that are in general use in the medical community in the United States, and:

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

The medical staff of BCBSTX shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational, and will consider the guidelines and practices of Medicare, Medicaid, or other government-financed programs in making its determination.

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

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

Health Benefit Plan means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a Health Maintenance Organization that provides benefits for health care services. The term does not include:

1. Accident only or disability income insurance, or a combination of accident-only and disability income insurance;
2. Credit-only insurance;
3. Disability insurance coverage;
4. Coverage for a specified disease or illness;
5. Medicare services under a federal contract;
6. Medicare supplement and Medicare Select policies regulated in accordance with federal law;
7. Long-term care coverage or benefits, home health care coverage or benefits, nursing home care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits;
8. Coverage that provides limited-scope dental or vision benefits;

9. Coverage provided by a single service health maintenance organization;
10. Coverage issued as a supplement to liability insurance;
11. Workers' compensation or similar insurance;
12. Automobile medical payment insurance coverage;
13. Jointly managed trusts authorized under 29 U.S.C. Section 141, et seq., that;
    - contain a plan of benefits for employees
    - is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees, and
    - is authorized under 29 U.S.C. Section 157;
14. Hospital indemnity or other fixed indemnity insurance;
15. Reinsurance contracts issued on a stop-loss, quota-share, or similar basis;
16. Short-term major medical contracts;
17. Liability insurance, including general liability insurance and automobile liability insurance;
18. Other coverage that is:
    - similar to the coverage described by this subdivision under which benefits for medical care are secondary or incidental to other insurance benefits; and
    - specified in federal regulations;
19. Coverage for onsite medical clinics; or
20. Coverage that provides other limited benefits specified by federal regulations.

Health Care Practitioner means an advanced practice nurse, doctor of medicine, doctor of dentistry, physician assistant, doctor of osteopathy, doctor of podiatry, or other licensed person with prescription authority.

Health Status Related Factor means:

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

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

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

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

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

5. Patient and family education; and
6. Nursing services.

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

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

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

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

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

Hospital means a short-term acute care facility which:

1. Is duly licensed as a Hospital by the state in which it is located and meets the standards established for such licensing, and is either accredited by the Joint Commission on Accreditation of Healthcare Organizations or is certified as a Hospital provider under Medicare;

2. Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians or Behavioral Health Practitioners for compensation from its patients;

3. Has organized departments of medicine and major surgery, either on its premises or in facilities available to the Hospital on a contractual prearranged basis, and maintains clinical records on all patients;

4. Provides 24-hour nursing services by or under the supervision of a Registered Nurse;

5. Has in effect a Hospital Utilization Review Plan; and

6. Is not, other than incidentally, a Skilled Nursing Facility, nursing home, Custodial Care home, health resort, spa or sanitarium, place for rest, place for the aged, place for the treatment of Chemical Dependency, Hospice, or place for the provision of rehabilitative care.

Hospital Admission means the period between the time of a Participant's entry into a Hospital or a Chemical Dependency Treatment Center as a *Bed patient* and the time of discontinuance of bed-patient care or discharge by the admitting Physician, Behavioral Health Practitioner or Professional Other Provider, whichever first occurs. The day of entry, but not the day of discharge or departure, shall be considered in determining the length of a Hospital Admission. If a Participant is admitted to and discharged from a Hospital within a 24-hour period but is confined as a *Bed patient* in a bed accommodation during the period of time he is confined in the Hospital, the admission shall be considered a Hospital Admission by BCBSTX.

Bed patient means confinement in a bed accommodation of a Chemical Dependency Treatment Center on a 24-hour basis or in a bed accommodation located in a portion of a Hospital which is designed, staffed, and

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

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

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

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

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

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

1. Furnished at the direction or prescription of a Physician, Behavioral Health Practitioner or Professional Other Provider; and

2. Provided by a Hospital or a Chemical Dependency Treatment Center; and

3. Furnished to and used by the Participant during an inpatient Hospital Admission.

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

Inpatient Hospital Expense shall include:

1. Room accommodation charges. If the Participant is in a private room, the amount of the room charge in excess of the Hospital's average semiprivate room charge *is not* an Eligible Expense.

2. All other usual Hospital services, including drugs and medications, which are Medically Necessary and consistent with the condition of the Participant. Personal items *are not* an Eligible Expense.

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

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

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

1. The individual:

a. Was covered under another Health Benefit Plan or self-funded Health Benefit Plan at the time the individual was eligible to enroll; and
b. Declines in writing, at the time of initial eligibility, stating that coverage under another Health Benefit Plan or self-funded Health Benefit Plan was the reason for declining enrollment; and
c. Has lost coverage under another Health Benefit Plan or self-funded Health Benefit Plan as a result of:

(1) termination of employment;
(2) reduction in the number of hours of employment;
(3) termination of the other plan's coverage;
(4) termination of contributions toward the premium made by the Employer;
(5) the death of a spouse;
(6) divorce or terminate a domestic partnership;
(7) COBRA coverage or State continuation benefits have been exhausted;
(8) cessation of Dependent status;
(9) the Plan no longer offers any benefits to the class of similarly situated individuals that include the individual; or
(10) in the case of coverage offered through an HMO, the individual no longer resides, lives, or works in the service area of the HMO and no other benefit option is available; and

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

2. The request for enrollment is made by the individual within the 60th day after the date on which coverage under Medicaid or CHIP terminates.
3. The individual is employed by an Employer who offers multiple Health Benefit Plans and the individual elects a different Health Benefit Plan during an Open Enrollment Period.
4. A court has ordered coverage to be provided for a spouse under a covered Employee's plan and the request for enrollment is made not later than the 31st day after the date on which the court order is issued.
5. A court has ordered coverage to be provided for a child under a covered Employee's plan and the request for enrollment is made not later than the 31st day after the date on which the Employer receives the court order or notice of the court order.
6. A Dependent child is not a Late Enrollee if the child:
   a. Was covered under Medicaid or the Children's Health Insurance Program (CHIP) at the time the child was eligible to enroll;
   b. The employee declined coverage for the child in writing, stating that coverage under Medicaid or CHIP was the reason for declining coverage;
   c. The child has lost coverage under Medicaid or CHIP; and
   d. The request for enrollment is made within the 60th day after the date on which coverage under Medicaid or CHIP terminates.
7. The individual has a change in family composition due to marriage or establishment of a domestic partnership, birth of a newborn child, adoption of a child, or because a Participant becomes a party in a suite for the adoption of a child, provided the request for enrollment is made no later than the 31st day after the date of the marriage or establishment of a domestic partnership, birth, adoption or date an insured becomes a party in a suite for the adoption.
8. The individual becomes a Dependent due to marriage or establishment of a domestic partnership, birth of a newborn child, adoption of a child, or because an insured becomes a party in a suite for the adoption of a child, provided the request for enrollment is made no later than the 31st day after the date of the marriage or establishment of a domestic partnership, birth, adoption or date an insured becomes a party in a suite for the adoption.

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

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

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

1. Social and emotional factors related to the Participant's sickness, need for care, response to treatment, and adjustment to care; and

2. Relationship of the Participant's medical and nursing requirements to the home situation, financial resources, and available community resources.

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

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

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

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

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

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

1. Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, or bodily malfunction; and
2. Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States; and
3. Not primarily for the convenience of the Participant, his Physician, Behavioral Health Practitioner, the Hospital, or the Other Provider; and
4. The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the Participant. When applied to hospitalization, this further means that the Participant requires acute care as a bed patient due to the nature of the services provided or the Participant's condition, and the Participant cannot receive safe or adequate care as an outpatient.

The medical staff of BCBSTX shall determine whether a service or supply is Medically Necessary under the Plan and will consider the views of the state and national medical communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a Physician, Behavioral Health Practitioner or Professional Other Provider may have prescribed treatment, such treatment may not be Medically Necessary within this definition.

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

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

2. The diagnosis or treatment of any symptom, condition, disease, or disorder by a Physician, Behavioral Health Practitioner or Professional Other Provider (or by any person working under the direction or supervision of a Physician, Behavioral Health Practitioner or Professional Other Provider) when the Eligible Expense is:

   a. Individual, group, family, or conjoint psychotherapy,
   b. Counseling,
   c. Psychoanalysis,
   d. Psychological testing and assessment,
   e. The administration or monitoring of psychotropic drugs, or
   f. Hospital visits or consultations in a facility listed in subsection 5, below;

3. Electroconvulsive treatment;

4. Psychotropic drugs;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. **Facility Other Provider** - an institution or entity, only as listed:
   a. Chemical Dependency Treatment Center
   b. Crisis Stabilization Unit or Facility
   c. Durable Medical Equipment Provider
   d. Home Health Agency
   e. Home Infusion Therapy Provider
   f. Hospice
   g. Imaging Center
   h. Independent Laboratory
   i. Prosthetics/Orthotics Provider
   j. Psychiatric Day Treatment Facility
   k. Renal Dialysis Center
   l. Residential Treatment Center for Children and Adolescents
   m. Skilled Nursing Facility
   n. Therapeutic Center

2. **Professional Other Provider** - a person or practitioner, when acting within the scope of his license and who is appropriately certified, only as listed:
   a. Advanced Practice Nurse
   b. Doctor of Chiropractic
   c. Doctor of Dentistry
   d. Doctor of Optometry
   e. Doctor of Podiatry
   f. Doctor in Psychology
   g. Licensed Acupuncturist
   h. Licensed Audiologist
   i. Licensed Chemical Dependency Counselor
   j. Licensed Dietitian
   k. Licensed Hearing Instrument Fitter and Dispenser

l. Licensed Marriage and Family Therapist
m. Licensed Clinical Social Worker
n. Licensed Occupational Therapist
o. Licensed Physical Therapist
p. Licensed Professional Counselor
q. Licensed Speech–Language Pathologist
r. Licensed Surgical Assistant
s. Nurse First Assistant
t. Physician Assistant
u. Psychological Associates who work under the supervision of a Doctor in Psychology

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

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

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

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

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

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

Physical Medicine Services means those modalities, procedures, tests, and measurements listed in the *Physicians' Current Procedural Terminology Manual* (Procedure Codes 97010–97799), whether the service or supply is provided by a Physician or Professional Other Provider, and includes, but is not limited to, physical therapy, occupational therapy, hot or cold packs, whirlpool, diathermy, electrical stimulation, massage, ultrasound, manipulation, muscle or strength testing, and orthotics or prosthetic training.

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

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

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

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

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

Preexisting Condition means a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the 6 months before the earlier of the:

- Effective date of coverage; or
- First day of the Waiting Period.

Proof of Loss means written evidence of a claim including:

1. The form on which the claim is made;
2. Bills and statements reflecting services and items furnished to a Participant and amounts charged for those services and items that are covered by the claim, and
3. Correct diagnosis code(s) and procedure code(s) for the services and items.

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

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

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

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

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

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

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

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

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

Residential Treatment Center for Children and Adolescents means a child-care institution which is appropriately licensed and accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Association of Psychiatric Services for Children as a residential treatment center for the

provisions of Mental Health Care and Serious Mental Illness services for emotionally disturbed children and adolescents.

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

Routine patient care costs do not include:

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

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

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

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

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

Small Employer (Employer) means a person (individual, corporation, partnership, or other legal entity) who employed an average of at least two Employees but not more than 50 Eligible Employees on business days during the preceding Calendar Year and who employs at least two Employees on the first day of the plan year. A small employer includes an independent school district that elects to participate in the small employer market as provided under Insurance Code Section 1501.009.

Specialty Care Provider means a Physician or Professional Other Provider who has entered into an agreement with BCBSTX (and in some instances with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care Provider of specialty services.

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

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

Waiting Period means a period established by an Employer that must pass before an individual who is a potential enrollee in a Health Benefit Plan is eligible to be covered for benefits.

Covered Drugs

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

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

As new drugs are approved by the Food and Drug Administration (FDA), such drugs, unless the intended use is specifically excluded under the Plan, are eligible for benefits. Some equivalent drugs are manufactured under multiple brand names. In such cases, BCBSTX may limit benefits to only one of the brand equivalents available. Benefits are available for Covered Drugs as indicated on your Schedule of Coverage.

Injectable Drugs

Injectable drugs approved by the FDA for self-administration are covered under the Plan. You are responsible for any Deductibles, Copayment Amounts and pricing differences that may apply to the Covered Drugs dispensed. Injectable drugs include, but are not limited to, insulin and Imitrex.

The day supply of disposable syringes and needles you will need for self-administered injections will be limited on each occasion dispensed to amounts appropriate to the dosage amounts of covered injectable drugs actually prescribed and dispensed, but cannot exceed 100 syringes and needles per Prescription Order in a 30-day period.

Diabetes Supplies for Treatment of Diabetes

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

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

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

Vaccinations obtained through Participating Pharmacies

Benefits for vaccinations, as shown on your Schedule of Coverage, are available through certain Participating Pharmacies that have contracted with BCBSTX to provide this service. To locate one of these contracting Participating Pharmacies in your area, call our Customer Service Helpline number shown in this booklet or on your Identification Card. At the time you receive services, present your BCBSTX Identification Card to the pharmacist. This will identify you as a Participant in the BCBSTX health care plan provided by your employer. The pharmacist will inform you of the appropriate Copayment Amount, if any.

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

Formulas for the Treatment of Phenylketonuria or Other Heritable Diseases
Benefits are available for dietary formulas necessary for the treatment of phenylketonuria or other heritable diseases.

Amino Acid-Based Elemental Formulas
Benefits are available for formulas, regardless of the formula delivery method, used for the diagnosis and treatment of:

a. Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
b. Severe food protein-induced enterocolitis syndromes;
c. Eosinophilic disorders, as evidenced by the results of biopsy; and
d. Disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

A Prescription Order from your Health Care Practitioner is required.

Benefits for Orally Administered Anticancer Medication
Benefits are available for Medically Necessary orally administered anticancer medication that is used to kill or slow the growth of cancerous cells. Coinsurance or a Copayment Amount will not apply to orally administered anticancer medication listed on the Managed Oral Cancer Drug List. To determine if a specific drug is on the Managed Oral Cancer Drug List, you may access the website at www.bcbstx.com/member/rx_drugs.html or contact Customer Service at the toll-free number on your Identification Card.

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

Selecting a Pharmacy

Participating Pharmacy

When you go to a Participating Pharmacy:

- present your Identification Card to the pharmacist along with your Prescription Order,
- provide the pharmacist with the birth date and relationship of the patient,
- sign the insurance claim log.

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

- the billed charges, or
- the Allowable Amount as determined by BCBSTX, or
- other contractually determined payment amounts.

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

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

Non-Participating Pharmacy

If you have a Prescription Order filled or obtain a covered vaccination at a non-Participating Pharmacy, you must pay the Pharmacy the full amount of its bill and submit a claim form to the Carrier with itemized receipts verifying that

the Prescription Order was filled or a covered vaccination was provided. The Plan will reimburse you for Covered Drugs and covered vaccinations equal to:

- the Coinsurance Amount indicated on your Schedule of Coverage,
- less the appropriate Copayment Amount, and
- less any pricing differences that may apply to the Covered Drug or covered vaccination you receive.

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

Mail-Order Program

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

Some drugs may not be available through the mail-order program. If you have any questions about this mail-order program, need assistance in determining the amount of your payment, or need to obtain the mail-order prescription form, you may access the website at www.bcbstx.com/member/rx_drugs.html or contact Customer Service at the toll-free number on your Identification Card. Mail the completed form, your Prescription Order(s) and payment to the address indicated on the form.

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

Specialty Pharmacy Program

The Specialty Drug delivery service integrates Specialty Drug benefits with the Participant's overall medical and prescription drug benefits. This program provides delivery of medications directly to your Health Care Practitioner, administration location or to the home of the Participant that is undergoing treatment for a complex medical condition.

The specialty pharmacy program delivery service offers:

- Coordination of coverage between you, your Health Care Practitioner and BCBSTX,
- Educational materials about the patient's particular condition and information about managing potential medication side effects,
- Syringes, sharps containers, alcohol swabs and other supplies with every shipment for FDA approved self-injectable medications, and
- Access to a pharmacist for urgent medication issues 24 hours a day, 7 days a week, 365 days each year

A list identifying these Specialty Drugs is available by accessing the website at www.bcbstx.com/member/rx_drugs.html (specialty prescription drugs) or by contacting Customer Service at the toll-free number on your Identification Card. Your cost will be the appropriate Drug Copayment indicated on the Schedule of Coverage and any applicable pricing differences.

Your Cost

Copayment Amounts

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

1. Generic Drug - You pay the Generic Drug Copayment Amount

2. Preferred Brand Name Drug – You pay the Preferred Brand Name Drug Copayment Amount

3. Non-Preferred Brand Name Drug – You pay the Non-Preferred Brand Name Drug Copayment Amount

If the Allowable Amount of the Covered Drug is less than the Copayment Amount, the Participant will pay the lower cost.

How Preferred Brand Name Drug Pricing Difference Applies

If there is no Generic Drug for your Preferred Brand Name Drug Prescription Order, you will pay no more than the applicable Preferred Brand Name Drug Copayment Amount. If you receive a Preferred Brand Name Drug when a Generic Drug is available, your payment amount will be the sum of:

(a) the difference between the Allowable Amount of the Preferred Brand Name Drug and the Allowable Amount of the Generic Drug, **plus**
(b) the Preferred Brand Name Drug Copayment Amount.

If there is no Generic Drug for your Non-Preferred Brand Name Drug Prescription Order, you will pay no more than the applicable Non-Preferred Brand Name Drug Copayment Amount. If you receive a Non-Preferred Brand Name Drug when a Generic Drug is available, your payment amount will be the sum of:

(a) the difference between the Allowable Amount of the Non-Preferred Brand Name Drug and the Allowable Amount of the Generic Drug, **plus**
(b) the Preferred Brand Name Drug Copayment Amount.

Drug Coupons, Rebates or Other Drug Discounts

Drug manufacturers may offer coupons, rebates or other drug discounts to Participants, which may impact the benefits provided under this Plan. The total benefits payable will not exceed the balance of the Allowable Amount remaining after all drug coupons, rebates or other drug discounts have been applied. The Participant agrees to reimburse BCBSTX any excess amounts for benefits that we have paid you and for which you are not eligible due to the applications of drug coupons, rebates or other drug discounts.

About Your Benefits

Preferred Drug List 1

A Preferred Brand Name Drug is subject to the Preferred Brand Name Drug Copayment Amount plus any pricing differences that may apply to the Covered Drug you receive. These drugs are identified on the *Preferred Drug List 1* that is maintained by the Carrier. This list is developed using monographs written by the American Medical Association, Academy of Managed Care Pharmacies, and other Pharmacy and medical related organizations, describing clinical outcomes, drug efficacy, and side effect profiles.

BCBSTX will routinely review the *Preferred Drug List 1* and periodically adjust it to modify the Preferred or Non-Preferred Brand Name Drug status of existing or new drugs. Changes to this list will be implemented on the Employer's Contract Anniversary. The *Preferred Drug List 1* and any modifications will be made available to Participants. Participants may access our website at www.bcbstx.com/member/rx_drugs.html or call the Customer Service Helpline at the telephone number shown in this Benefit Booklet or on your Identification Card to determine if a particular drug is on the *Preferred Drug List 1*. Drugs that do not appear on the *Preferred Drug List 1* are subject to the Non-Preferred Brand Name Drug Copayment Amount plus any pricing differences that may apply to the Covered Drug you receive.

Day Supply

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

If you are leaving the country or need an extended supply of medication, call Customer Service at least two weeks before you intend to leave. (Extended supplies or vacation override are not available through the mail-order Pharmacy but may be approved through the retail Pharmacy only. In some cases, you may be asked to provide proof of continued enrollment eligibility under the Plan.)

Quantity Versus Time Limits

The maximum quantity of a given prescription drug indicates the number of units to be dispensed and is determined based on pertinent medical information and clinical efficacy and safety. Quantities of some drugs are restricted regardless of the quantity ordered by the Health Care Practitioner. To determine if a specific drug is subject to this limitation, you may access the website at www.bcbstx.com/member/rx_drugs.html or contact Customer Service at the toll-free number on your Identification Card.

If a Prescription Order is written for a certain quantity of medication to be taken in a time period directed by a Health Care Practitioner, the Prescription Order will only be covered for a clinically appropriate pre-determined quantity of medication for the specified amount of time. Dispensing limits are based upon FDA dosing recommendations and nationally recognized clinical guidelines.

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

Step Therapy

Coverage for certain designated prescription drugs may be subject to a step therapy program. Step therapy programs favor the use of clinically acceptable alternative medications that may be less costly for you prior to those medications on the step therapy list of drugs being covered under the Plan.

When you submit a Prescription Order to a Participating Pharmacy for one of these designated medications, the Pharmacist will be alerted if the online review of your prescription claims history indicates an acceptable alternative medication has not been previously tried. If so, a toll free number will be provided to you for your Health Care Practitioner to call and obtain additional program and criteria information. A list of step therapy medication and possible alternatives are available to you and your Health Care Practitioner on our website at www.bcbstx.com/provider.

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

Prior Authorizations

Coverage for certain designated prescription drugs is subject to prior authorization criteria. This means that in order to ensure that a drug is safe, effective, and part of a specific treatment plan, certain medications may require prior authorization and the evaluation of additional clinical information before dispensing. A list of the medications which require prior authorization is available to you and your Health Care Practitioner on our website at www.bcbstx.com/provider.

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

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

Right of Appeal

In the event that a requested Prescription Order is denied on the basis of quantity versus time dispensing limits, step therapy criteria, or prior authorization criteria with or without your authorized Health Care Practitioner having submitted clinical documentation, you have the right to appeal as indicated under the **Review of Claim Determinations** section of this Benefit Booklet.

Limitations and Exclusions

Pharmacy benefits are not available for:

1. Drugs which do not by law require a Prescription Order from a Provider or authorized Health Care Practitioner (**except** insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and vaccinations administered through certain Participating Pharmacies, as shown on your Schedule of Coverage); and Legend Drugs or covered devices for which no valid Prescription Order is obtained.

2. Devices or durable medical equipment of any type (even though such devices may require a Prescription Order,) such as, but not limited to, therapeutic devices, including support garments and other non-medicinal substances, artificial appliances, or similar devices (except disposable hypodermic needles and syringes for self-administered injections and those devices listed as Diabetes Supplies).

3. Administration or injection of any drugs.

4. Vitamins (**except** those vitamins which by law require a Prescription Order and for which there is **no** non-prescription alternative).

5. Drugs injected, ingested or applied in a Physician's or authorized Health Care Practitioner's office or during confinement while a patient is in a Hospital, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.

6. Covered Drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.

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

8. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery. Vaccinations shown on your Schedule of Coverage, administered through certain Participating Pharmacies are an exception to this exclusion.

9. Covered Drugs for which the Pharmacy's usual retail price to the general public is less than or equal to the Participant's cost share determined under this Plan.

10. Oral and injectable infertility and fertility medications.

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

12. 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.

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

14. Legend Drugs which are not approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation.

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

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

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

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

20. 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.

21. Services and supplies for smoking cessation programs and the treatment of nicotine addiction.

22. Compounded drugs that do not meet the definition of Compound Medications.

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

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

25. Retin A or pharmacologically similar topical drugs.

26. Athletic performance enhancement drugs.

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

28. Allergy serum and allergy testing materials.

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

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

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

32. Some equivalent drugs manufactured under multiple brand names. BCBSTX may limit benefits to only one of the brand equivalents available. If you do not accept the brand that is covered under this Plan, the Brand Name Drug purchased will not be covered under any benefit level.

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

34. Shipping, handling or delivery charges.

35. Drugs that are repackaged by anyone other than the original manufacturer.

36. Prescription Orders written by a member of your immediate family, or a self-prescribed Prescription Order.

Definitions

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

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

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

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

Compound Medications mean those drugs that have been measured and mixed with U. S. Food and Drug Administration (FDA)-approved pharmaceutical ingredients by a pharmacist to produce a unique formulation that is Medically Necessary because commercial products either do not exist or do not exist in the correct dosage, size, or form. The drugs used must meet the following requirements:

1. The drugs in the compounded product are Food and Drug Administration (FDA) approved;
2. The approved product has an assigned National Drug Code (NDC); and
3. The primary active ingredient is a Covered Drug under the Plan.

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

Covered Drugs means any Legend Drug (except 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):

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

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 and corresponding Participant Copayment responsibility, BCBSTX utilizes the generic/brand status assigned by a nationally recognized provider of drug product database information.

Health Care Practitioner means an advanced practice nurse, doctor of medicine, doctor of dentistry, physician assistant, doctor of osteopathy, doctor of podiatry, or other licensed person with prescription authority.

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

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

Non-Preferred Brand Name Drug means a Brand Name Drug which does not appear on the *Preferred Drug List* and is subject to the Non-Preferred Brand Name Drug Copayment. This *Preferred Drug List* is available by accessing the website at www.bcbstx.com/member/rx_drugs.html.

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

Pharmacy means a state and federally licensed establishment 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 he practices.

Preferred Brand Name Drug means a brand name prescription drug product that is identified on the *Preferred Drug List* and is subject to the Preferred Brand Name Drug Copayment. This list is available by accessing the website at www.bcbstx.com/member/rx_drugs.html.

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

Specialty Drug means a high cost prescription drug that meets any of the following criteria.

1. used in limited patient populations or indications,
2. typically self-injected,
3. limited availability, requires special dispensing, or delivery and/or patient support is required and therefore, they are difficult to obtain via traditional pharmacy channels,
4. complex reimbursement procedures are required, and/or
5. a considerable portion of the use and costs are frequently generated through office-based medical claims.

GENERAL PROVISIONS

Agent

The Employer is not the agent of the Carrier.

Amendments

The Plan may be amended or changed at any time by agreement between the Employer and BCBSTX. No notice to or consent by any Participant is necessary to amend or change the Plan.

Assignment and Payment of Benefits

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

Conformity with State Statutes

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

Disclosure Authorization

If you file a claim for benefits, it will be necessary that you authorize any health care Provider, insurance carrier, or other entity to furnish BCBSTX all information and records or copies of records relating to the diagnosis, treatment, or care of any individual included under your coverage. If you file claims for benefits, you and your Dependents will be considered to have waived all requirements forbidding the disclosure of this information and records.

Medicare

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

Participant/Provider Relationship

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

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

Refund Of Benefit Payments

If BCBSTX pays benefits for Eligible Expenses incurred by you or your Dependents and it is found that the payment was more than it should have been, or was made in error, BCBSTX has the right to a refund from the person to or for whom such benefits were paid, any other insurance company, or any other organization. If no refund is received, BCBSTX may deduct any refund due it from any future benefit payment.

State Government Programs

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

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

    a. The Texas Department of Human Services is paying benefits pursuant to provisions in the *Human Resources Code*; and

    b. The parent who is covered under the Plan has possession or access to the child pursuant to a court order, or is not entitled to access or possession of the child and is required by the court to pay child support; and

    c. The Carrier receives written notice at its Administrative Office affixed to the benefit claim when the claim is first submitted, that the benefits claimed must be paid directly to the Texas Department of Human Services.

Subrogation

When BCBSTX pays benefits under the Contract and it is determined that a negligent third party is liable for the same expenses, BCBSTX has the right to subrogate from the monies payable from the negligent third party equal to the amount BCBSTX has paid for such expenses. The Participant hereby agrees to reimburse BCBSTX from any monies recovered from a negligent third party as a result of a judgment against, settlement with, or otherwise paid by the third party. The Participant agrees to take action against the third party, furnish all information, and provide assistance to BCBSTX regarding the action taken, and execute and deliver all documents and information necessary for BCBSTX to enforce our rights of subrogation.

Coordination of Benefits

The availability of benefits specified in this Contract is subject to Coordination of Benefits (COB) as described below. This COB provision applies to This Plan when a Participant has health care coverage under more than one Plan.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan shall not be reduced when This Plan determines its benefits before another Plan; but may be reduced when another Plan determines its benefits first.

Coordination of Benefits – Definitions

1. **Plan** means any group insurance or group-type coverage, whether insured or uninsured. This includes:

   a. group or blanket insurance;
   b. franchise insurance that terminates upon cessation of employment;
   c. group hospital or medical service plans and other group prepayment coverage;
   d. any coverage under labor-management trustee arrangements, union welfare arrangements, or employer organization arrangements;
   e. governmental plans, or coverage required or provided by law.

   Plan does *not* include:
   a. any coverage held by the Participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy;
   b. a policy of health insurance that is individually underwritten and individually issued;
   c. school accident type coverage; or
   d. a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

   Each contract or other arrangement for coverage is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

2. **This Plan** means the part of this Contract that provides benefits for health care expenses.

3. **Primary Plan/Secondary Plan**
   The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan covering the Participant. A *Primary Plan* is a Plan whose benefits are determined before those of the other Plan and without considering the other Plan's benefit. A *Secondary Plan* is a Plan whose benefits are determined after those of a Primary Plan and may be reduced because of the other Plan's benefits.

   When there are more than two Plans covering the Participant, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

4. **Allowable Expense** means a necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part by one or more Plans covering the Participant for whom claim is made.

5. **Claim Determination Period** means a Calendar Year. However, it does not include any part of a year during which a Participant has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

6. **We** or **Us** means Blue Cross and Blue Shield of Texas.

Order of Benefit Determination Rules

1. **General Information**

   a. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless (a) the other Plan has rules coordinating its benefits with those of This Plan, and (b) both those rules and This Plan's rules require that This Plan's benefits be determined before those of the other Plan.

   b. If this Contract contains any dental or vision benefits, the benefits provided by the health portion of this contract will be the Secondary Plan.

2. **Rules**
   This Plan determines its order of benefits using the first of the following rules which applies:

   a. ***Non-Dependent/Dependent.*** The benefits of the Plan which covers the Participant as an Employee, member or subscriber are determined before those of the Plan which covers the Participant as a Dependent. However, if the Participant is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is

      (1) secondary to the Plan covering the Participant as a Dependent and

      (2) primary to the Plan covering the Participant as other than a Dependent (e.g., a retired Employee), then the benefits of the Plan covering the Participant as a Dependent are determined before those of the Plan covering that Participant other than a Dependent.

   b. ***Dependent Child/Parents Not Separated or Divorced.*** Except as stated in Paragraph c below, when This Plan and another Plan cover the same child as a Dependent of different parents:

      (1) The benefits of the Plan of the parent whose birthday falls earlier in a Calendar Year are determined before those of the Plan of the parent whose birthday falls later in that Calendar Year; but

      (2) If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

      However, if the other Plan does not have the rule described in this Paragraph b, but instead has a rule based on gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

   c. ***Dependent Child/Parents Separated or Divorced.*** If two or more Plans cover a Participant as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

      (1) First, the Plan of the parent with custody of the child;
      (2) Then, the Plan of the spouse of the parent with custody, if applicable;
      (3) Finally, the Plan of the parent not having custody of the child.

      However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Calendar Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

   d. ***Joint Custody.*** If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in Paragraph b.

e. ***Active/Inactive Employee.*** The benefits of a Plan which covers a Participant as an Employee who is neither laid off nor retired are determined before those of a Plan which covers that Participant as a laid off or retired Employee. The same would hold true if a Participant is a Dependent of a person covered as a retired Employee and an Employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Paragraph e does not apply.

f. ***Continuation Coverage.*** If a Participant whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another Plan, the following shall be the order of benefit determination:

(1) First, the benefits of a Plan covering the Participant as an Employee, member or subscriber (or as that Participant's Dependent);

(2) Second, the benefits under the continuation coverage.

If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits this Paragraph f does not apply.

g. ***Longer/Shorter Length of Coverage.*** If none of the above rules determine the order of benefits, the benefits of the Plan which covered an Employee, member or subscriber longer are determined before those of the Plan which covered that Participant for the shorter period of time.

Effect on the Benefits of This Plan

1. **When This Section Applies**
This section applies when This Plan is the Secondary Plan in accordance with the order of benefits determination outlined above. In that event, the benefits of This Plan may be reduced under this section.

2. **Reduction in this Plan's Benefits**
The benefits of This Plan will be reduced when the sum of:

a. The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and

b. The benefits that would be payable for the Allowable Expense under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made exceeds those Allowable Expenses in a Claim Determination Period.

In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as previously described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Right to Receive and Release Needed Information

We assume no obligation to discover the existence of another Plan, or the benefits available under the other Plan, if discovered. We have the right to decide what information we need to apply these COB rules. We may get needed information from or release information to any other organization or person without telling, or getting the consent of, any person. Each person claiming benefits under This Plan must give us any information concerning the existence of other Plans, the benefits thereof, and any other information needed to pay the claim.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again.

Right to Recovery

If the amount of the payments We make is more than We should have paid under this COB provision, We may recover the excess from one or more of:

1. the persons We have paid or for whom We have paid;
2. insurance companies; or
3. Hospitals, Physicians, or Other Providers; or
4. any other person or organization.

Termination of Coverage

BCBSTX is not required to give you prior notice of termination of coverage. BCBSTX will not always know of the events causing termination until after the events have occurred.

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

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

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

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

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

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

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

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

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

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

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

Total Disability or *Totally Disabled* means as applied to:
1. An Employee, the complete inability of the Employee to perform all of the substantial and material duties and functions of his occupation and any other gainful occupation in which the Employee earns substantially the same compensation earned prior to disability; and

2. A Dependent, confinement as a bed patient in a Hospital.

Notice of Creditable Coverage

Upon termination of your coverage under this Plan, you will be issued a Certificate of Creditable Coverage. You may request a Certificate of Creditable Coverage within 24 months of termination of your or your Dependent's coverage under this Plan.

Continuation Privilege

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

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

1. The date the group coverage would otherwise terminate; or

2. The date the Participant is given notice of the right of continuation by either the Employer or the group Contractholder.

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

Continuation may not terminate until the earliest of:

1. The date on which the maximum continuation period is exhausted, which is:

    a. For covered persons not eligible for COBRA continuation coverage, nine months after the date of state continuation coverage; or
    b. For covered persons covered under COBRA continuation coverage, six additional months following any period of COBRA continuation coverage;

2. The date on which failure to make timely payments would terminate coverage;

3. The date on which the group coverage terminates in its entirety;

4. The date on which the covered person is or could be covered under Medicare;

5. The date on which the covered person is covered for similar benefits by another hospital, surgical, medical, or major medical expense insurance policy or hospital or medical subscriber contract or medical practice or other prepayment plan or any other plan or program;

6. The date the covered person is eligible for similar benefits whether or not covered therefor under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or

7. Similar benefits are provided or available to such person, pursuant to or in accordance with the requirements of any state or federal law, other than COBRA continuation coverage.

Additional Continuation for Certain Dependents – State

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

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

1. The Contract is canceled; or

2. The Dependent fails to make any timely premium payments.

Continuation ends after the earliest of the following:

1. The third anniversary of the severance of the family relationship or the retirement or death of the Subscriber;

2. The insured fails to make premium payments within the time required to make the payments;

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

4. The Contract is canceled.

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

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

COBRA Continuation - Federal

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

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

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

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

1. divorce from the covered Employee,

2. death of the covered Employee,

3. the covered Employee becomes eligible for Medicare, or

4. a covered Dependent child no longer meets the Dependent eligibility requirements.

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

1. The last day of the eighteen (18) month period for events which have a maximum continuation period of eighteen (18) months.

2. The last day of the thirty-six (36) month period for events which have a maximum continuation period of thirty-six (36) months.

3. The first day for which timely payment of premium is not made to the Plan with respect to the qualified beneficiary.

4. The date upon which the Employer ceases to provide any group health plan to any Employee.

5. The date, after the date of the election, upon which the qualified beneficiary first becomes covered under any other employer group health benefit plan.

6. The date, after the date of the election, upon which the qualified beneficiary first becomes entitled to Medicare benefits.

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

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

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

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

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

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

1. The Employer will furnish summary plan descriptions, annual reports, and summary annual reports to you and other plan participants and to the government as required by ERISA and its regulations.

2. BCBSTX will furnish the Employer with this Benefit Booklet as a description of benefits available under this Health Benefit Plan. Upon written request by the Employer, BCBSTX will send any information which BCBSTX has that will aid the Employer in making its annual reports.

3. Claims for benefits must be made in writing on a timely basis in accordance with the provisions of this Health Benefit Plan. Claim filing and claim review health procedures are found in the **CLAIM FILING AND APPEALS PROCEDURES** section of this Benefit Booklet.

4. BCBSTX is not the ERISA "Plan Administrator" for benefits or activities pertaining to the Health Benefit Plan.

5. This Benefit Booklet is a Certificate of Coverage and not a Summary Plan Description.

6. The Employer has given BCBSTX the authority and discretion to interpret the Health Benefit Plan provisions and to make eligibility and benefit determinations.

RIDERS

Serious Mental Illness Rider

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

Benefits for Serious Mental Illness

Benefits for Eligible Expenses incurred for the treatment of Serious Mental Illness are shown on your Schedule of Coverage. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection to determine what services require preauthorization.

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

The benefits provided for Serious Mental Illness will not exceed the "Maximum Lifetime Benefits" amount shown on your Schedule of Coverage.

Form No. SMI.1009

AMENDMENTS

AMENDMENT TO THE BENEFIT BOOKLET

Provisions in the Benefit Booklet, including the Schedule of Coverage and any Amendments, are hereby changed as follows:

1. The **ELIGIBLE EXPENSE, PAYMENT OBLIGATION AND BENEFITS** section of your benefit booklet is amended by deleting the **Maximum Lifetime Benefits** subsection in its entirety. All maximum lifetime dollar limits referenced in your benefit booklet, any amendments or any Schedule of Coverage are deleted and no longer apply.

2. The **ELIGIBLE EXPENSE, PAYMENT OBLIGATION AND BENEFITS** section of your benefit booklet is amended by deleting the **Annual Maximum Benefits** subsection, if any, in its entirety. Any other reference in your benefit booklet to Annual Maximum Benefits is deleted.

3. Skilled Nursing Facility – Any mention of a Calendar Year dollar maximum benefit is hereby removed in its entirety. The Calendar Year maximum benefit is 25 days.

4. Home Health Care – Any mention of a Calendar Year dollar maximum benefit is hereby removed in its entirety. The Calendar Year maximum benefit is 60 visits.

5. Hospice – Any mention of a lifetime maximum benefit is hereby removed in its entirety.

6. Mental Health Care – Any mention of Calendar Year dollar maximum or Lifetime dollar maximum is hereby removed in its entirety. The Calendar Year maximum benefit is 10 Inpatient days and 25 outpatient visits.

7. Physical Medicine Services – Any mention of a Calendar Year dollar maximum benefit is hereby removed in its entirety. The Calendar Year maximum benefit is 35 visits.

8. Emergency Care and Treatment of Accidental Injury – Any mention of a 48 hour time limit following the onset of a medical emergency is deleted.

9. Preventive care services will be provided for the following covered services and In-Network services will not be subject to Coinsurance, Deductible, Copayment or dollar maximums:
   a. evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");
   b. immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved;
   c. evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents; and
   d. with respect to women, such additional preventive care and screenings, not described in item a. above, as provided for in comprehensive guidelines supported by the HRSA.

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

   The preventive care services described in items a through d may change as USPSTF, CDC and HRSA guidelines are modified. For more information, you may access the website at www.bcbstx.com or contact customer service at the toll-free number on your identification card.

   Examples of covered services included are routine annual physicals, immunizations, well-child care, cancer screening mammograms, bone density test, screening for prostate cancer and colorectal cancer, smoking cessation counseling services and healthy diet counseling and obesity screening/counseling.

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

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

10. The **COVERED MEDICAL SERVICES** section of your benefit booklet is amended by adding the following paragraph to ***Benefits for Emergency Care and Treatment of Accidental Injury***:

    Notwithstanding anything in this certificate to the contrary, for Out-of-Network Emergency Care services rendered by non-contracting Providers, the Allowable Amount shall be equal to the greatest of the following three possible amounts:

    1. the amount negotiated with In-Network Providers for Emergency Care services furnished;
    2. the amount for the Emergency Care service calculated using the same method the Plan generally uses to determine payments for Out-of-Network services but substituting the In-Network cost-sharing provisions for the Out-of-Network cost sharing provisions; or
    3. the amount that would be paid under Medicare for the Emergency Care service.

    Each of these three amounts is calculated excluding any In-Network Copayment or Coinsurance imposed with respect to the Participant.

11. The **PHARMACY BENEFITS** section of your benefit booklet is amended by deleting the **Pharmacy Calendar Year Maximum** or **Pharmacy Plan Year Maximum** subsection, if included, in its entirety. Any references, in your benefit booklet or Schedule of Coverage, to these Pharmacy Maximums, are deleted and no longer apply.

12. The **MEDICAL LIMITATIONS AND EXCLUSIONS** section of your benefit booklet is amended by deleting the exclusion for smoking cessation and substituting the following new exclusion.

    Supplies for smoking cessation programs and the treatment of nicotine addiction.

13. The **MEDICAL LIMITATIONS AND EXCLUSIONS** section of your benefit booklet is amended by modifying the following:

    Any services or supplies provided for reduction of obesity or weight, including surgical procedures, even if the Participant has other health conditions which might be helped by a reduction of obesity or weight, except for healthy diet counseling and obesity screening/counseling as may be provided under **Preventive Services**.

14. The **Preexisting Conditions Provision** in the **HOW THE PLAN WORKS** section of your benefit booklet is amended to include the following on the list of items the Preexisting Conditions exclusion will not apply to:

    Any Participants under the age of 19

15. The definition of **Dependent** in the **DEFINITIONS** section of your benefit booklet, and anywhere else the term Dependent *child* is used hereafter, means a natural child, a stepchild, an adopted child (including a child for whom you or your spouse is a party in a suit in which the adoption of the child is sought), under twenty-six (26) years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage, or any combination of those factors. A child of your child must be dependent on you for federal income tax purposes at the time of application of coverage for the child of your child is made under the Plan. A child not listed above whose primary residence is your household and to whom you are legal guardian or related by blood or marriage and who is dependent upon you for more than one-half of his support as

defined by the Internal Revenue Code of the United States, is also considered a Dependent *child* under the Plan.

16. Organ and Tissue Transplants – the $15,000 maximum benefit per Calendar Year for donor search and acceptability testing of potential live donors is hereby removed in its entirety.

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 Benefit Booklet to which this amendment is attached will remain in full force and effect. For contracts in effect on or after September 23, 2010, this amendment is effective on the Contract Date or Contract Anniversary.

Blue Cross and Blue Shield of Texas (BCBSTX)

By: 

President, Blue Cross and Blue Shield of Texas

AMENDMENT TO THE BENEFIT BOOKLET

Provisions in the Benefit Booklet, including the Schedule of Coverage and any Amendments, are hereby changed as follows:

A. The following wording replaces the new ***Benefits for Emergency Care and Treatment of Accidental Injury*** paragraph that added to the **COVERED MEDICAL SERVICES** section of your benefit booklet on Form No. Amend HCR-non-Grandfther.BK.SG.1010R.

Notwithstanding anything in this certificate to the contrary, for Out-of-Network Emergency Care services rendered by non-contracting Providers, the Allowable Amount shall be equal to the greatest of the following three possible amounts—not to exceed billed charges:

1. the median amount negotiated with In-Network Providers for Emergency Care services furnished;
2. the amount for the Emergency Care service calculated using the same method the Plan generally uses to determine payments for Out-of-Network services but substituting the In-Network cost-sharing provisions for the Out-of-Network cost sharing provisions; or
3. the amount that would be paid under Medicare for the Emergency Care service.

Each of these three amounts is calculated excluding any In-Network Copayment or Coinsurance imposed with respect to the Participant.

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 Benefit Booklet to which this amendment is attached will remain in full force and effect. For contracts in effect on or after September 23, 2010, this amendment is effective on the Contract Date or Contract Anniversary.

Blue Cross and Blue Shield of Texas (BCBSTX)

By: 

President, Blue Cross and Blue Shield of Texas

AMENDMENT TO THE BENEFIT BOOKLET

Provisions in the Benefit Booklet, including the Schedule of Coverage and any Amendments, are hereby changed as follows:

The **CLAIMS FILING AND APPEALS PROCEDURES** section of your Benefit Booklet is hereby deleted in its entirety and replaced with the attached **CLAIMS FILING AND APPREALS PROCEDURES** section.

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 Benefit Booklet to which this amendment is attached will remain in full force and effect. For contracts in effect on or after September 23, 2010, this amendment is effective on the Contract Date or Contract Anniversary.

Blue Cross and Blue Shield of Texas (BCBSTX)

By: 

President, Blue Cross and Blue Shield of Texas

CLAIM FILING PROCEDURES

Filing of Claims Required

Notice of Claim

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

Claim Forms

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

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

Who Files Claims

Providers that contract with BCBSTX and some other health care Providers (such as *ParPlan* Providers) will submit your claims directly to BCBSTX for services provided to you or any of your covered Dependents. At the time services are provided, inquire if they will file claim forms for you. To assist Providers in filing your claims, you should carry your Identification Card with you.

Contracting Providers

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

Non-Contracting Providers

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

Mail-Order Program

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

Participant-filed claims

- Medical Claims

If your Provider does not submit your claims, you will need to submit them to BCBSTX using a Subscriber–filed claim form provided by BCBSTX. Your Employer should have a supply of claim forms or you can obtain copies from the BCBSTX website. Follow the instructions on the reverse side of the form to complete the claim. Remember to file each Participant's expenses separately because any Deductibles, maximum benefits, and other provisions are applied to each Participant separately. Include itemized bills from the health care Providers, labs, etc., printed on their letterhead and showing the services performed, dates of service, charges, and name of the Participant involved.

- Prescription Drug Claims

  When you receive Covered Drugs dispensed from a non–Participating Pharmacy, a *Prescription Reimbursement Claim Form* must be submitted. This form can be obtained from the Carrier or your Employer. This claim form, accompanied by an itemized bill obtained from the Pharmacy showing the prescription services you received, should be mailed to the address shown below or on the claim form.

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

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

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

www.bcbstx.com

Where to Mail Completed Claim Forms

Medical Claims

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

Prescription Drug Claims

Blue Cross and Blue Shield of Texas
c/o Prime Therapeutics LLC
P. O. Box 14624
Lexington, KY 40512–4624

Mail Order Program

Blue Cross and Blue Shield of Texas
c/o PrimeMail Pharmacy
P. O. Box 650041
Dallas, Texas 75265–0041

Who Receives Payment

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

Except as provided in the section **Assignment and Payment of Benefits,** rights and benefits under the Plan are not assignable, either before or after services and supplies are provided.

Benefit Payments to a Managing Conservator

Benefits for services provided to your minor Dependent child may be paid to a third party if:

- the third party is named in a court order as managing or possessory conservator of the child; and
- BCBSTX has not already paid any portion of the claim.

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

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

An *Explanation of Benefits* summary is sent to you so you will know what has been paid.

When to Submit Claims

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

Receipt of Claims by BCBSTX

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

REVIEW OF CLAIM DETERMINATIONS

Claim Determinations

When BCBSTX receives a properly submitted claim, it has authority and discretion under the Plan to interpret and determine benefits in accordance with the Plan provisions. You have the right to seek and obtain a full and fair review by BCBSTX of any determination of a claim, any determination of a request for Preauthorization, or any other determination made by BCBSTX of your benefits under the Plan.

If a Claim Is Denied or Not Paid in Full

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

- The reasons for the determination;
- A reference to the benefit Plan provisions on which the determination is based, or the contractual, administrative or protocol basis for the determination;
- A description of additional information which may be necessary to perfect an appeal and an explanation of why such material is necessary;
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- An explanation of BCBSTX's internal review/appeals and external review processes (and how to initiate a review/appeal or external review)[and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal];
- In certain situations, a statement in non-English language(s) that written notice of claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by BCBSTX;

- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
- In the case of a denial of an urgent care clinical claim, a description of the expedited review procedure applicable to such claim. An urgent care claim decision may be provided orally, so long as a written notice is furnished to the claimant within 3 days of oral notification; and
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

Timing of Required Notices and Extensions

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

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

Urgent Care Clinical Claims*

Type of Notice or Extension	Timing
If your claim is incomplete, BCBSTX must notify you within:	**24 hours**
If you are notified that your claim is incomplete, you must then provide completed claim information to BCBSTX within:	**48 hours** after receiving notice
BCBSTX must notify you of the claim determination (whether adverse or not):	
if the initial claim is complete as soon as possible (taking into account medical exigencies), but no later than:	**72 hours**
after receiving the completed claim (if the initial claim is incomplete), within:	**48 hours**

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

Pre-Service Claims

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

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

Post-Service Claims

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

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

Concurrent Care

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

Claim Appeal Procedures

Claim Appeal Procedures - Definitions

An "**Adverse Benefit Determination**" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental/Investigational or not Medically Necessary or appropriate. If an ongoing course of treatment had been approved by BCBSTX and BCBSTX reduces or terminates such treatment (other than

by amendment or termination of the Employer's benefit Plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A rescission of coverage is also an Adverse Benefit Determination. A rescission does not include a termination of coverage for reasons related to non-payment of premium.

Expedited Clinical Appeals

If your situation meets the definition of an expedited clinical appeal, you may be entitled to an appeal on an expedited basis. An "expedited clinical appeal" is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care provider, as well as continued hospitalization. Before authorization of benefits for an ongoing course of treatment/continued hospitalization is terminated or reduced, BCBSTX will provide you with notice and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an expedited pre-service or concurrent clinical appeal, BCBSTX will notify the party filing the appeal, as soon as possible, but in no event later than 24 hours after submission of the appeal, of all the information needed to review the appeal. BCBSTX will render a decision on the appeal within 24 hours after it receives the requested information, but no later than 72 hours after the appeal has been received by BCBSTX.

How to Appeal an Adverse Benefit Determination

You have the right to seek and obtain a full and fair review of any determination of a claim, any determination of a request for Preauthorization, or any other determination made by BCBSTX in accordance with the benefits and procedures detailed in your Plan. An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care provider may appeal on his/her own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call BCBSTX at the number on the back of your Identification Card. If you believe BCBSTX incorrectly denied all or part of your benefits, you may have your claim reviewed. BCBSTX will review its decision in accordance with the following procedure:

- Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to BCBSTX to request a claim review. BCBSTX will need to know the reasons why you do not agree with the Adverse Benefit Determination. Send your request to:

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

- BCBSTX will honor telephone requests for information; however, such inquiries will not constitute a request for review.

- In support of your claim review, you have the option of presenting evidence and testimony to BCBSTX. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the claim review process.

  BCBSTX will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the review of your claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made

in order to give you a chance to respond. If the initial benefit determination regarding the claim is based in whole or in part on a medical judgement, the appeal determination will be made by a Physician associated or contracted with BCBSTX and/or by external advisors, but who were not involved in making the initial denial of your claim. Before you or your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by BCBSTX.

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

Timing of Appeal Determinations

BCBSTX will render a determination of the non-urgent concurrent or pre-service appeal as soon as practical, but in no event more than 30 days after the appeal has been received by BCBSTX.

BCBSTX will render a determination of the post-service appeal as soon as practical, but in no event more than 60 days after the appeal has been received by BCBSTX.

If You Need Assistance

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

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

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

Notice of Appeal Determination

BCBSTX will notify the party filing the appeal, you, and, if a clinical appeal, any health care provider who recommended the services involved in the appeal, by a written notice of the determination.

The written notice will include:

- The reasons for the determination;
- A reference to the benefit Plan provisions on which the determination is based, or the contractual, administrative or protocol basis for the determination;
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;

- An explanation of BCBSTX's external review processes (and how to initiate an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on external appeal;
- In certain situations, a statement in non-English language(s) that written notice of claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by BCBSTX;
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
- A description of the standard that was used in denying the claim and a discussion of the decision; and
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

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

How to Appeal a Final Internal Adverse Determination to an Independent Review Organization (IRO)

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

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

This procedure (not part of the complaint process) pertains only to appeals of Adverse Determinations. In addition, in life-threatening or urgent care circumstances, you are entitled to an immediate appeal to an IRO and are not required to comply with BCBSTX's appeal of an Adverse Determination process.

Any party whose appeal of an Adverse Determination is denied by BCBSTX may seek review of the decision by an IRO. At the time the appeal is denied, BCBSTX will provide you, your designated representative or Provider of record, information on how to appeal the denial, including the approved form, which you, your designated representative, or your Provider of record must complete. In life-threatening or urgent care situations, you, your designated representative, or your Provider of record may contact BCBSTX by telephone to request the review and provide the required information. For all other situations, you or your designated representative must sign the form and return to BCBSTX to begin the independent review process.

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

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

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

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

For more information about the IRO process, call Texas Department of Insurance (TDI) on the IRO information line at (888) TDI-2IRO (834-2476), or in Austin call (512) 322-3400.

Interpretation of Employer's Plan Provisions

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

Actions Against BCBSTX

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

AMENDMENT TO THE BENEFIT BOOKLET
REGARDING CHANGES TO YOUR GROUP HEALTH PLAN

The **Schedule of Coverage** in your benefit booklet is amended as follows:

Remove "Preauthorization is required" under Treatment of Chemical Dependency, Serious Mental Illness and Mental Health Care and replace with "Certain Services will require Preauthorization".

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Benefit Booklet to which this amendment is attached will remain in full force and effect. This amendment shall become effective on the Employer's Contract Anniversary date or on the Plan Year of the Employer's Group Health Plan.

Blue Cross and Blue Shield of Texas
(BCBSTX)

By: 

President, Blue Cross and Blue Shield of Texas

AMENDMENT TO THE BENEFIT BOOKLET
FOR WOMEN'S PREVENTIVE CARE SERVICES

Provisions in the Benefit Booklet, including any Amendments, are hereby changed as follows.

1. The **COVERED MEDICAL SERVICES** section of your Benefit Booklet is amended by adding the following information to the **Preventive Care Services**. The items listed below will not be subject to Coinsurance, Deductible, Copayment and/or dollar maximum if provided by Network Providers or Participating Pharmacies.

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

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

   Contraceptive drugs and devices covered under this benefit provision are listed on the Women's Preventive Health Services Fact Sheet. To determine if a specific drug or device is on the Women's Preventive Health Services Fact Sheet, you may access the website at www.bcbstx.com or contact Customer Service at the toll-free number on your Identification Card.

   Benefits are not available under this benefit provision for contraceptive drugs and devices not listed on the Women's Preventive Health Services Fact Sheet. You may, however, have coverage under other sections of this certificate, subject to any applicable Coinsurance, Copayments, Deductibles and/or benefit maximum.

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

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

   Benefits for Breastfeeding Support, Services and Supplies

   Benefits will be provided for breastfeeding counseling and support services when rendered by a Provider, during pregnancy and/or in the post-partum period. Benefits include the rental (or the purchase if more cost effective) of manual breast pumps, accessories and supplies. You may be required to pay the full amount and submit a claim form to BCBSTX with the itemized receipt for the manual breast pump, accessories and supplies. Visit the BCBSTX website at www.bcbstx.com to obtain a claim form.

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

2. The **MEDICAL LIMITATIONS AND EXCLUSIONS** section of your Benefit Booklet is amended by adding the following new exclusion:

   Any non-prescription contraceptive medications or devices for male use.

3. The **DEFINITIONS** section of your Benefit Booklet is amended by adding the following new definition:

   Health Care Practitioner means and advanced practice nurse, doctor of medicine, doctor of dentistry, physician assistant, doctor of osteopathy, doctor of podiatry, or other licensed person with prescription authority.

4. The **PHARMACY BENEFITS Limitations and Exclusions** section of your Benefit Booklet is amended:

   a. By modifying item 2 as indicated below:

      Devices or durable medical equipment of any type (even though such devices may require a Prescription Order,) such as, but not limited to, contraceptive devices, therapeutic devices, including support garments and other non-medicinal substances, artificial appliances, or similar devices (except disposable hypodermic needles and syringes for self-administered injections and those devices listed as Diabetes Supplies). NOTE: Coverage for female contraceptive devices and the rental or purchase of manual breast pumps is provided as indicated under the Medical Surgical Expense portion of this Plan.

   b. By adding the following new exclusion:

      Any non-prescription contraceptive medications or devices for male use.

5. If your group has certified that either the Temporary Enforcement Safe Harbor Disclosure or Religious Employer Exemption Disclosure applies to your group health plan you Benefit Booklet is amended by adding the applicable new section.

   Temporary Enforcement Safe Harbor Disclosure

   Your group has certified that its group health plan is established or maintained by an organization that satisfies all of the criteria for a one year temporary enforcement safe harbor ("Safe Harbor") from the Affordable Care Act requirement to cover certain contraceptive services without cost sharing under guidelines supported by the Health Resources and Services Administration. During this one-year period and provided your group qualifies for the Safe Harbor, coverage under your group health plan will not include such coverage of contraceptive services as set forth in the **Preventive Care Services** section of the **COVERED MEDICAL SERVICES**. Questions regarding the Safe Harbor should be directed to your group or the Plan Administrator.

   Religious Employer Exemption Disclosure

   Your group has certified that its group health plan is established or maintained by an organization that is a "religious employer" as defined in 45 C.F.R. 147.130(a)(1)(iv)(B) and qualifies for a religious employer exemption from the Affordable Care Act requirement to cover certain contraceptive services without cost sharing under guidelines supported by the Health Resources and Services Administration (Religious Employer Exemption"). Provided that your group is a religious employer and satisfies this Religious Employer Exemption, coverage under your group health plan will not include such coverage of contraceptive services as set forth in the **Preventive Care Services** section of the **COVERED MEDICAL SERVICES**. Questions regarding the Religious Employer Exemption should be directed to your group or the Plan Administrator.

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 Benefit Booklet to which this amendment is attached will remain in full force and effect.

For contracts in effect on or after August 1, 2012, this amendment is effective on the Contract Date or Contract Anniversary.

Blue Cross and Blue Shield of Texas (BCBSTX)

By: 

President, Blue Cross and Blue Shield of Texas

AMENDMENTS TO THE BENEFIT BOOKLET

Provisions in your Benefit Booklet, including any Amendments, are hereby changed as follows.

The **DEFINITIONS** section of your Benefit Booklet is amended by adding the following to the definition of **Allowable Amount**:

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

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Benefit Booklet to which this amendment is attached will remain in full force and effect. This amendment shall become effective on the Employer's Contract Anniversary Date or on the Plan Year of the Employer's Group Health Plan.

Blue Cross and Blue Shield of Texas (BCBSTX)

By
President, Blue Cross and Blue Shield of Texas

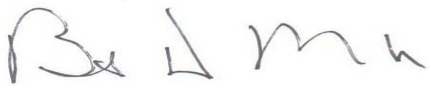
AMENDMENTS TO THE BENEFIT BOOKLET

Provisions in your Benefit Booklet, including any Amendments, are hereby changed as follows.

The **COVERED MEDICAL SERVICES** section of your Benefit Booklet is amended by deleting the current age limits indicated in the ***Benefits for Autism Spectrum Disorder*** subsection.

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Benefit Booklet to which this amendment is attached will remain in full force and effect. This amendment shall become effective on the Employer's Contract Anniversary Date or on the Plan Year of the Employer's Group Health Plan.

Blue Cross and Blue Shield of Texas (BCBSTX)

By 
President, Blue Cross and Blue Shield of Texas

AMENDMENT TO THE BENEFIT BOOKLET REGARDING CHANGES TO YOUR GROUP HEALTH COVERAGE

Provisions in the Benefit Booklet, including the Schedule of Coverage and any Amendments, are hereby changed as follows:

I. Speech and Hearing Services – If your plan includes a Hearing Aids dollar maximum, it is hereby deleted in its entirety, and replaced with the following:

Limited to one hearing aid per ear each 36-month period.

II. Cardiovascular Tests – The maximum benefit of $200 is removed in its entirety, and replaced with the following:

Maximum benefit of 1 test every 5 years.

III. The **HOW THE PLAN WORKS** section of your booklet is amended by deleting the **Preexisting Conditions Provision** subsection in its entirety.

IV. The **COVERED MEDICAL SERVICES** section of your booklet is amended by deleting the ***Benefits for Autism Spectrum Disorder*** subsection in its entirety and replacing it with the following:

Benefits for Autism Spectrum Disorder

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

Individuals providing treatment prescribed under that plan must be:

1. a Health Care Practitioner:

- who is licensed, certified, or registered by an appropriate agency of the state of Texas;
- whose professional credential is recognized and accepted by an appropriate agency of the United States; or
- who is certified as a provider under the TRICARE military health system; or

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

For purposes of this section, generally recognized services may include services such as:

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

Benefits for Autism Spectrum Disorder will not apply towards any maximum indicated on your Schedule of Coverage.

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

V. The **DEFINITIONS** section of your booklet is amended by adding the following to the definition of **Allowable Amount**:

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

VI. The **DEFINITIONS** section of your booklet is amended by deleting the definition of **Dependent** in its entirety and replacing it with the following:

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

Child means a natural child, a stepchild, an eligible foster child, an adopted child (including a child for whom you or your spouse is a party in a suit in which the adoption of the child is sought), under twenty-six (26) years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage, or any combination of those factors. A child of your child must be dependent on you for federal income tax purposes at the time of application of coverage for the child of your child is made under the Plan. A child not listed above whose primary residence is your household and to whom you are legal guardian or related by blood or marriage and who is dependent upon you for more than one-half of his support as defined by the Internal Revenue Code of the United States, is also considered a Dependent *child* under the Plan.

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

VII. The **DEFINITIONS** section of your booklet is amended by deleting the definition of **Late Enrollee** in its entirety and replacing it with the following:

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

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

1. The individual:
   a. Was covered under another Health Benefit Plan or self-funded Health Benefit Plan at the time the individual was eligible to enroll; and
   b. Declines in writing, at the time of initial eligibility, stating that coverage under another Health Benefit Plan or self-funded Health Benefit Plan was the reason for declining enrollment; and

c. Has lost coverage under another Health Benefit Plan or self-funded Health Benefit Plan as a result of:

(1) termination of employment;
(2) reduction in the number of hours of employment;
(3) termination of the other plan's coverage;
(4) termination of contributions toward the premium made by the Employer;
(5) the death of a spouse;
(6) divorce or terminate a domestic partnership;
(7) COBRA coverage or State continuation benefits have been exhausted;
(8) cessation of Dependent status;
(9) the Plan no longer offers any benefits to the class of similarly situated individuals that include the individual; or
(10) in the case of coverage offered through an HMO, the individual no longer resides, lives, or works in the service area of the HMO and no other benefit option is available; and

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

2. The request for enrollment is made by the individual within the 60th day after the date on which coverage under Medicaid or CHIP terminates.
3. The individual is employed by an Employer who offers multiple Health Benefit Plans and the individual elects a different Health Benefit Plan during an Open Enrollment Period.
4. A court has ordered coverage to be provided for a spouse under a covered Employee's plan and the request for enrollment is made not later than the 31st day after the date on which the court order is issued.
5. A court has ordered coverage to be provided for a child under a covered Employee's plan and the request for enrollment is made not later than the 31st day after the date on which the Employer receives the court order or notice of the court order.
6. A Dependent child is not a Late Enrollee if the child:
   a. Was covered under Medicaid or the Children's Health Insurance Program (CHIP) at the time the child was eligible to enroll;
   b. The employee declined coverage for the child in writing, stating that coverage under Medicaid or CHIP was the reason for declining coverage;
   c. The child has lost coverage under Medicaid or CHIP;
   d. The request for enrollment is made within the 60th day after the date on which coverage under Medicaid or CHIP terminates.
7. The individual has a change in family composition due to marriage or establishment of a domestic partnership, birth of a newborn child, placement as a foster child, adoption of a child, or because a Participant becomes a party in a suite for the adoption of a child, provided the request for enrollment is made no later than the 31st day after the date of the marriage or establishment of a domestic partnership, birth, adoption or date an insured becomes a party in a suite for the adoption.
8. The individual becomes a Dependent due to marriage or establishment of a domestic partnership, birth of a newborn child, placement as a foster child, adoption of a child, or because an insured becomes a party in a suite for the adoption of a child, provided the request for enrollment is made no later than the 31st day after the date of the marriage or establishment of a domestic partnership, birth, adoption or date an insured becomes a party in a suite for the adoption.

VIII. The **DEFINITIONS** section of your booklet is amended by deleting the definition of **Waiting Period** in its entirety and replacing it with the following:

Waiting Period means a period established by an Employer that must pass before an individual who is a potential enrollee in a Health Benefit Plan is eligible to be covered for benefits. No such Waiting Period may exceed 90 days unless permitted by applicable law. If our records show that your group

has a Waiting Period that exceeds the time period permitted by applicable law, then we reserve the right to begin your coverage on a date that we believe is within the required period. Regardless of whether we exercise that right, your group is responsible for your Waiting Period. If you have questions about your Waiting Period, please contact your Employer.

IX. The **PHARMACY BENEFITS** section of your booklet is amended by adding the following new subsection:

Preventive Care
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.

X. The **Limitations and Exclusions** portion of the **PHARMACY BENEFITS** section of your booklet is amended by deleting items 1. and 4. and replacing them in their entirety with the following:

1. Drugs which do not by law require a Prescription Order, except as indicated under ***Preventive Care*** in **PHARMACY BENEFITS**, from a Provider or authorized Health Care Practitioner (**except** insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and vaccinations administered through certain Participating Pharmacies, as shown on your Schedule of Coverage); and Legend Drugs or covered devices for which no valid Prescription Order is obtained.

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

XI. The **GENERAL PROVISION** section of your booklet is amended by deleting the **Amendments** portion in its entirety and replacing it with the following:

Amendments

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

XII. The **GENERAL PROVISION** section of your booklet is amended by adding the following:

Member Data Sharing

You may, under certain circumstances, as specified below, apply for and obtain, subject to any applicable terms and conditions, replacement coverage. The replacement coverage will be that which is offered by BCBSTX, or, if you do not reside in the Plan Service Area, by the Blue Cross and/or Blue Shield Plan whose service area covers the geographic area in which you reside. The circumstances mentioned above may arise in various circumstances, such as from involuntary termination of your

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

XIII. The **GENERAL PROVISION** section of your booklet is amended by deleting the **Coordination of Benefits** portion in its entirety and replacing it with the following:

Coordination of Benefits

Coordination of Benefits ("COB") applies when you have health care coverage through more than one Health Care Plan. The order of benefit determination rules govern the order in which each Health Care Plan will pay a claim for benefits. The Health Care Plan that pays first is called the primary plan. The primary plan must pay benefits in 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 rendered is considered to be both an Allowable Expense and a benefit paid. In addition, any expense that a health care provider or Physician by law or in accord with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

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

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

Health Care Plan does not include: disability income protection coverage; the Texas Health Insurance Pool; workers' compensation insurance coverage; hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage; supplemental benefit coverage; accident only coverage; specified accident coverage; school accident-type coverages

that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis; benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; a state plan under Medicaid; a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan; or other nongovernmental plan; or an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

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

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

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

1. The benefits of a Health Care Plan that does not have a coordination of benefits provision shall in all cases be determined before the benefits of this Plan.

2. If according to the rules set forth below in this section the benefits of another Health Care Plan that contains a provision coordinating its benefits with this Health Care Plan would be determined before the benefits of this Health Care Plan have been determined, the benefits of the other Health Care Plan will be considered before the determination of benefits under this Health Care Plan.

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

1. **Nondependent or Dependent.** The Health Care Plan that covers the person other than as a Dependent, for example as an employee, member, policyholder, subscriber, or retiree, is the primary plan, and the Health Care Plan that covers the person as a Dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Health Care Plan covering the person as a dependent and primary to the Health Care Plan covering the person as other than a dependent, then the order of benefits between the two plans is reversed so that the Health Care Plan covering the person as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other Health Care Plan is the primary plan. An example includes a retired employee.
2. **Dependent Child Covered Under More Than One Health Care Plan.** Unless there is a court order stating otherwise, Health Care Plans covering a Dependent child must determine the order of benefits using the following rules that apply.

    a. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
    (i) The Health Care Plan of the parent whose birthday falls earlier in the Calendar Year is the primary plan; or
    (ii) If both parents have the same birthday, the Health Care Plan that has covered the parent the longest is the primary plan.

b. For a Dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:
(i) if a court order states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Health Care Plan of that parent has actual knowledge of those terms, that Health Care Plan is primary. This rule applies to plan years commencing after the Health Care Plan is given notice of the court decree.
(ii) if a court order states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 2.a. must determine the order of benefits.
(iii) if a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 2.a. must determine the order of benefits.
(iv) if there is no court order allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
(I) the Health Care Plan covering the custodial parent;
(II) the Health Care Plan covering the spouse of the custodial parent;
(III) the Health Care Plan covering the noncustodial parent; then
(IV) the Health Care Plan covering the spouse of the noncustodial parent.

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

d. For a Dependent child who has coverage under either or both parents' Health Care Plans and has his or her own coverage as a Dependent under a spouse's Health Care Plan, paragraph 5. below applies.

e. In the event the Dependent child's coverage under the spouse's Health Care Plan began on the same date as the Dependent child's coverage under either or both parents' Health Care Plans, the order of benefits must be determined by applying the birthday rule in 2.a. to the Dependent child's parent(s) and the Dependent's spouse.

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

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

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

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

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

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

When benefits are available to you as primary benefits under Medicare, those benefits will be determined first and benefits under this Plan may be reduced accordingly. You must complete and submit consents, releases, assignments and other documents requested by BCBSTX to obtain or assure reimbursement by Medicare. If you fail to cooperate or enroll in Part B of the Medicare program, you will be liable for the amount of money We would have received if you had cooperated or enrolled.

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

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

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

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

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

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

XIV. The **GENERAL PROVISION** section of your booklet is amended by deleting the following from the **Termination of Coverage** provisions:

BCBSTX is not required to give you prior notice of termination of coverage. BCBSTX will not always know of the events causing termination until after the events have occurred.

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 Benefit Booklet to which this amendment is attached will remain in full force and effect. The above changes are effective on the Employer's Contract Date occurring on or after September 1, 2014.

Blue Cross and Blue Shield of Texas (BCBSTX)

By 
President, Blue Cross and Blue Shield of Texas

AMENDMENT TO THE BENEFIT BOOKLET REGARDING CHANGES TO YOUR GROUP HEALTH COVERAGE

Provisions in the Benefit Booklet and any Amendments, are hereby changed as follows:

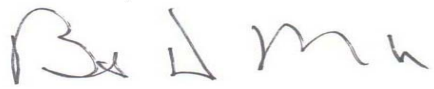
The **COVERED MEDICAL SERVICES** section of your booklet is amended to include the following additional preventive screening and is subject to Copayment/Coinsurance and any Deductibles.

> **Early detection test for ovarian cancer**. Benefits are available for a CA 125 blood test once every twelve months for female Members age eighteen (18) and older.

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

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Benefit Booklet to which this amendment is attached will remain in full force and effect. This amendment shall become effective on the Employer's Contract Anniversary Date or on the Plan Year of the Employer's Group Health Plan occurring on or after September 1, 2015.

Blue Cross and Blue Shield of Texas (BCBSTX)

By 

President, Blue Cross and Blue Shield of Texas

AMENDMENT TO THE BENEFIT BOOKLET REGARDING CHANGES TO YOUR GROUP HEALTH COVERAGE

Provisions in the Benefit Booklet, including the Schedule of Coverage and any Amendments, are hereby changed as follows:

1. The ***Treatment of Chemical Dependency*** section of the **SCHEDULE OF COVERAGE** portion of your benefit booklet is amended by adding "Hospital (facility)" to the following:

   Inpatient treatment must be provided in a Chemical Dependency Treatment Center / Hospital (facility)

2. The ***Preventive Care*** section of the **SCHEDULE OF COVERAGE** portion of your benefit booklet is amended by removing the following language:

   Routine well baby care exams, routine lab and x-ray, annual vision exams, annual hearing exams and immunizations. Note: Deductibles will not be applicable to immunizations of a Dependent child 7 years of age or younger

   Routine annual physical exam which includes but is not limited to diagnostic examination for early detection of cervical cancer (Pap smear) for female Participants age 18 and over

   Annual screening by low-dose mammography for the presence of occult breast cancer for female participants age 35 and older Outpatient facility or imaging centers

   Bone mass measurement for the detection of low bone mass to determine risk of osteoporosis and fractures associated with osteoporosis for Qualified Individuals (refer to your booklet for details) Outpatient facility or imaging centers.

   Routine annual physical exam

   For male Participants who are at least 50 years of age and asymptomatic or at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor:
   Diagnostic examination for the detection of prostate cancer and Prostate-specific antigen test used for the detection of prostate cancer

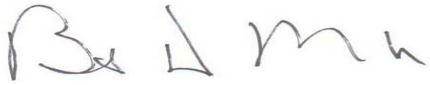
   The section will now indicate ***Preventive Care***. The Coinsurance Amount or Copayment Amount, as applicable, will not change as a result of removing this language and the In-Network Benefits and Out-of-Network Benefits columns are not being amended by this Amendment

3. The booklet is amended by removing the ***Notice of Creditable Coverage*** provision and all references to Creditable Coverage.

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 Benefit Booklet to which this amendment is attached will remain in full force and effect. The above changes are effective on the Employer's Contract Date occurring on or after September 1, 2015.

Blue Cross and Blue Shield of Texas (BCBSTX)

By 
President, Blue Cross and Blue Shield of Texas

AMENDMENT TO THE BENEFIT BOOKLET REGARDING CHANGES TO YOUR GROUP HEALTH COVERAGE

Provisions in the Benefit Booklet and any Amendments, are hereby changed as follows:

The **IMPORTANT NOTICE** section in the booklet is removed in its entirety and replaced with the attached **IMPORTANT NOTICE** section.

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Benefit Booklet to which this amendment is attached will remain in full force and effect. This amendment shall become effective on the Employer's Contract Anniversary Date or on the Plan Year of the Employer's Group Health Plan occurring on or after December 1, 2015.

Blue Cross and Blue Shield of Texas
(BCBSTX)
By:

President, Blue Cross and Blue Shield of Texas

IMPORTANT NOTICE

To obtain information or make a complaint:

- You may call Blue Cross and Blue Shield of Texas's toll-free telephone number for information or to make a complaint at:

1-800-521-2227

- You may also write to Blue Cross and Blue Shield of Texas at:

P. O. Box 660044
Dallas, Texas 75266-0044

- You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

- You may write the Texas Department of Insurance:

P. O. Box 149104
Austin, Texas 78714-9104
Fax: (512) 490-1007
Web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

- **PREMIUM OR CLAIM DISPUTES:** Should you have a dispute concerning your premium or about a claim, you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

- **ATTACH THIS NOTICE TO YOUR POLICY:** This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para presentar una queja:

- Usted puede llamar al número de teléfono gratuito de Blue Cross and Blue Shield of Texas's para obtener información o para presentar una queja al:

1-800-521-2227

- Usted también puede escribir a Blue Cross and Blue Shield of Texas:

P. O. Box 660044
Dallas, Texas 75266-0044

- Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al :

1-800-252-3439

- Usted puede escribir al Departamento de Seguros de Texas a:

P. O. Box 149104
Austin, Texas 78714-9104
Fax: (512) 490-1007
Sitio web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

- **DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES:** Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con la compañía primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

- **ADJUNTE ESTE AVISO A SU PÓLIZA:** Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

NOTICES

ALLOWABLE AMOUNT NOTICE

IMPORTANT TO YOUR COVERAGE

To pay less out-of-pocket expenses for your health care costs and to receive a higher level of benefits, it is to your advantage to use In-Network Providers. If you use contracting Providers, you will not be responsible for any charges over the Allowable Amount as determined by BCBSTX. What follows is an example of how much you would pay if you use an In-Network Provider and how much you would pay if you use a non-contracting Out-of-Network Provider. To make the example easier to follow, assume the Allowable Amount is the same (Note: In most cases, however, the non-contracting Allowable Amount will be less than the contracting Allowable Amount, meaning your total payment responsibility will be even greater):

EXAMPLE ONLY

	In-Network 90% of eligible charges $250 Deductible	**Out-of-Network** 80% of eligible charges $500 Deductible
Amount Billed	$20,000	$20,000
Allowable Amount	$5,000	$5,000
Deductible Amount	$250	$500
Plan's Coinsurance Amount	$4,275	$3,600
Your Coinsurance Amount	$475	$900
Non-Contracting Provider's additional charge to you	None	$15,000
YOUR TOTAL PAYMENT	**$725 to a Network Provider**	**$16,400 to a Non-Contracting Out-of-Network Provider**

Even when you consult an In-Network Provider, ask questions about the Providers rendering care to you "behind the scenes." If you are scheduled for surgery, for example, ensure that your Network surgeon will be using a Network facility for your procedure and a Network Provider for your anesthesia services.

If you choose to receive services from an Out-of-Network Provider, inquire if the Provider participates in a contractual arrangement with BCBSTX or any other Blue Cross and/or Blue Shield Plan. Providers who do not contract with BCBSTX may bill the patient for expenses over the Allowable Amount. [1]Refer to *PARPLAN* in the **HOW THE PLAN WORKS** portion of your booklet for more information.

NOTICE

Other Blue Cross and Blue Shield Plans Separate Financial Arrangements with Providers

BlueCard

Blue Cross and Blue Shield of Texas hereby informs you that other Blue Cross and Blue Shield Plans outside of Texas ("Host Blues") may have contracts similar to the contracts described above with certain Providers ("Host Blue Providers") in their service areas.

When you access health care services through BlueCard outside of Texas and from a Provider which does not have a contract with Blue Cross and Blue Shield of Texas, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your Covered Services, or
- The negotiated price that the Host Blue passes on to Blue Cross and Blue Shield of Texas.

To help you understand how this calculation would work, please consider the following example:

a. Suppose you receive covered medical services for an illness while you are on vacation outside of Texas. You show your identification card to the provider to let him or her know that you are covered by Blue Cross and Blue Shield of Texas.

b. The provider has negotiated with the Host Blue a price of $80, even though the provider's standard charge for this service is $100. In this example, the provider bills the Host Blue $100.

c. The Host Blue, in turn, forwards the claim to Blue Cross and Blue Shield of Texas and indicates that the negotiated price for the Covered Service is $80. Blue Cross and Blue Shield of Texas would then base the amount you must pay for the service – the amount applied to your deductible, if any, and your Coinsurance percentage – on the $80 negotiated price, not the $100 billed charge.

d. So, for example, if your Coinsurance is 20%, you would pay $16 (20% of $80), not $20 (20% of $100). You are not responsible for amounts over the negotiated price for a Covered Service.

PLEASE NOTE: The coinsurance percentage in the above example is for illustration purposes only. The example assumes that you have met your deductible and that there are no Copayments associated with the service rendered. Your deductible(s), Coinsurance and Copayment(s) are specified in this Certificate.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. Sometimes, however, it is an estimated price that takes into consideration the actual price increased or reduced to reflect aggregate payment from expected settlements, withholds, any other contingent payment arrangements and non–claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be charged as a billed charge reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over– or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate your liability calculation methods that differ from the usual BlueCard method noted above or require a surcharge, Blue Cross and Blue Shield of Texas would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

NOTICE

ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER HEALTH CARE PRACTITIONERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR HEALTH BENEFIT PLAN.

Form No. NTC–1731–0907

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided in your health plan insured by Blue Cross and Blue Shield of Texas. This notice is required by legislation to be provided to you. *If you have questions regarding this notice, call Blue Cross and Blue Shield of Texas at 1-800-521-2227 or write us at P.O. Box 660044, Dallas, Texas 75266-0044.*

Mastectomy or Lymph Node Dissection

Minimum Inpatient Stay: If due to treatment of breast cancer, any person covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of:

a. 48 hours following a mastectomy; and
b. 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the covered person receiving the treatment and the attending physician determine that a shorter period of inpatient care is appropriate.

Prohibitions: We may not (a) deny any covered person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours; (b) provide money payments or rebates to encourage any covered person to accept less than the minimum inpatient hours; (c) reduce or limit the amount paid to the attending physician, or otherwise penalize the physician, because the physician required a covered person to receive the minimum inpatient hours; or (d) provide financial or other incentives to the attending physician to encourage the physician to provide care that is less than the minimum hours.

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy

Coverage and/or benefits are provided to each covered person for reconstructive surgery after mastectomy, including:

a. All stages of the reconstruction of the breast on which mastectomy has been 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 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 Inpatient Hospital Expense or Medical-Surgical Expense, as shown on the Schedule of Coverage.

Prohibitions: We may not (a) offer the covered person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above; (b) condition, limit, or deny any covered person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above; or (c) reduce or limit the amount paid to the physician or provider, nor otherwise penalize, or provide a financial incentive to induce the physician or provider to provide care to a covered person in a manner inconsistent with the coverage and/or benefits shown above.

NOTICE OF CERTAIN MANDATORY BENEFITS

Examinations for Detection of Prostate Cancer

Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include:

a. A physical examination for the detection of prostate cancer; and

b. A prostate-specific antigen test for each covered male who is:

   (1) At least 50 years of age; or
   (2) At least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

Inpatient Stay Following Birth of a Child

For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

a. 48 hours following an uncomplicated vaginal delivery; and
b. 96 hours following an uncomplicated delivery by Cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to:

a. Give birth in a hospital or other health care facility; or
b. Remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours has expired, we will provide coverage for post-delivery care. Post-delivery care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. Care will be provided by a physician, registered nurse or other appropriately 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.

Prohibitions: We may not (a) modify the terms of this coverage based on any covered person requesting less than the minimum coverage required; (b) offer the mother financial incentives or other compensation for waiver of the minimum number of hours required; (c) refuse to accept a physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians; (d) reduce payments or reimbursements below the usual and customary rate; or (e) penalize a physician for recommending inpatient care for the mother or the newborn child.

Coverage of Tests for Detection of Human Papillomavirus 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 cervical cancer. Coverage required under this section includes at a minimum a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

Texas Department of Insurance Notice

- You have the right to an adequate network of preferred providers (also known as "network providers").

  - If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.

  - If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network deductible and out-of-pocket maximum.

- You have the right, in most cases, to obtain estimates in advance:

  - from out-of-network providers of what they will change for their services; and

  - from your insurer of what it will pay for the services.

- You may obtain a current directory of preferred providers at the following website: www.bcbstx.com or by calling the Customer Service number on the back of your ID card for assistance in finding available preferred providers. If the directory is materially inaccurate, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.

- If you are treated by a provider or hospital that is not a preferred provider, you may be billed for anything not paid by the insurer.

- If the amount you owe to an out-of-network hospital-based radiologist, anesthesiologist, pathologist, emergency department physician, neonatologist or assistant surgeon is greater than $500 (not including your copayment, coinsurance, and deductible responsibilities) for services received in a network hospital, you may be entitled to have the parties participate in a teleconference, and if the result is not to your satisfaction, in a mandatory mediation at no cost to you. You can learn more about mediation at the Texas Department of Insurance website: www.tdi.texas.gov/consumer/cpmmediation.html.

NOTICE

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

INTRODUCTION

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

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

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

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

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

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

WHEN IS COBRA COVERAGE AVAILABLE?

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

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

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

HOW IS COBRA COVERAGE PROVIDED?

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

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

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

DISABILITY EXTENSION OF 18–MONTH PERIOD OF CONTINUATION COVERAGE

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

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

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

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

PLAN CONTACT INFORMATION

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

BlueCross BlueShield of Texas

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