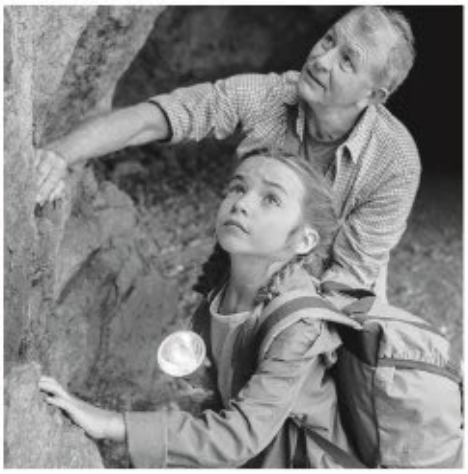
Administered by:

BlueCross BlueShield of Texas




Your Health Care Benefits Program

Managed Health Care

City of Corpus Christi
Account #242772
Group #242773 – CDHP Public Safety Plan

October 1, 2025

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SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Deductibles		
• Plan Year Deductible *Applies to all Eligible Expenses*	$3,300 – per individual $6,000 – per family	$5,000 – per individual $10,000 – per family
Out-of-Pocket Maximum *Includes Plan Year Deductible*	$3,300 – per individual $6,000 – per family	$7,000 – per individual $14,000 – per family
Inpatient Hospital Expenses		
All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	100% of Allowable Amount after Plan Year Deductible	70% of Allowable Amount after Plan Year Deductible
Newborn Admission only preventive or routine newborns care covered prior to deductible		
	No penalty for failure to obtain Prior Authorization for services	$250 penalty for failure to obtain Prior Authorization for services
Medical-Surgical Expenses		
• Office visit/consultation including lab and x-rays • Inpatient visits and Certain Diagnostic Procedures • Physician surgical services in any setting • Home Infusion Therapy • Allergy Injections (without office visit) • Independent Lab & X-ray	100% of Allowable Amount after Plan Year Deductible	70% of Allowable Amount after Plan Year Deductible
Extended Care Expenses (Certain services will require Prior Authorization.)		
• Skilled Nursing Facility	100% of Allowable Amount after Plan Year Deductible	70% of Allowable Amount after Plan Year Deductible
	25 days maximum per Plan Year	
• Home Health Care	100% of Allowable Amount after Plan Year Deductible	70% of Allowable Amount after Plan Year Deductible
	60 visits maximum per Plan Year	
• Hospice Care	100% of Allowable Amount after Plan Year Deductible	70% of Allowable Amount after Plan Year Deductible
	Unlimited	

SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Mental Health Care/Serious Mental Illness/Treatment of Substance Use Disorder (SUD) (Certain services will require Prior Authorization.)		
Inpatient Services		
• Hospital Services (facility)	100% of Allowable Amount after Plan Year Deductible	70% of Allowable Amount after Plan Year Deductible
• Behavioral Health Practitioner Services	100% of Allowable Amount after Plan Year Deductible	70% of Allowable Amount after Plan Year Deductible
Outpatient Services		
• Behavioral Health Practitioner Expenses (office setting)	100% of Allowable Amount after Plan Year Deductible	70% of Allowable Amount after Plan Year Deductible
• Other Outpatient Services	100% of Allowable Amount after Plan Year Deductible	70% of Allowable Amount after Plan Year Deductible
Emergency Care		
Accidental Injury & Emergency Care (including Accidental Injury, Emergency and non-emergency Care for Behavioral Health Services)		
• Facility Charges	100% of Allowable Amount after Plan Year Deductible	
• Lab & X-ray without emergency room or treatment room	100% of Allowable Amount after Plan Year Deductible	
• Physician Charges	100% of Allowable Amount after Plan Year Deductible	
Non-Emergency Care		
• Facility Charges	100% of Allowable Amount after Plan Year Deductible	70% of Allowable Amount after Plan Year Deductible
• Physician Charges	100% of Allowable Amount after Plan Year Deductible	70% of Allowable Amount after Plan Year Deductible
Urgent Care Services		
• Urgent Care Center visit - including lab & x-ray services (excluding Certain Diagnostic Procedures)	100% of Allowable Amount after Plan Year Deductible	70% of Allowable Amount after Plan Year Deductible
Ambulance Services	100% of Allowable Amount after Plan Year Deductible	
Retail Health Clinic	100% of Allowable Amount after Plan Year Deductible	70% of Allowable Amount after Plan Year Deductible

SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Telehealth		
• Primary Care telehealth/telemedicine visit/consultation	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
• Primary Care telehealth/telemedicine visit/consultation for treatment of Behavioral Health	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
• Specialty telehealth/telemedicine visit/consultation	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Virtual Visit		
• Medical	100% of Allowable Amount after $10 Copayment Amount	Not Applicable
• Behavioral Health	100% of Allowable Amount after $10 Copayment Amount	Not Applicable
Preventive Care Services • 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") • Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved • Evidence-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 • With respect to women, such additional preventive care and screenings, not described in the first bullet above, as provided for in comprehensive guidelines supported by the HRSA • Routine physical examinations, well baby care, immunizations and routine lab • Routine X-Rays, Routine EKG, Routine Diagnostic Medical Procedures (Independent Lab & X-Ray Provider)	100% of Allowable Amount	70% of Allowable Amount after Plan Year Deductible

SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Preventive Care Services (Cont'd)		
• Colonoscopy Professional (physician charges)	100% of Allowable Amount	70% of Allowable Amount after Plan Year Deductible
• Colonoscopy facility charges		
• Healthy diet counseling and obesity screening/counseling		
• Immunizations Birth up to age 6	100% of Allowable Amount	100% of Allowable Amount
Other Routine Services		
• Routine X-Rays, Routine EKG, Routine Diagnostic Medical Procedures, routine digital rectal exam, routine prostate test	100% of Allowable Amount	70% of Allowable Amount after Plan Year Deductible
• Annual Hearing Examination	100% of Allowable Amount after $30 Copayment Amount	70% of Allowable Amount after Plan Year Deductible
• Annual Vision Examination	100% of Allowable Amount after $30 Copayment Amount	70% of Allowable Amount after Plan Year Deductible
Hearing Services	100% of Allowable Amount after Plan Year Deductible	70% of Allowable Amount after Plan Year Deductible
	1 per ear per lifetime for bone anchored hearing aids	
	Limited to $2,500 per ear per 36-month period hearing aids (This limit does not apply to bone anchored hearing aids)	
Speech Therapy**	100% of Allowable Amount after Plan Year Deductible	70% of Allowable Amount after Plan Year Deductible
	30 visits maximum per Plan Year	
**Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any speech services visits maximum.		
Cognitive Rehabilitation Therapy	100% of Allowable Amount after Plan Year Deductible	70% of Allowable Amount after Plan Year Deductible
	30 visits maximum per Plan Year	
Post Cochlear Implant Aural Therapy	100% of Allowable Amount after Plan Year Deductible	70% of Allowable Amount after Plan Year Deductible
	30 visits maximum per Plan Year	

SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Pulmonary Rehabilitation Therapy	100% of Allowable Amount after Plan Year Deductible	70% of Allowable Amount after Plan Year Deductible
	30 visits maximum per Plan Year	
Cardiac Rehabilitation Therapy	100% of Allowable Amount after Plan Year Deductible	70% of Allowable Amount after Plan Year Deductible
	30 visits maximum per Plan Year	
Chiropractic Services	100% of Allowable Amount after Plan Year Deductible	70% of Allowable Amount after Plan Year Deductible
	35 visits maximum per Plan Year	
• Airrosti Provider	100% of Allowable Amount after Plan Year Deductible	70% of Allowable Amount after Plan Year Deductible
	30 visits maximum per Plan Year	
Physical Medicine Services* **	100% of Allowable Amount after Plan Year Deductible	70% of Allowable Amount after Plan Year Deductible
	30 visits maximum per Plan Year	
***Benefits for Autism Spectrum disorder will not apply towards and are not subject to any Physical Medicine Services visits maximum.		
Occupational Therapy	100% of Allowable Amount after Plan Year Deductible	70% of Allowable Amount after Plan Year Deductible
	30 visits maximum per Plan Year	
Temporomandibular Joint (TMJ)	100% of Allowable Amount after Plan Year Deductible	Not Covered
	Limited to $10,000 per lifetime maximum	
Wigs	100% of Allowable Amount after Plan Year Deductible	70% of Allowable Amount after Plan Year Deductible
	Replacement is limited to once every 3 Years	
	Limited to $1,500 per lifetime maximum	
Obesity Surgery	100% of Allowable Amount after Plan Year Deductible	70% of Allowable Amount after Plan Year Deductible
	Limited to $20,000 per lifetime maximum	
Ostomy Supplies (professional supplies only)	100% of Allowable Amount after Plan Year Deductible	70% of Allowable Amount after Plan Year Deductible

SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Diagnostic Colonoscopies (Ancillary service)	100% of Allowable Amount after Plan Year Deductible	Not Covered
	Limited to one per Plan Year	
Diagnostic Mammograms (Ancillary service)	100% of Allowable Amount after Plan Year Deductible	Not Covered

* Therapy visits beyond the listed maximums may be available based on medical necessity. The ordering physician can send in treatment plans, progress reports, goals and any other pertinent medical records and request additional visits.

SCHEDULE OF COVERAGE

Plan Provisions Blue Distinction	Blue Distinction + Designated Center	Blue Distinction Designated Center	In-Network Benefits	Out-of-Network Benefits
Bariatric Surgery	80% of Allowable Amount after Plan Year Deductible	80% of Allowable Amount after Plan Year Deductible	Not Covered	Not Covered
	Limited to $20,000 per lifetime maximum			
Transplants	80% of Allowable Amount after Plan Year Deductible	80% of Allowable Amount after Plan Year Deductible	Not Covered	Not Covered
	Limited to $25,000 per lifetime maximum for bone marrow donor research			

SCHEDULE OF COVERAGE

Dependent Eligibility

Dependent Child Age Limit to age 26.

Dependent children are eligible for Maternity Care benefits.

Preexisting Conditions

Preexisting conditions are covered immediately.

INTRODUCTION

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

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

The terms "you" and "your" as used in this Benefit Booklet refer to the Employee.

Managed Health Care - In-Network Benefits

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

If you choose a Network Provider, the Provider will bill the Claim Administrator - 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 the Claim Administrator, or
- Other contractually determined payment amounts.

You are responsible for paying any Deductibles and Co-Share Amounts. The Deductibles and Co-Share will be applied to the Out-of-Pocket Maximum. 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 paying…

- Billed charges above the Allowable Amount as determined by the Claim Administrator,
- Co-Share Amounts and Deductibles, which will be applied to the Out-of-Pocket Maximum,
- Limited or non-covered services, and
- Failure to obtain Prior Authorization penalty.

Important Contact Information

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

Customer Service Helpline

Customer Service Representatives can:

- Identify your Plan Service Area
- Give you information about Network and *ParPlan* Providers
- 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 Plan
- Record comments about Providers

Benefits Value Advisor (BVA)

The Benefit Value Advisor (BVA) program has been established to assist Participants in maximizing their benefits under the Plan. Benefit Value Advisors are specially-trained customer service representatives who assist Participants by comparing cost and providing information on Participating Providers for certain types of health care services. A BVA helps Participants navigate their benefits.

In addition to calling the Benefit Value Advisors, Participants may have other call requirements. A call to BVA does not satisfy any other call requirements Participants may have.

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/Substance Use Disorder Prior Authorization Helpline

To satisfy Prior Authorization requirements for Participants seeking treatment for Behavioral Health Services, Mental Health Care, Serious Mental Illness, and Substance Use Disorder, you, your Behavioral Health Practitioner, or a family member may call the Mental Health/Substance Use Disorder Prior Authorization Helpline at any time, day or night.

Medical Prior Authorization Helpline

To satisfy all medical Prior Authorization requirements for inpatient Hospital Admissions, Extended Care Expenses, or Home Infusion Therapy, call the Medical Prior Authorization 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 the person becomes an Employee or a Dependent and is in a class eligible to be covered under the Plan as determined by your Employer or the Plan Administrator. 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*** subsection for a new Dependent of an Employee already having coverage under the Plan.

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

Employee Eligibility

Any person eligible under this Plan as determined by your Employer or the Plan Administrator and covered by the Employer's previous Health Benefit Plan on the date prior to the Plan Effective Date, including any person who has continued group coverage under applicable federal or state law, is eligible on the Plan Effective 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 as determined by your Employer or the Plan Administrator.

If you are a retired Employee, you may continue your coverage under the Plan, but only if you were covered under the Employer's Health Benefit Plan as an Employee on the date of retirement.

Dependent Eligibility

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

1. Your spouse;
2. A child under the limiting age shown in your Schedule of Coverage;
3. A child of your child who is your Dependent for federal income tax purposes at the time application for coverage of the child is made and legal dependent;
4. Any other child included as an eligible Dependent under the Plan.

A detailed description of Dependent is in the **DEFINITIONS** section of this Benefit Booklet. An Employee must be covered first in order to cover their eligible Dependents. No Dependent shall be covered hereunder prior to the Employee's Effective Date. If you are married to another Employee, you may not cover your spouse as a Dependent, and only one of you may cover any Dependent children.

Effective Dates of Coverage

In order for an Employee's coverage to take effect, the Employee must submit written 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 Plan 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 Claim Administrator through the Plan Administrator.

If you apply for coverage and make the required contributions for yourself or for yourself and your eligible Dependents and if you:

1. Are eligible on the Plan Effective Date and the application is received by the Claim Administrator through the Plan Administrator prior to or within 31 days following such date, your coverage will become effective on the Plan Effective Date;

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

3. Become eligible after the Plan Effective Date and if the application is received by the Claim Administrator through the Plan Administrator within the first 31 days following your Eligibility Date, the coverage will become effective in accordance with eligibility information provided by your Employer.

Effective Dates - Delay of Benefits Provided

Coverage becomes effective for you and/or your Dependents on the Plan Effective 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 Plan Effective Date, your coverage is effective on the Plan Effective Date. However, if this Plan 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 Plan Anniversary Date.

Loss of Other Health Insurance Coverage

An Employee who is eligible, but not enrolled for coverage under the terms of the Plan (and/or 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 was 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. Exhaustion of continuation under Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended; 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 Plan Month following receipt of the application by the Claim Administrator through the Plan Administrator.

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 Children's Health Insurance Program (CHIP), Chapter 62, Health and Safety Code, is not a Late Enrollee provided appropriate enrollment application/change forms and applicable contributions are received by the Claim Administrator 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 Medicaid Program or enrolled in CHIP, and who is a participant in the 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 Claim Administrator receives (i) written notice from the Texas Health and Human Services Commission, or (ii) enrollment forms, from you, provided such forms and applicable contributions are received by the Claim Administrator 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. For coverage to continue beyond this time, you must notify the Claim Administrator through the Plan Administrator within 31 days of birth and pay any required contributions 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 Claim Administrator is notified through the Plan Administrator after that 31-day period, the newborn child's coverage will become effective on the Plan Anniversary Date 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 Claim Administrator through the Plan Administrator must receive all necessary forms and the required contributions 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 Claim Administrator through the Plan Administrator after that 31-day period, the child's coverage will become effective on the Plan Anniversary Date 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 Claim Administrator through the Plan Administrator must receive all necessary forms and the required contributions within the 31-day period. If you notify the Claim Administrator through the Plan Administrator after that 31-day period, the Dependent child's coverage will become effective on the Plan Anniversary Date following your Employer's next Open Enrollment Period.

4. ***Other Dependents***
   Written application must be received within 31 days of the date that a spouse or child first qualifies as a Dependent. If the written application is received within 31 days, coverage will become effective on the date the child or spouse 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 Plan Anniversary Date following your Employer's next Open Enrollment Period.

   If you ask that your Dependent be provided health care coverage after having canceled their coverage while your Dependent was still entitled to coverage, your Dependent's coverage will become effective in accordance with the provisions of the Plan.

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, and a newborn child, adopted child, or child involved in a suit for adoption. If the written application is received within 31 days of the birth, adoption, or suit for adoption, coverage for the child, you, or your spouse will become effective on the date of the birth, adoption, or date suit for adoption is sought.

If you marry 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. If the written application is received within 31 days of the marriage, coverage for you and your spouse will become effective on the first day of the month following receipt of the application by the Claim Administrator through the Plan Administrator.

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 written 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.

Enrollment Application/Change Form

Use this form to...

- Notify the Plan of a change to your name
- Add Dependents
- Drop Dependents
- Cancel all or a portion of your coverage
- Notify the Plan 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, or by calling the Claim Administrator's 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 Claim Administrator through the Plan Administrator 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, 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 *Enrollment Application/Change Form* and the coverage of the Dependent will become effective as described in ***Dependent Enrollment Period***.
- When you divorce or your child reaches the age indicated on your Schedule of Coverage as "Dependent Child Age Limit," 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, refund of contributions will not be made for any period before the date of notification. If benefits are paid prior to notification to the Claim Administrator by the Plan Administrator, refunds will be requested.

  Please refer to the **Continuation of Group Coverage - Federal** subsection in this Benefit Booklet for additional information.

HOW THE PLAN WORKS

Allowable Amount

The Allowable Amount is the maximum amount of benefits the Claim Administrator will pay for Eligible Expenses you incur under the Plan. The Claim Administrator has established an Allowable Amount for Medically Necessary services, supplies, and procedures provided by Providers that have contracted with the Claim Administrator or any other Blue Cross and/or Blue Shield Plan, and Providers that have not contracted with the Claim Administrator 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 the Claim Administrator, you will be responsible for any difference between the Claim Administrator's 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, any applicable Deductibles and Co-Share amounts.

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

Case Management

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

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

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

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 (not a contracting Provider)***
• You receive the higher level of benefits (In-Network Benefits) • You are not required to file claim forms • You are not balance billed; Network Providers will not bill for costs exceeding the Claim Administrator's Allowable Amount for covered services • Your Provider will obtain Prior Authorization for 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 Claim Administrator's Allowable Amount for covered services • In most cases, *ParPlan* Providers will obtain Prior Authorization for 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 Claim Administrator's Allowable Amount for covered services • You must obtain Prior Authorization for necessary services

Identification Card

The Identification Card tells Providers that you are entitled to benefits under your Employer's Health Benefit Plan. 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 Claim Administrator.
- ***Your group number***. This is the number assigned to identify your Employer's Health Benefit Plan with the Claim Administrator.
- ***Important telephone numbers***.

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

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

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

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

   a. Use of the Identification Card prior to your Effective Date;
   b. Use of the Identification Card after your date of termination of coverage under the Plan;
   c. Obtaining other benefits for persons not covered under the Plan;
   d. Obtaining other benefits that are not covered under the Plan.

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

   a. Denial of benefits;
   b. Cancellation of coverage under the Plan for **all** Participants under your coverage;
   c. Recoupment from you or any of your covered Dependents of any benefit payments made;
   d. Pre-approval of medical services for all Participants receiving benefits under your coverage;
   e. Notice to proper authorities of potential violations of law or professional ethics.

Medical Necessity

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

ParPlan

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

- File all claims for you,
- Accept the Claim Administrator'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,
- Co-Share 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 the *ParPlan*, please contact the Claim Administrator's Customer Service Helpline.

Preexisting Conditions Provision

Benefits for Eligible Expenses incurred for treatment of a preexisting condition will be available immediately with no preexisting condition Waiting Period.

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.
- 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, any applicable Deductibles and Co-Share Amounts**.

UTILIZATION MANAGEMENT

Utilization Management

Utilization management may be referred to as Medical Necessity reviews, utilization review (UR) or medical management reviews. A Medical Necessity review for a procedure/service, inpatient admission, and length of stay is based on BCBSTX medical policy and/or level of care review criteria. Medical Necessity reviews may occur prior to services rendered, during the course of care, or after care has been completed for a Post-Service Medical Necessity Review. Some services may require a Prior Authorization before the start of services, while other services will be subject to a Post-Service Medical Necessity Review. If requested, services normally subject to a Post-Service Medical Necessity Review may be reviewed for Medical Necessity prior to the service through a Recommended Clinical Review.

Refer to the definition of Medical Necessity or Medically Necessary in the **DEFINITIONS** section of this Benefit Booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

Prior Authorization Requirements

Prior Authorization establishes in advance the Medical Necessity or Experimental/Investigational nature of certain care and services covered under this Plan. It ensures that the care and services described below for which you have obtained Prior Authorization will not be denied on the basis of Medical Necessity or Experimental/Investigational. However, Prior Authorization does not guarantee payment of benefits.

Coverage is always subject to other requirements of the Plan, such as limitations and exclusions, payment of contributions, and eligibility at the time care and services are provided.

The following types of services require Prior Authorization:

- All inpatient Hospital Admissions,
- Extended Care Expenses,
- Home Health,
- Home Infusion Therapy,
- Home Hospice,
- Transplants and transplant evaluations,
- Outpatient Surgery performed at a Hospital or Ambulatory Surgical Facility for Out-of-Network services only,
- Non-emergency Air Ambulance: Fixed Wing;
  Please refer to Fixed-Wing Air Ambulance definition in the **DEFINITIONS** section of this Benefit Booklet.

  Ears, Nose and Throat (ENT):
  - Bone conduction hearing aids,
  - Cochlear implant,
  - Nasal and sinus surgery,

  Gastroenterology (Stomach):
  - Gastric electrical stimulation (GES),

  Neurology:
  - Deep brain stimulation,
  - Sacral nerve neuromodulation/stimulation,

  Surgical Procedures:
  - Outpatient Surgery Jaw,
  - Outpatient Breast,
  - Surgical deactivation of headache trigger sites,

Specialty Pharmacy:

- Specialty Pharmacy Medications covered by Medical Benefits including Infusion Site of Care, Medical Oncology & Supportive Care and Provider Administered Drug Therapies,

Wound Care:

- Hyperbaric oxygen **(**HBO2**)** therapy-systemic.

- All inpatient treatment of Mental Health Care/Serious Mental Illness including partial hospitalization programs and treatment received at Residential Treatment Centers,
- All inpatient treatment of Substance Use Disorder (SUD) including partial hospitalization programs and treatment received at Residential Treatment Centers, and
- If you transfer to another facility or to or from a specialty unit within the facility.
- The following outpatient treatment of Mental Health Care, Serious Mental Illness and Substance Use Disorder (SUD):
  - Psychological Testing or Neuropsychological Testing in some cases (BCBSTX will notify your Provider if Prior Authorization is required for these testing services),
  - Applied Behavioral Analysis (Please see coverage details as described in the Benefits for Autism Spectrum Disorder in the **COVERED MEDICAL SERVICES** section of this Benefit Booklet),
  - Electroconvulsive therapy,
  - Intensive Outpatient Program, and
  - Repetitive Transcranial Magnetic Stimulation.

For specific details about the Prior Authorization requirement for the above referenced outpatient procedures/services, please call Customer Service at the number on the back of your Identification Card. BCBSTX reserves the right to no longer require Prior Authorization during the Calendar Year. Updates to the list of services requiring Prior Authorization may be confirmed by calling Customer Service.

In-Network Benefits will be available if you use a Network Provider or Network Specialty Care Provider. In-Network Providers will obtain Prior Authorization of services for you, when required.

If you elect to use Out-of-Network Providers for services and supplies available In-Network, Out-of-Network Benefits will be paid.

However, if care is not available from Network Providers as determined by the Claim Administrator, and the Claim Administrator acknowledges your visit to an Out-of-Network Provider **prior to the visit**, In-Network Benefits will be paid; otherwise, Out-of-Network Benefits will be paid and the claim will have to be resubmitted for review and adjusted, if appropriate.

Your Network Provider is required to obtain Prior Authorization for inpatient Hospital admissions. You are responsible for satisfying all other Prior Authorization requirements. This means that you must ensure that you, an authorized representative, your Physician, Behavioral Health Practitioner or Provider of services must comply with the guidelines below. Failure to obtain Prior Authorization of services will require additional steps and/or benefit reductions as described in the subsection entitled *Failure to Obtain Prior Authorization*.

Prior Authorization for Inpatient Hospital Admissions

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

Your Network Provider is required to obtain Prior Authorization for any inpatient admissions. If Prior Authorization is not obtained, the Network Provider will be sanctioned based on BCBSTX's contractual agreement with the Provider, and you will be held harmless for the Provider sanction.

If the Physician or Provider of services is not a Network Provider then you, your Physician, the participating Provider of services, or an authorized representative should obtain Prior Authorization by the Plan by calling one of the toll-free numbers shown on the back of your Identification Card. The call should be made between 6:00 a.m. and 6:00 p.m., Central Time, on business days and 9:00 a.m. and 12:00 p.m., Central Time on Saturdays, Sundays and

legal holidays. Calls made after these hours will be recorded and returned no later than 24 hours after the call is received. We will follow-up with your Provider's office. After working hours or on weekends, please call the **Medical Prior Authorization Helpline** toll-free number listed on the back of your Identification Card. Your call will be recorded and returned the next working day. A benefits management nurse will follow up with your Provider's office. All timelines for Prior Authorization requirements are provided in keeping with applicable state and federal regulations.

In-Network Benefits will be available if you use a Network Provider or Network Specialty Care Provider. If you elect to use Out-of-Network Providers for services and supplies available In-Network, Out-of-Network Benefits will be paid. In-Network and Out-of-Network Providers may obtain Prior Authorization of services for you, when required, but it is your responsibility to ensure Prior Authorization 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 Prior Authorization of an inpatient Hospital Admission is obtained, a length-of-stay is assigned. If you require a longer stay, your Provider may seek an extension for the additional days. Benefits will not be available for room and board charges for medically unnecessary days. For more information regarding lengths of stay, refer to the **Length of Stay/Service Review** subsection of this Benefit Booklet.

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

- Maternity Care
  - 48 hours following an uncomplicated vaginal delivery
  - 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 Prior Authorization from BCBSTX for a length of stay less than 48 hours (or 96 hours) for Maternity Care or less than 48 hours (or 24 hours) for Treatment of Breast Cancer. If you require a longer stay, you or your Provider must seek an extension for the additional days by obtaining Prior Authorization from BCBSTX.

Prior Authorization for Extended Care Expenses and Home Infusion Therapy
Prior Authorizations for Extended Care Expenses and Home Infusion Therapy may be obtained by having the agency or facility providing the services contact the Claim Administrator to request Prior Authorization. The request should be made:

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

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

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

Prior Authorization for Mental Health Care, Serious Mental Illness, and Treatment of Substance Use Disorder
In order to receive maximum benefits, you must obtain Prior Authorization from the Plan for all inpatient treatment for Mental Health Care, Serious Mental Illness, and Substance Use Disorder. Prior Authorization is also required for certain outpatient services. Outpatient services requiring Prior Authorization include psychological testing,

neuropsychological testing, repetitive transcranial magnetic stimulation, Intensive Outpatient Programs, applied behavior analysis and outpatient electroconvulsive therapy. Prior Authorization is not required for therapy visits to a Physician, Behavioral Health Practitioner and/or Professional Other Provider.

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

In-Network Benefits will be available if you use a Network Provider or Network Specialty Care Provider. If you elect to use Out-of-Network Providers for services and supplies available In-Network, Out-of-Network Benefits will be paid. In-Network and Out-of-Network Providers may obtain Prior Authorization of services for you, when required, but it is your responsibility to ensure Prior Authorization 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 you obtain Prior Authorization for a treatment or service, a length of stay or length of service is assigned. If you require a longer stay or length of service, your Behavioral Health Practitioner may seek an extension for the additional days or visits. Benefits will not be available for medically unnecessary treatments or services.

Length of Stay/Service Review

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

Upon completion of the preadmission or emergency admission review, BCBSTX will send you a letter confirming that you or your representative called BCBSTX. A letter authorizing a length of service or length of stay will be sent to you, your Physician, Provider of services, and/or the Hospital or facility.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care services are Medically Necessary. If the extension is determined not to be Medically Necessary, the coverage for the length of stay/service will not be extended, except as otherwise described in the **CLAIM FILING AND APPEALS PROCEDURES** section of this Benefit Booklet.

A length of stay/service review, also known as a concurrent Medical Necessity review, is when you, your Provider, or other authorized representative may submit a request to BCBSTX for continued services. If you, your Provider or authorized representative requests to extend care beyond the approved time limit and it is a request involving Urgent Care or an ongoing course of treatment, BCBSTX will make a determination on the request as soon as possible (taking into account medical exigencies) but no later than 72 hours after it receives the initial request, or within 48 hours after it receives the missing information (if the initial request is incomplete).

Recommended Clinical Review Option

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

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

In the event a Recommended Clinical Review determines the proposed services are not Medically Necessary, you have the right to file an appeal as described in the CLAIM FILING AND APPEALS PROCEDURES section. All appeal and review requirements related to Medical Necessity determinations, including independent review, apply to services where your Provider requests a Recommended Clinical Review.

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

General Provisions Applicable to All Recommended Clinical Reviews

1. **No Guarantee of Payment**

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

2. **Request for Additional Information**

   The Recommended Clinical Review process may require additional documentation from your Provider or pharmacist. In addition to the written request for a Recommended Clinical Review, the Provider or pharmacist may be required to include pertinent documentation explaining the proposed services, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by BCBSTX to make a determination of coverage pursuant to the terms and conditions of this Plan.

Post-Service Medical Necessity Review

A Post-Service Medical Necessity Review, sometimes referred to as a retrospective review or post-service claims request, is the process of determining coverage after treatment has been provided and is based on Medical Necessity guidelines. A Post-Service Medical Necessity Review confirms your eligibility, availability of benefits at the time of service, and reviews necessary clinical documentation to ensure the service was Medically Necessary. Providers should submit appropriate documentation at the time of a Post-Service Medical Necessity Review request. A Post-Service Medical Necessity Review may be performed when a Prior Authorization or Recommended Clinical Review was not obtained prior to services being rendered.

General Provisions Applicable to All Post-Service Medical Necessity Reviews

1. **No Guarantee of Payment**

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

2. **Request for Additional Information**

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

Failure to Obtain Prior Authorization

If Prior Authorization for inpatient Hospital Admissions, Extended Care Expense, Home Infusion Therapy, all inpatient and the above specified outpatient treatment of Mental Health Care, treatment of Serious Mental Illness, and treatment of Substance Use Disorder 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 Mental Health Care, treatment of Serious Mental Illness, and treatment of Substance Use Disorder

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

The penalty charge will be deducted from any benefit payment which may be due for covered services.

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

Prior Authorization Renewal Process

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

CLAIM FILING AND APPEALS PROCEDURES

Claim Filing Procedures

Filing of Claims Required

Claim Forms

When the Claim Administrator 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.

The Claim Administrator for the Plan 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 the Claim Administrator and some other health care Providers (such as *ParPlan* Providers) will submit your claims directly to the Claim Administrator 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 that contracts with the Claim Administrator, you will generally not be required to file claim forms. The Provider will usually submit the claims directly to the Claim Administrator for you.

Non-Contracting Providers

When you receive treatment or care from a health care Provider that does not contract with the Claim Administrator, 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.

Participant-Filed Claims - Medical Claims

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

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, TX 75266-0044

Who Receives Payment

Benefit payments will be made directly to contracting Providers when they bill the Claim Administrator. Written agreements between the Claim Administrator and some Providers may require payment directly to them.

Any benefits payable to you, if unpaid at your death, will be paid to your surviving spouse, as beneficiary. If there is no surviving spouse, then the benefits will be paid to your estate.

Except as provided in the subsection **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
- the Claim Administrator 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 the Claim Administrator, 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.

The Claim Administrator for the Health Benefit Plan 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 the Plan from benefit payments of amounts owed to it, 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 Health Benefit Plan must be properly submitted to the Claim Administrator within twelve (12) months of the date you receive the services or supplies. Claims submitted and received by the Claim Administrator after that date will not be considered for payment of benefits except in the absence of legal capacity.

Receipt of Claims by the Claim Administrator

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

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

Review of Claim Determinations

Claim Determinations

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

You have the right to seek and obtain a full and fair review of your claim in accordance with the benefits and procedures detailed in your Health Benefit Plan.

Timing of Required Notices and Extensions for Initial Determinations

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

1. **Urgent Care Clinical Claim** is any Pre-Service Claim that requires Prior Authorization, as described in this Benefit Booklet, for benefits for medical care or Treatment with respect to which the application of regular time periods for making health Claim decisions could seriously jeopardize the life 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.
2. **Pre-Service Claim** is any non-urgent request for benefits with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.

3. **Concurrent Care Claim** is a claim for a health benefit which the Claim Administrator, after having previously approved an ongoing course of treatment provided over a period of time or a specific number of treatments, subsequently reduces or terminates coverage for the treatments (other than by Plan amendment or termination) or a request to extend the course of the treatment beyond what was previously approved that is an Urgent Care Clinical Claim.

4. **Post-Service Claim** is any other claim for a benefit for a service that has been provided to you. Your Claim must be in a form acceptable to the Claim Administrator. Your Claim must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim charge, and any other information which the Claim Administrator may request in connection with services rendered to you.

The following table summarizes the applicable deadlines and extension periods for each type of claim:

	Urgent Care Claims	Pre-Service Claims	Post-Service Claims	Concurrent Care Claims
What is the general deadline for initial determination?	No later than 72 hours from receipt of the claim	15 calendar days from receipt of the claim	30 calendar days from receipt of the claim	Must be provided sufficiently in advance to give you an opportunity to appeal and obtain a decision before the previously approved treatment is reduced or terminated. A request to extend an approved course of treatment that is an Urgent Care Clinical Claim will receive a response within 24 hours, if the request is made at least 24 hours prior to the expiration of the previously approved period or number of treatments. **Note:** If such request for extension is not made at least 24 hours prior to the expiration of the previously approved period of time or number of treatments, then the claim will be handled as an Urgent Care Clinical Claim. If a request to extend a course of treatment is not an Urgent Care Clinical Claim, the request may be treated as a new Pre-Service or Post-Service claim depending on the circumstances.
Are there any extensions?	No, but see below for extensions based on insufficient information	Yes. One 15 calendar day extension is allowed if the Claim Administrator determines it is necessary due to matters beyond its control and informs you of the extension within the initial 15 calendar day timeframe.	Yes. One 15 calendar day extension is allowed if the Claim Administrator determines it is necessary due to matters beyond its control and informs you of the extension within the initial 30 calendar day timeframe.	No

	Urgent Care Claims	Pre-Service Claims	Post-Service Claims	Concurrent Care Claims
What if additional information is needed?	You must be notified of the need for additional information to decide the claim within 24 hours of receipt of the claim. You must be given at least 48 hours to respond.	If an extension is necessary because you failed to provide information necessary to decide the claim, notice of extension must specify the information needed. You must be given at least 45 calendar days to respond. The running of time for the initial claims determination is suspended until the end of the prescribed response period or until the information is received, whichever is earlier.	If an extension is necessary because you failed to provide information necessary to decide the claim, notice of extension must specify the information needed. You must be given at least 45 calendar days to respond. The running of time for the initial claims determination is suspended until the end of the prescribed response period or until the information is received, whichever is earlier.	Not applicable
What is the deadline if additional information is needed?	You must be notified of the decision no later than 48 hours after the earlier of: 1) the Claim Administrator's receipt of the requested information; or 2) the end of the prescribed response period.	If there is an extension, you must be notified of the decision no later than 15 calendar days after the Claim Administrator receives a response to the request for information or 15 calendar days after the end of the deadline for you to provide the information, whichever is earlier.	If there is an extension, you must be notified of the decision no later than 15 calendar days after the Claim Administrator receives a response to the request for information or 15 calendar days after the end of the deadline for you to provide the information, whichever is earlier.	

NOTE: Improperly Filed Claims. For Pre-Service Claims which name a specific claimant, medical condition, and service or supply for which approval is requested and which are submitted to a representative of the Claim Administrator responsible for handling benefit matters, but which otherwise fail to follow the procedures for filing Pre-Service Claims, you will be notified on the failure within 5 days (within 24 hours in the case of an Urgent Care Claim) and of the proper procedures to be followed. The notice may be oral, but you may also request a written notice.

If a Claim Is Denied or Not Paid in Full

On occasion, the Claim Administrator may deny all or part of your claim. There are a number of reasons why this may happen. We suggest that you first read the *Explanation of Benefits* summary prepared by the Claim Administrator; then review this Benefit Booklet to see whether you understand the reason for the determination. If you have

additional information that you believe could change the decision, send it to the Claim Administrator and request a review of the decision as described in **Claim Appeal Procedures** below.

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

- The reasons for the determination;
- A reference to the Health Benefit Plan provisions on which the determination is based;
- A description of additional information which may be necessary to perfect the claim and an explanation of why such material is necessary;
- Information sufficient to identify the claim including the date of service, health care provider, claim amount (if applicable), denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- In certain situations, a statement in non-English 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 the Claim Administrator;
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge upon request;
- An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
- In the case of a denial of an Urgent Care Clinical Claim, a description of the expedited internal and external review procedures applicable to such claims. An Urgent Care Clinical Claim decision may be provided orally, so long as a written notice is furnished to the claimant within three days of oral notification;
- Contact information for any applicable office of health insurance consumer assistance or ombudsman.

Claim Review/Appeal Procedures

Claim Appeal Procedures Definitions

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

A "**Final Internal Adverse Benefit Determination**" means an Adverse Benefit Determination that has been upheld by the Claim Administrator or, if applicable, your Employer, at the completion of the internal review/appeal process of an Adverse Benefit Determination with respect to which the internal review/appeal process has been deemed exhausted.

Note: Expedited Internal Review of Urgent Care Claims

If your claim is an Urgent Care Claim, you have the right to an expedited review. You also have the right to request an expedited external review of your Urgent Care Claim at the same time you request expedited internal review.

How to Appeal an Adverse Benefit Determinations

You have the right to seek and obtain a full and fair internal review of your claim and an Adverse Benefit Determination in accordance with the benefits and procedures detailed below and 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 Urgent Care Clinical Claim situations, a health care provider may appeal on your behalf. With the exception of Urgent Care Clinical Claim situations, your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call the Claim Administrator at the number on the back of your Identification Card.

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

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

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

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

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

  The appeal determination will be made by the Claim Administrator or, if required by a Physician associated or contracted with the Claim Administrator and/or by external advisors, who were not involved in making the initial denial of your claim and the individuals who made the Adverse Benefit Determination will not conduct the appeal. Before you or your authorized representative may bring any action to recover benefits you must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by the Claim Administrator and, if applicable, your Employer.
- If you have any questions about the claims procedures or the review procedure, write to the Claim Administrator's Administrative Office or call the toll-free Customer Service Helpline number shown in this Benefit Booklet or on your Identification Card.

If you don't appeal on time, you lose your right to later object to the decision on the claim.

Timing of Appeal Determinations - Note: Your Plan provides for one level of internal review

	Urgent Care Claim	Pre-Service Claim	Post-Service Claim
Deadline by which a claimant will be notified of an appeals decision	As soon as possible taking into account the medical exigencies, but no more than 72 hours after receipt of the request for review. **Note:** The request may be submitted in writing or orally.	Not later than 30 days after receipt of the request for review. (Not later than 15 days for each level if your Plan offers two levels of Internal review.)	Not later than 60 days after receipt of the request for review. (Not later than 30 days for each level if your Plan offers two levels of internal review).

Notice of Appeal Determination

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

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

1. A reason for the determination;
2. A reference to the benefit Plan provisions on which the determination is based, and the contractual, administrative or protocol for the determination;
3. Information sufficient to identify the claim including the date of service, health care provider, claim amount (if applicable), denial codes with their meanings and the standards used. Diagnosis/treatment codes with their meanings and the standards used are also available upon request;
4. In certain situations, a statement in non-English language(s) that written notice of claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
5. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;
6. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
7. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
8. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
9. A description of the standard that was used in denying the claim and a discussion of the decision;
10. Contact information for any applicable office of health insurance consumer assistance or ombudsman.

If the Claim Administrator's or, if applicable, your Employer's decision is to continue to deny or partially deny your claim or you do not receive timely decision and your claim meets the External Review Criteria below, you have the right to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the **Standard External Review** subsection below.

If You Need Assistance

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

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

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

External Review Criteria

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

Standard External Review

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

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

   You will be notified within one business day after we complete the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the four month external review request period (or 48 hours following receipt of the notice), whichever is later, to perfect the request for external review. If your claim is not eligible for external review, we will outline the reasons it is ineligible in the notice, and provide contact information for the Department of Labor's Employee Benefits Security Administration (toll-free number 1-866-444-EBSA (3272)).
3. **Referral to Independent Review Organization (IRO).** When an eligible request for external review is completed within the time period allowed, the Claim Administrator will assign the matter to an IRO. The IRO assigned will be accredited by URAC or by similar nationally-recognized accrediting organization. Moreover, the Claim Administrator will ensure that the IRO is unbiased and independent. Accordingly, the Claim Administrator must contract with at least three IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

   The IRO must provide the following:

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

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

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

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

e. Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

   (1) Your medical records;
   (2) The attending health care professional's recommendation;
   (3) Reports from appropriate health care professionals and other documents submitted by the Claim Administrator, you, or your treating provider;
   (4) The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
   (5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
   (6) Any applicable clinical review criteria developed and used by the Claim Administrator, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
   (7) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

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

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

   (1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

(2) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(3) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Claim Administrator or you or your authorized representative;

(6) A statement that judicial review may be available to you or your authorized representative; and

(7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

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

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

Expedited External Review

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

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

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

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

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

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

4. **Notice of final external review decision.** The assigned IRO will provide notice of the final external review decision, in accordance with the requirements set forth in the **Standard External Review** subsection above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the

IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing verbal notice, the assigned IRO must provide written confirmation of the decision to the Claim Administrator and you or your authorized representative.

Exhaustion

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

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

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

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

Except as described above, you must exhaust the mandatory levels of appeal before you request external review or seek other legal recourse.

Interpretation of Employer's Plan Provisions

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

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

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

Claim Dispute Resolution

You must exhaust all administrative remedies as described in the **Claim Review/Appeal Procedures** subsection prior to taking further action under your Health Benefit Plan.

After exhaustion of all remedies offered by the Claim Administrator, your Health Benefit Plan may afford you the right to appeal an adverse determination with the Plan Administrator of your Health Benefit Plan. In that instance, the Plan Administrator is the final interpreter of the Health Benefit Plan and may correct any defect, supply any omission, or reconcile any inconsistency or ambiguity in such manner as it deems advisable. All final determinations and actions concerning the Health Benefit Plan administration and interpretation of benefits shall be made by the Plan Administrator. The Claim Administrator will cooperate in providing the Plan Administrator documents relevant to the claim or Prior Authorization decision upon receipt of a valid written authorization from you or your representative to release the relevant information. Our decision letter will inform you of any right that you have to appeal an adverse determination with the Plan Administrator. You may also contact your Plan Administrator for additional information.

ELIGIBLE EXPENSES, PAYMENT OBLIGATIONS, AND BENEFITS

Eligible Expenses

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

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

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

Deductibles

The benefits of the Plan will be available after satisfaction of the applicable Deductibles as shown on your Schedule of Coverage. The Deductibles will be increased in the future in direct proportion to the increase as determined from the cost-of-living adjustments based on the Consumer Price Index (CPI-U).

The Deductibles are explained as follows:

1. The individual Deductible amount shown under "Deductibles" on your Schedule of Coverage must be satisfied by each Participant under your coverage each Plan Year. This Deductible, unless otherwise indicated, will be applied to all categories of Eligible Expenses, before benefits are available under the Plan.
2. 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 Plan Year. No Participant will contribute more than the individual Deductible amount to the "family" Deductible amount.

The following are exceptions to the Deductibles described above:

In-Network ***Preventive Care Services*** are not subject to Deductibles.

Eligible Expenses applied toward satisfying the "individual" Deductible will apply toward both the In-Network and the Out-of-Network Deductible amounts shown on your Schedule of Coverage. Eligible Expenses applied toward satisfying the "family" Deductible will apply toward both the In-Network and the Out-of-Network Deductible amount shown on your Schedule of Coverage.

Out-of-Pocket Maximum

Most of your Eligible Expense payment obligations are applied to the Out-of-Pocket Maximum. The Out-of-Pocket Maximum will be increased in the future in direct proportion to the increase as determined from the cost-of-living adjustments based on the Consumer Price Index (CPI-U).

The Out-of-Pocket Maximum will not include:

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

Individual Out-of-Pocket Maximum

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

Family Out-of-Pocket Maximum

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

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

There are separate Out-of-Pocket Maximums for In-Network Benefits and Out-of-Network Benefits.

Eligible Expenses applied toward satisfying the "individual" Out-of-Pocket Maximum will apply toward both the In-Network and the Out-of-Network Out-of-Pocket Maximum amounts shown on your Schedule of Coverage. Eligible Expenses applied toward satisfying the "family" Out-of-Pocket Maximum will apply toward both the In-Network and the Out-of-Network Out-of-Pocket Maximum amounts shown on your Schedule of Coverage.

Changes In Benefits

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

COVERED MEDICAL SERVICES

Inpatient Hospital Expenses

The Plan provides coverage for Inpatient Hospital Expenses for you and your eligible Dependents. Each inpatient Hospital Admission requires Prior Authorization. Refer to the **UTILIZATION MANAGEMENT** section 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 your Schedule of Coverage is the Plan's obligation. The remaining unpaid Inpatient Hospital Expense, in excess of any Deductible, is your obligation to pay and will be applied to your Out-of-Pocket Maximum. This excess amount will be applied to the Out-of-Pocket Maximum.

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 the Claim Administrator 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 your Schedule of Coverage for information regarding Deductibles, Co-Share percentages, and penalties for failure to obtain Prior Authorization that may apply to your coverage.

Medical-Surgical Expenses

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

The benefit percentage of your total eligible Medical Surgical Expenses, in excess of any Deductible, shown under "Deductibles" on your Schedule of Coverage is the Plan's obligation. The remaining unpaid Medical Surgical Expenses, including the Deductible is your obligation to pay and will be applied to the Out-of-Pocket Maximum.

Medical-Surgical Expense shall include:

1. Services of Physicians and Professional Other Providers.
2. Consultation services of a Physician and Professional Other Provider.
3. Services of a certified registered nurse-anesthetist (CRNA).
4. Diagnostic x-ray and laboratory procedures.
5. Radiation therapy.
6. Rental of durable medical equipment required for therapeutic use unless purchase of such equipment is required by the Plan. 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.
7. For Emergency Care, professional local ground ambulance transportation or air ambulance transportation to the nearest Hospital appropriately equipped and staffed for treatment of the Participant's condition. Non-emergency ground ambulance transportation from one acute care Hospital to another acute care Hospital for diagnostic or therapeutic services (e.g., MRI, CT scans, acute interventional cardiology, intensive care unit services, etc.) may be considered Medically Necessary when specific criteria are met. The non-emergency ground ambulance transportation to or from a Hospital or medical facility, outside of the acute care Hospital setting, may be considered Medically Necessary when the Participant's condition is such that trained ambulance attendants are required to monitor the Participant's clinical status (e.g., vital signs and oxygenation), or provide treatment such as oxygen, intravenous fluids or medications, in order to safely transport the Participant, or the Participant is confined to bed and cannot be safely transported by any other means. Non-emergency ground

ambulance transportation services provided primarily for the convenience of the Participant, the Participant's family/caregivers or Physician, or the transferring facility are considered not Medically Necessary.

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

8. Anesthetics and its administration, when performed by someone other than the operating Physician or Professional Other Provider.
9. Oxygen and its administration provided the oxygen is actually used.
10. Blood, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for the Participant.
11. Prosthetic Appliances, including replacements necessitated by growth to maturity of the Participant.
12. 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.
13. Home Infusion Therapy.
14. Services or supplies used by the Participant during an outpatient visit to a Hospital, a Therapeutic Center, or a Substance Use Disorder Treatment Center, or scheduled services in the outpatient treatment room of a Hospital.
15. Certain Diagnostic Procedures.
16. Outpatient Contraceptive Services, prescription contraceptive devices and specified FDA-approved over-the-counter female contraceptives with a written prescription by a Health Care Practitioner to women with reproductive capacity as shown in ***Benefits for Preventive Care Services***. The Participant will be responsible for submitting a claim form, written prescription and the itemized receipt for the over-the counter female contraceptive. Visit the BCBSTX website at www.bcbstx.com to obtain a claim form.
17. Foot care in connection with an illness, disease, or condition, such as but not limited to peripheral neuropathy, chronic venous insufficiency, and diabetes.
18. 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.
19. Telehealth Services and Telemedicine Medical Services.
20. Elective Sterilizations.
21. Wigs, prosthesis regardless of the reason for hair loss.

Extended Care Expenses

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

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

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

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

The benefit maximums will also include any benefits provided to a Participant for Extended Care Expenses under a Health Benefit Plan held by the Employer with the Claim Administrator immediately prior to the Participant's Effective Date of coverage under the Plan.

Any unpaid Extended Care Expenses in excess of the benefit maximums shown on your Schedule of Coverage will not be applied to any Out-of-Pocket Maximum.

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

Services and supplies for Extended Care Expenses:

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.
   e. 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:

   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.

   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 Expenses, Medical-Surgical Expenses, and Extended Care Expenses, except to the extent described in each item. Benefits for Medically Necessary expenses will be determined as indicated on your Schedule(s) of Coverage. Remember that certain services require **Prior Authorization** and that any Co-Share

percentages, and Deductibles shown on your Schedule(s) of Coverage will also apply. Refer to the **UTILIZATION MANAGEMENT** section of this Benefit Booklet for more information.

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. Dependent children will be eligible for treatment of Complications of Pregnancy.

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 as described under **Inpatient Hospital Expenses**. Benefits will also be subject to any Deductible amounts shown on your Schedule of Coverage.

Benefits for Emergency Care and Treatment of Accidental Injury

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

Emergency Care does not require Prior Authorization. However, if reasonably possible, contact your Network Physician or Behavioral Health Practitioner before going to the Hospital emergency room/treatment room. They 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 they can recommend the continuation of any necessary medical services.

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. If admitted for the emergency condition immediately following the visit, Prior Authorization of the inpatient Hospital Admission will be required.

All treatment received following the onset of an accidental injury or emergency care will be eligible for In-Network Benefits. For a non-emergency, In-Network Benefits will be available only if you use Network Providers. For a non-emergency, 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. 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 or physician's office. The necessary medical care is for a condition that is not life-threatening.

Benefits for Retail Health Clinics

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

Benefits for Virtual Visits

Benefits for Eligible Expenses for Virtual Visits will be determined as shown on your Schedule of Coverage. BCBSTX provides you with access to Virtual Providers that can provide diagnosis and treatment of non-emergency medical and behavioral health conditions in situations that can be handled without a traditional primary care office visit, behavioral health office visit, Urgent Care visit or Emergency Care visit. Covered services may be provided via consultation with a licensed medical professional through interactive audio via telephone or interactive audio-video via online portal or mobile application. For information on accessing this service, you may access the website at www.bcbstx.com or contact customer service at the toll-free number on the back of your Identification Card.

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

Benefits for Hearing Services

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

Any benefit payments made by the Claim Administrator for hearing aids, whether under the In-Network or Out-of-Network Benefits level, will apply toward the benefit maximum amount indicated on your Schedule of Coverage for each level of benefits.

One cochlear implant, which includes an external speech processor and controller, per impaired ear is covered. Coverage also includes related treatments such as habilitation and rehabilitation services, fitting and dispensing services and the provision of ear molds as necessary to maintain optimal fit of hearing aids. Implant components may be replaced as Medically Necessary or audiologically necessary.

Benefits for 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 Participant.

Individuals providing treatment prescribed under that plan must be:

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

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

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

Benefits for Autism Spectrum Disorder will not apply towards any maximum indicated on your Schedule of Coverage. Please review the *Benefits for Physical Medicine Services* and *Benefits for Hearing Services* provisions of this Benefit Booklet for more specific information about how visits maximums for Physical Medicine Services and speech services apply to benefits for Autism Spectrum Disorder.

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

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

Benefits for 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
- Services and supplies for reduction mammoplasty when Medically Necessary and in accordance with the medical policy guidelines of the Claim Administrator; 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; or

- Reconstructive surgery performed on a covered Dependent child due to craniofacial abnormalities to improve the function of, or attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

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 your 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 Accidental Injury, and such injury resulting from domestic violence or a medical condition, to healthy, un-restored natural teeth and supporting tissues. An injury sustained as a result of biting or chewing shall not be considered an Accidental Injury.

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 Expenses for a Medically Necessary inpatient Hospital Admission, will be determined as described in **Benefits for Inpatient Hospital Expenses**.

Benefits for Organ and Tissue Transplants

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

   a. The transplant procedure is not Experimental/Investigational in nature; and
   b. Donated human organs or tissue or an FDA-approved artificial device are used; and
   c. The recipient is a Participant under the Plan; and
   d. The transplant procedure obtains Prior Authorization as required under the Plan; and
   e. The Participant meets all of the criteria established by the Claim Administrator in pertinent written medical policies; and
   f. 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, procurement of organs or tissues from a living or deceased donor, and complications arising from such transplant.

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

   Benefits will be available for:

   a. A recipient who is covered under this Plan; and
   b. A donor who is a Participant under this Plan.

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

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

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

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

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

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

6. No benefits are available for any organ or tissue transplant procedure (or the services performed in preparation for, or in conjunction with, such a procedure) which the Claim Administrator 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. Eligible Expenses include the following *services* as a result of and related to an Acquired Brain Injury:

- Cognitive communication therapy - *Services* designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information;
- Cognitive rehabilitation therapy - *Services* designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits;
- Community reintegration services - *Services* that facilitate the continuum of care as an affected individual transitions into the community, including outpatient day treatment or other post-acute care treatment;
- Neurobehavioral testing - An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and pre-morbid 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 - Interventions that focus on behavior and the variables that control behavior;
- Neurocognitive rehabilitation - *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 - *Services* designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities;
- Neurofeedback therapy - *Services* that utilizes operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood;
- Neurophysiological testing - An evaluation of the functions of the nervous system;
- Neurophysiological treatment - Interventions that focus on the functions of the nervous system;
- Neuropsychological testing - 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 - Interventions designed to improve or minimize deficits in behavioral and cognitive processes;
- Post-acute transition services - *Services* that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration;
- Psychophysiological testing - An evaluation of the interrelationships between the nervous system and other bodily organs and behavior;
- Psychophysiological treatment - Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors;
- Remediation - The process(es) of restoring or improving a specific function.

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.

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.

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:

1. *Diabetes Equipment*

    a. Blood glucose monitors (including noninvasive glucose monitors and monitors for the blind);
    b. 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
    c. Podiatric appliances, including up to two pairs of therapeutic footwear per Plan Year, for the prevention of complications associated with diabetes.

2. *Diabetes Supplies*

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

3. 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.

4. 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.

5. 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:

    a. The physical cause and process of diabetes;
    b. Nutrition, exercise, medications, monitoring of laboratory values and the interaction of these in the effective self-management of diabetes;
    c. Prevention and treatment of special health problems for the diabetic patient;

d. Adjustment to lifestyle modifications; and
e. Family involvement in the care and treatment of the diabetic patient. The family will be included in certain sessions of instruction for the patient.

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

A *Qualified Participant* means an individual eligible for coverage under this Plan 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 Expenses incurred for Physical Medicine Services are available and will be determined up to the visit maximum benefit amount shown on your Schedule of Coverage.

All benefit payments made by the Claim Administrator for Physical Medicine Services, whether under the In-Network or Out-of-Network Benefits level, will apply toward the benefit visit maximum amount shown on your Schedule of Coverage.

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

Benefits for Speech Therapy

Benefits for Medical-Surgical Expenses incurred for Speech Therapy are available and will be determined up to the visit maximum benefit amount shown on your Schedule of Coverage.

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

All benefit payments made by the Claim Administrator for Speech Therapy, whether under the In-Network or Out-of-Network Benefits level, will apply toward the benefit visit maximum amount shown on your Schedule of Coverage.

Benefits for Cognitive Rehabilitation Therapy

Benefits for Medical-Surgical Expenses incurred for Cognitive Rehabilitation Therapy are available and will be determined up to the visit maximum benefit amount shown on your Schedule of Coverage.

All benefit payments made by the Claim Administrator for Cognitive Rehabilitation Therapy, whether under the In-Network or Out-of-Network Benefits level, will apply toward the benefit visit maximum amount shown on your Schedule of Coverage.

Benefits for Post Cochlear Implant Aural Therapy

Benefits for Medical-Surgical Expenses incurred for Post Cochlear Implant Aural Therapy are available and will be determined up to the visit maximum benefit amount shown on your Schedule of Coverage.

All benefit payments made by the Claim Administrator for Post Cochlear Implant Aural Therapy, whether under the In-Network or Out-of-Network Benefits level, will apply toward the benefit visit maximum amount shown on your Schedule of Coverage.

Benefits for Pulmonary Rehabilitation Therapy

Benefits for Medical-Surgical Expenses incurred for Pulmonary Rehabilitation Therapy are available and will be determined up to the visit maximum benefit amount shown on your Schedule of Coverage.

All benefit payments made by the Claim Administrator for Pulmonary Rehabilitation Therapy, whether under the In-Network or Out-of-Network Benefits level, will apply toward the benefit visit maximum amount shown on your Schedule of Coverage.

Benefits for Cardiac Rehabilitation Therapy

Benefits for Medical-Surgical Expenses incurred for Cardiac Rehabilitation Therapy are available and will be determined up to the visit maximum benefit amount shown on your Schedule of Coverage.

All benefit payments made by the Claim Administrator for Cardiac Rehabilitation Therapy, whether under the In-Network or Out-of-Network Benefits level, will apply toward the benefit visit maximum amount shown on your Schedule of Coverage.

Benefits for Occupational Therapy

Benefits for Medical-Surgical Expenses incurred for Occupational Therapy are available and will be determined up to the visit maximum benefit amount shown on your Schedule of Coverage.

All benefit payments made by the Claim Administrator for Occupational Therapy, whether under the In-Network or Out-of-Network Benefits level, will apply toward the benefit visit maximum amount shown on your Schedule of Coverage.

Benefits for Chiropractic Services

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

However, Chiropractic Services benefits for all visits during which physical treatment is rendered, whether under the In-Network or Out-of-Network Benefits level, will not be provided for more than the maximum number of visits (outpatient facility and office combined) shown on your Schedule of Coverage. Any visits during which no physical treatment is rendered will not count toward the visit maximum.

Benefits for Routine Patient Costs for Participants in Approved Clinical Trials

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

Benefits for Certain Tests for Detection of Prostate Cancer

Benefits are available as shown on the Schedule of Coverage 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:

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

Benefits for Preventive Care Services

Preventive Care Services will be provided for the following covered services:

a. evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");

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

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

Examples of covered services included are routine annual physicals; immunizations; well-child care; breastfeeding support, services and supplies; cancer screening mammograms; bone density test; screening for colorectal cancer; smoking cessation counseling services and intervention (including a screening for tobacco use, counseling and FDA-approved tobacco cessation medications); 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.

Examples of covered services for women with reproductive capacity are female sterilization procedures and Outpatient Contraceptive Services; FDA-approved over-the-counter female contraceptives with a written prescription by a Health Care Practitioner; and specified FDA-approved contraception methods with a written prescription by a Health Care Practitioner provided in this section from the following categories: progestin-only contraceptives, combination contraceptives, emergency contraceptives, extended cycle/continuous oral contraceptives, cervical caps, diaphragms, implantable contraceptives, intra-uterine devices, injectables, transdermal contraceptives, vaginal contraceptive devices, spermicide, and female condoms. To determine if a specific contraceptive drug or device is included in this benefit, refer to the Women's Preventive Health Services - Contraceptive Information page located on the website at www.bcbstx.com or contact Customer Service at the toll-free number on your Identification Card. The list may change as FDA guidelines are modified.

Benefits are not available under this benefit provision for contraceptive drugs and devices not listed on the Women's Preventive Health Services - Contraceptive Information page. You may, however, have coverage under other sections of this Benefit Booklet, subject to any applicable Co-Share Amounts, Deductibles, Copayment Amounts and/or benefit maximums.

Preventive Care Services provided by an In-Network Provider for the items a. through d. above and/or the Women's Preventive Health Services - Contraceptive Information List will not be subject to Co-Share Amounts, Deductibles, Copayment Amounts and/or dollar maximums.

Preventive Care Services provided by an Out-of-Network Provider for the items a. through d. above and/or the Women's Preventive Health Services - Contraceptive Information List will be subject to Co-Share Amounts, Deductibles, Copayment Amount and/or applicable dollar maximums. Deductibles are not applicable to immunizations covered under ***Benefits for Childhood Immunizations*** provision.

Covered services not included in items a. through d. above and/or the Women's Preventive Health Services - Contraceptive Information List will be subject to Co-Share Amounts, Deductibles, Copayment Amount and/or applicable dollar maximums.

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 purchase of manual or electric breast pumps, accessories and supplies. Benefits for electric breast pumps are limited to one per Calendar Year. Limited benefits are also included for the rental only of Hospital grade breast pumps. You may be required to pay the full amount and submit a claim form to BCBSTX with a written prescription and the itemized receipt for the manual, electric or Hospital grade breast pump, 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, Co-Share and/or benefit maximum.

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

Benefits for Mammography Screening

Benefits are available for a screening by low-dose mammography for the presence of occult breast cancer for a Participant, as shown in ***Preventive Care Services*** on your Schedule of Coverage, except that benefits will not be available for more than one routine mammography screening each Plan Year. Low-dose mammography includes digital mammography or breast tomosynthesis.

Benefits for Diagnostic Mammography and Other Breast Imaging

Diagnostic Imaging is covered to the same extent as ***Benefits for Mammography Screening*** as described in the ***Preventive Care Services*** section of the Benefit booklet but without Participant age restrictions.

In addition to the applicable terms provided in the **DEFINITIONS** section of the Benefit Booklet, the following term will apply specifically to this provision.

Diagnostic Imaging means an imaging examination using mammography, ultrasound imaging, or magnetic resonance imaging that is designed to evaluate:

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

The Copayment Amounts and Co-Share Amounts shown on your Schedule of Coverage for Preventive Services will apply, after the Calendar Year Deductible.

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 in ***Preventive Care Services*** on your Schedule of Coverage.

Qualified Individual means:

1. A postmenopausal woman not receiving estrogen replacement therapy;
2. An individual with:
    - vertebral abnormalities,
    - primary hyperparathyroidism, or
    - a history of bone fractures; or
3. An individual who is:
    - receiving long-term glucocorticoid therapy, or
    - being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

Benefits for Tests for Detection of Colorectal Cancer

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

- A fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years; or
- A colonoscopy performed every ten years.

Benefits will be provided for Physician Services, as shown in ***Preventive Care Services*** on your Schedule of Coverage.

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

Benefits are available for certain tests for detection of Human Papillomavirus and Cervical Cancer for each woman enrolled in the Plan who is 18 years of age or older, for an annual medically recognized diagnostic examination for the early detection of cervical cancer, as shown in ***Preventive Care Services*** 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 Childhood Immunizations

Benefits for Medical-Surgical Expenses incurred by a Dependent child for childhood immunizations will be determined at 100% of the Allowable Amount. Deductibles and Out-of-Pocket Maximum will not be applicable, as shown in ***Preventive Care Services*** on your Schedule of Coverage.

Benefits are available for:

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

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

Benefits for Morbid Obesity

Benefits for Eligible Expenses incurred by a Participant for the Medically Necessary treatment of Morbid Obesity will be provided on the same basis as for any other sickness. Benefits are available for healthy diet counseling and obesity screening/counseling as shown in ***Preventive Care Services*** on your Schedule of Coverage.

Benefits for Other Routine Services

Benefits for other routine services are available for the following as indicated on your Schedule of Coverage:

- routine x-rays, routine EKG, routine diagnostic medical procedures;
- annual hearing examinations, except for benefits as provided under ***Benefits for Screening Tests for Hearing Impairment***; and
- annual vision examinations.

Behavioral Health Services

Benefits for Mental Health Care, Treatment of Serious Mental Illness and Treatment of Substance Use Disorder

Benefits for Eligible Expenses incurred for Mental Health Care, treatment of Serious Mental Illness and treatment of Substance Use Disorder will be the same as for treatment of any other sickness. Refer to the **UTILIZATION MANAGEMENT** section to determine what services require Prior Authorization.

Any Eligible Expenses incurred for the services of a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, a Residential Treatment Center, or a Residential Treatment Center for Children and Adolescents for Medically Necessary Mental Health Care or treatment of Serious Mental Illness in lieu of inpatient Hospital services will, for the purpose of this benefit, be considered **Inpatient Hospital Expenses**.

Inpatient treatment of Substance Use Disorder must be provided in a Substance Use Disorder Treatment Center or Hospital. Benefits for the medical management of acute life-threatening intoxication (toxicity) in a Hospital will be available on the same basis as for sickness generally as described under **Inpatient Hospital Expense**.

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

Benefits for Eligible Expenses incurred for family and marriage counseling are covered under this Plan.

Blue Distinction® and Blue Distinction Specialty Care Program

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

Blue Distinction Centers

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

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

- Cardiac Care
- Cellular Immunotherapy (CAR- T)
- Fertility Care*
- Substance Use Treatment and Recovery
- Cancer Care
- Gene Therapy
- Spine Surgery
- Bariatric Surgery
- Knee and Hip Replacement Surgery
- Maternity Care
- Transplants (stem cell/bone marrow, solid organ (heart, liver, lung, kidney) and combination solid organ (heart/lung, liver/kidney, pancreas/kidney))

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

BDC and BDC+ Benefit Differential

Your plan offers lower out-of-pocket costs when you receive treatment at a BDC and/or BDC+ Provider for certain services related to Transplants and Bariatric Surgery services. You may choose to receive treatment at a Non-BDC and/or Non-BDC+ Provider; however, your out-of-pocket costs will be higher. Please refer to your Schedule of Coverage section to review the payment levels for procedures performed at a BDC or a BDC+ designated Provider and procedures performed at other facilities. Blue Distinction benefit levels apply to Blue Distinction facility benefits only, except for Fertility, which offers Professional Provider services.

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

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 the Claim Administrator.
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, 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 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 United States of America tax supported institution.
7. Any services or supplies provided by a person who is related to the Participant by blood or marriage.
8. 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.
9. 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.
10. 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.
11. 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.
12. Any services or supplies provided for Dietary and Nutritional Services, except as may be provided under the Plan for:
    - ***Preventive Care Services*** as shown on your Schedule of Coverage; or
    - an inpatient nutritional assessment program provided in and by a Hospital and approved by the Claim Administrator; or
    - ***Benefits for Autism Spectrum Disorder*** as described in **Special Provisions Expenses**; or
    - ***Benefits for Treatment of Diabetes*** as described in **Special Provisions Expenses**.
13. Any services or supplies provided for Custodial Care.
14. Any non-surgical (dental restorations, orthodontics, or physical therapy) or non-diagnostic services provided for the treatment of the temporomandibular joint (including the jaw and craniomandibular joint) and all adjacent or related muscles.

15. Any items of Medical-Surgical Expenses incurred for dental care and treatments, dental 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.

16. 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.

17. 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; or
    - restoration of loss or correction to an impaired speech or hearing function, except as may be provided under the ***Benefits for Hearing Services*** and ***Benefits for Autism Spectrum Disorder*** provisions in the **Special Provisions Expenses** portion of this Benefit Booklet.

18. 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 Physical Medicine Services and Benefits for Autism Spectrum Disorder*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet.

19. 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.

20. 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.

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

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

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

23. 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 severe systemic disease.

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

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

26. With the exception of prescription and over-the-counter medications for tobacco cessation and tobacco cessation counseling covered in this Plan, supplies for smoking cessation programs and the treatment of nicotine addiction are excluded.

27. 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.

28. Any services or supplies furnished by a Contracting Facility for which such facility had not been specifically approved to furnish under a written contract or agreement with the Claim Administrator will be paid at the Out-of-Network benefit level.

29. 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.

30. Any benefits in excess of any specified dollar, day/visit, or Plan Year maximums.

31. 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.

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

33. Replacement Prosthetic Appliances when it is necessitated by misuse or loss by the Participant.

34. Private duty nursing services.

35. Any outpatient prescription or nonprescription drugs (except for contraceptive drugs with a written prescription by a Health Care Practitioner provided under the **COVERED MEDICAL SERVICES** portion of this Plan as shown in ***Benefits for Preventive Care Services)***.

36. Any non-prescription contraceptive medications or devices for male use.

37. Self-administered drugs dispensed or administered by a Physician in their office.

38. Any drugs and medicines purchased for use outside a Hospital which require a written prescription for purchase other than injectable drugs not approved by the FDA for self-administration that are administered by or under the direct supervision of a Physician or Professional Other Provider.

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

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

41. Any related services to a non-covered service. Related services are:

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

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

43. Behavioral health services provided at behavioral modification facilities, boot camps, emotional group academies, military schools, therapeutic boarding schools, wilderness programs, halfway houses and group homes, except for covered services provided by appropriate Providers as described in this Benefit Booklet.

44. Any of the following applied behavior analysis (ABA) services;

    - services with a primary diagnosis that is not Autism Spectrum Disorder;
    - services that are facilitated by a Provider that is not properly credentialed. Please see the definition of Qualified ABA Provider in the **DEFINITIONS** section of this Benefit Booklet;
    - activities primarily of an educational nature;
    - respite, shadow, or companion services; or
    - any other services not provided by an appropriately licensed Provider in accordance with nationally accepted treatment standards.

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

46. Any services or supplies provided for cranial banding.

47. Any services or supplies provided for growth hormone therapy.

48. Medical and Surgical treatment of excessive sweating (hyperhidrosis).

49. Any services or supplies for elective abortions.

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

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 the Claim Administrator (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 the Claim Administrator in Texas or any other Blue Cross and Blue Shield Plan*** - The Allowable Amount is based on the terms of the Provider contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis-related groups (DRG), fee schedule, package pricing, global pricing, per diems, case-rates, discounts, or other payment methodologies.
- ***For Hospitals and Facility Other Providers, Physicians, Professional Other Providers, and any other provider not contracting with the Claim Administrator in Texas*** - 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 the Claim Administrator. 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 the Claim Administrator. 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 the Claim Administrator. Such factor shall be not less than 75% and shall be updated not less than every two years.

  The Claim Administrator will utilize the same claim processing rules and/or edits that it utilizes in processing Network Provider claims for processing claims submitted by non-contracted Providers which may also alter the Allowable Amount for a particular service. In the event the Claim Administrator does not have any claim edits or rules, the Claim Administrator 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 the Claim Administrator 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.

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

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

Behavioral Health Practitioner means a Physician or Professional Other Provider who renders services for Mental Health Care, Serious Mental Illness or Substance Use Disorder, only as listed in this Benefit Booklet.

Blue Distinction Centers (BDC) means a health care Provider, Hospital or medical facility recognized for their expertise in delivering specialty care. Please see the subsection entitled **Blue Distinction Centers** for more information.

Blue Distinction Centers+ (BDC+) means a health care Provider, Hospital or medical facility recognized for their expertise and efficiency in delivering specialty care. Please see the subsection entitled **Blue Distinction Centers** for more information.

Blue Distinction Centers (BDC) and Blue Distinction Centers+ (BDC+) Benefit Differential Product means your employer has chosen to provide a lower out- of- pocket cost when you utilize a BDC or BDC+ designated provider for certain specialty care procedures and treatment.

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

Care Coordination means organized, information-driven patient care activities intended to facilitate the appropriate responses to Covered Person's healthcare needs across the continuum of care.

Care Coordinator Fee means a fixed amount paid by a Blue Cross and/or Blue Shield Plan to providers periodically for Care Coordination under a Value-Based Program.

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)

Chiropractic Services means any of the following services, supplies or treatment provided by or under the direction of a Doctor of Chiropractic acting within the scope of their license: general office services, general services provided in an outpatient facility setting, x-rays, supplies, and physical treatment. Physical treatment includes functional occupational therapy, physical/mechano therapy, muscle manipulation therapy and hydrotherapy.

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

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).

Complications of Pregnancy means:

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

Contracting Facility means a Hospital, a Facility Other Provider, or any other facility or institution with which the Claim Administrator 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.

Co-Share Amount means the dollar amount of Eligible Expenses during a Plan Year to be applied toward the Out-of-Pocket Maximum.

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. Surgical, oral appliances and diagnostic treatment of conditions affecting the temporomandibular joint (including the jaw and the craniomandibular joint) as a result of an accident, a trauma, a congenital defect, a developmental defect, or a pathology;
3. Incision and drainage of facial abscess; and
4. Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses.

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

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

Deductible means the dollar amount of Eligible Expenses that must be incurred by a Participant, if "Individual Coverage" is elected, before benefits under this Plan will be available.

Dependent means your spouse as defined by applicable law or any *child* covered under the Plan who is under the Dependent child limiting age shown on your Schedule of Coverage.

Child means:

a. an individual who:

i. is the Employee's son, daughter, stepson, or stepdaughter; or

ii. legally adopted or lawfully placed for adoption with the Employee;

iii. is an individual for who the Employee has been appointed Legal Guardian until such individual reaches the age of majority or the age such guardianship no longer applies as specified in the court documents.;

iv. is a foster child who has been placed with the Employee by an authorized placement agency, or by judgement, decree or other court order of any court of competent jurisdiction; or

v. is an Incapacitated Dependent.

b. is (except for an Incapacitated Dependent) less than 26 years of age.

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).

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.

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.

Effective Date means the date the coverage for a Participant actually begins. It may be different from the Eligibility Date.

Eligibility Date means the date the Participant satisfies the definition of either "Employee" or "Dependent", as determined by your Employer or the Plan Administrator, and is in a class eligible for coverage under the Plan as described in the **WHO GETS BENEFITS** section of this Benefit Booklet.

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

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

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

Employee means a person who:

1. Regularly provides personal services at the Employee's usual and customary place of employment with the Employer; and
2. Works a specified number of hours per week or month as required by the Employer; and
3. Is recorded as an Employee on the payroll records of the Employer; and
4. Is compensated for services by salary or wages. If applicable to this group, proprietors, partners, corporate officers and directors need not be compensated for services by salary or wages.

For purposes of this plan, the term *Employee* will also include those individuals who are no longer an Employee of the Employer, but who are participants covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

In addition, the term *Employee* will include a retired Employee who meets all the criteria established by the Employer in order to be eligible for continued coverage under this Plan after retirement. Such criteria has been established by the Employer on a basis that precludes individual selection.

Employer means the person, firm, or institution named on this Benefit Booklet.

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 and any of such items requiring Federal or other governmental agency approval not granted at the time services were provided.

Approval by a Federal agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient. Approval by a federal agency will be taken into consideration by BCBSTX in assessing Experimental/Investigational status but will not be determinative.

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

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

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

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

Although a Physician or Professional Other Provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, the Claim Administrator 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.

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

Group Health Plan (GHP) as applied to this Benefit Booklet means a self-funded employee welfare benefit plan. For additional information, refer to the definition of Plan Administrator.

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

HIPAA means the Health Insurance Portability and Accountability Act of 1996.

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

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

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

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

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

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

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

1. Licensed in accordance with state law (where the state law provides for such licensing); or

2. Certified by Medicare as a supplier of Hospice Care.

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

Hospital means a short-term acute care facility which:

1. Is duly licensed as a Hospital by the state in which it is located and meets the standards established for such licensing, and is either accredited by the Joint Commission on Accreditation of Healthcare Organizations or is certified as a Hospital provider under Medicare;
2. Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians or Behavioral Health 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; and
5. Has in effect a Hospital Utilization Review Plan.

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

Bed patient means confinement in a bed accommodation of a Substance Use Disorder 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 Substance Use Disorder 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 Claim Administrator of the Plan indicating pertinent information applicable to their coverage.

Imaging Center means a Provider that can furnish technical or total services with respect to diagnostic imaging services and is licensed through the *Department of State Health Services Certificate of Equipment Registration and/or Department of State Health Services Radioactive Materials License*.

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 the Claim Administrator.

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 Substance Use Disorder Treatment Center; and
3. Furnished to and used by the Participant during an inpatient Hospital Admission.

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

Inpatient Hospital Expense shall include:

1. Room accommodation charges. If the Participant is in a private room, the amount of the room charge in excess

of the Hospital's average semiprivate room charge *is not* an Eligible Expense.

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

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

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

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

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

1. The individual:
   a. Was covered under another Health Benefit Plan or self-funded Health Benefit Plan at the time the individual was eligible to enroll; and
   b. Declines in writing, at the time of initial eligibility, stating that coverage under another Health Benefit Plan or self-funded Health Benefit Plan was the reason for declining enrollment; and
   c. Has lost coverage under another Health Benefit Plan or self-funded Health Benefit Plan as a result of:
      (1) termination of employment;
      (2) reduction in the number of hours of employment;
      (3) termination of the other plan's coverage;
      (4) termination of contributions toward the premium made by the Employer;
      (5) COBRA coverage has been exhausted;
      (6) cessation of Dependent status;
      (7) the Plan no longer offers any benefits to the class of similarly situated individuals that include the individual; or
      (8) 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 or in the event of the attainment of a lifetime limit on all benefits, the individual must request to enroll not later than 31 days after a claim is denied due to the attainment of a lifetime limit on all benefits.
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 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.

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

Managed Care means a type of health care focused on helping to reduce costs while delivering the appropriate quality services to the Participant.

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

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

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

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

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

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

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

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

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

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

1. Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, or bodily malfunction; and
2. Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States; and
3. Not primarily for the convenience of the Participant, their Physician, Behavioral Health Practitioner, the Hospital, or the Other Provider; and
4. The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the Participant. 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. BCBSTX does not determine course of treatment or whether particular health care services are received. The decision regarding the course of treatment and receipt of particular health

care services is a matter entirely between the Participant, their Physician, Behavioral Health Practitioner, the Hospital, or the Other Provider.

The medical staff of the Claim Administrator 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 Claim Administrator, whether or not the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin;
2. The diagnosis or treatment of any symptom, condition, disease, or disorder by a 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.

Morbid Obesity means a Body Mass Index (BMI) of greater than or equal to 40 kg/meter^2 or a BMI greater than or equal to 35 kg/meters^2 with at least two of the following co-morbid conditions which have not responded to a maximum medical management and which are generally expected to be reversed or improved by bariatric treatment:

- Hypertension
- Dyslipidemia
- Type 2 diabetes
- Coronary heart disease
- Sleep Apnea

Negotiated National Account Arrangement means an agreement negotiated between one or more Blue Cross and/or Blue Shield Plans for any national account that is not delivered through the BlueCard Program.

Network means identified Physicians, Behavioral Health Practitioner, 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.

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.

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 Plan Anniversary Date during which Employees and Dependents may enroll for coverage.

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

1. **Facility Other Provider** - an institution or entity, only as listed:
   a. Substance Use Disorder 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 their 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 Substance Use Disorder 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. Midwife
   t. Nurse First Assistant
   u. Physician Assistant
   v. Psychological Associates who work under the supervision of a Doctor in Psychology

In states where there is a licensure requirement, other Providers must be licensed by the appropriate state administrative agency.

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

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

Out-of-Pocket Maximum means, if "Individual only" coverage is elected, the cumulative dollar amount of Eligible Expenses, including the Plan Year Deductible, incurred by the Employee during a Plan Year. If "Family" coverage is elected, Out-of-Pocket Maximum means the cumulative dollar amount of Eligible Expenses, including the Plan Year Deductible, incurred by the family during a Plan Year.

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

Participant means an Employee or Dependent or a retired Employee whose coverage has become effective under this Plan.

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 their license, who is a Doctor of Medicine or Doctor of Osteopathy.

Plan means a program of health and welfare benefits established for the benefit of its Participants whether the plan is subject to the rules and regulations of the Employee's Retirement and Income Security Act (ERISA) or, for government and/or church plans, where compliance is voluntary.

Plan Administrator means a named administrator of the Group Health Plan (GHP), as that term is used under ERISA, having fiduciary responsibility for its operation. BCBSTX is not the Plan Administrator of Employer's employee welfare benefit plan as defined under ERISA.

Plan Anniversary Date means the day, month, and year of the 12-month period following the Plan Effective Date and corresponding date in each year thereafter for as long as this Benefit Booklet is in force.

Plan Effective Date means the date on which coverage for the Employer's Plan begins with the Claim Administrator.

Plan Month means each succeeding calendar month period, beginning on the Plan Effective Date.

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

Plan Year means the period commencing on the Contract Date/Contract Anniversary and ending on the day before the next Contract Anniversary date. Please contact your Employer for Plan Year information.

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

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

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

Proof of Loss means written evidence of a claim including:

1. The form on which the claim is made;
2. Bills and statements reflecting services and items furnished to a Participant and amounts charged for those services and items that are covered by the claim; and

3. Correct diagnosis code(s) and procedure code(s) for the services and items.

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

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

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

Provider Incentive means an additional amount of compensation paid to a healthcare provider by a Blue Cross and/or Blue Shield Plan, based on the provider's compliance with agreed-upon procedural and/or outcome measures for a particular population of covered persons.

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.

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

For the treatment supervisor/case manager/facilitator:

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

For the para-professional/line therapist:

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

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

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

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

Residential Treatment Center means a facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a level of security, supervision, and structure medically necessary to meet the needs of patients served or to be served by such facility. Residential Treatment Centers must be licensed by the appropriate state and local authority as a Residential Treatment Facility or its equivalent under the laws or regulations of such locality and/or must be accredited by a national accrediting body as a Residential Treatment Center or its equivalent. Accepted accrediting bodies are The Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), Accreditation Association for Ambulatory Healthcare

(AAAHC), Council on Accreditation of Services for Families and Children Inc. (COA), or National Integrated Accreditation of Healthcare Organizations (NIAHOSM). This includes any specialized licensing that may be applicable given the services to be provided or population to be served. As they do not provide the level of care, security, or supervision appropriate of a Residential Treatment Center, the following shall not be included in the definition of Residential Treatment Center: half-way houses, supervised living, group homes, wilderness programs, boarding houses or other facilities that provide primarily a supportive/custodial environment and/or primarily address long term social needs, even if counseling is provided in such facilities. To qualify as a Residential Treatment Center, patients must be medically monitored with 24-hour medical professional availability and on-site nursing care and supervision for at least one shift a day with on call availability for the other shifts.

Residential Treatment Center for Children and Adolescents means a child-care institution which is appropriately licensed and accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Association of Psychiatric Services for Children as a residential treatment center for the provisions of Mental Health Care and Serious Mental Illness services for emotionally disturbed children and adolescents.

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

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

Routine Patient Care Costs do not include:

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

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

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

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

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

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

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

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

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral; or
2. Accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations; or
3. Licensed as a Substance Use Disorder treatment program by the Texas Commission on Alcohol and Drug Abuse; or
4. Licensed, certified, or approved as a Substance Use Disorder treatment program or center by any other state agency having legal authority to so license, certify, or approve.

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

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

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

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

Value-Based Program means an outcome-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.

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

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

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

GENERAL PROVISIONS

Agent

The Employer is not the agent of the Claim Administrator.

Amendments

The Plan may be amended or changed at any time by agreement between the Employer and the Claim Administrator.

The Claim Administrator's Ownership Interests

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

Assignment and Payment of Benefits

Rights and benefits under the Plan shall not be assignable, either before or after services and supplies are provided.

In the absence of a written agreement with a Provider, the Claim Administrator reserves the right to make benefit payments to the Provider or the Employee, as the Claim Administrator elects. Payment to either party discharges the Plan's responsibility to the Employee or Dependents for benefits available under the Plan.

Claims Liability

BCBSTX, in its role as Claim Administrator, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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 the Claim Administrator 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, this 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. The Claim Administrator does not furnish services or supplies but only makes payment for Eligible Expenses incurred by Participants. The Claim Administrator is not liable for any act or omission by any health care Provider. The Claim Administrator 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.

The Claim Administrator, Network Providers, and/or other contracting Providers are independent contractors with respect to each other. The Claim Administrator in no way controls, influences, or participates in the health care treatment decisions entered into by said Providers. The Claim Administrator 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.

Overpayment

If your Group Health Plan or the Claim Administrator 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 it was made in error ("Overpayment"), your Group Health Plan or the Claim Administrator has the right to obtain a refund of the Overpayment amount from: (i) the person to, or for whom, such benefits were paid, or (ii) any insurance company or plan, or (iii) any other persons, entities, or organizations, including, but not limited to Network Providers or Out-of-Network Providers.

If no refund is received, your Group Health Plan and/or Blue Cross and Blue Shield (in its capacity as insurer or administrator) has the right to deduct any refund for any Overpayment due up to an amount equal to the Overpayment, from:

1. Any future benefit payment made to any person or entity under this Benefit Booklet, whether for the same or a different Participant; or
2. Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield administered ASO benefit program and/or Blue Cross and Blue Shield administered insured benefit program or policy, if the future benefit payment owed is to a Network Provider; or
3. Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield insured group benefit plan or individual policy, if the future benefit payment owed is to a Network Provider; or
4. Any future benefit payment, or other payment, made to any person or entity; or
5. Any future payment owed to one or more Network Providers.

Further, the Claim Administrator has the right to reduce your Group Health Plan's payment to a Network Provider by the amount necessary to recover another Blue Cross and Blue Shield's plan or policy Overpayment to the same Network Provider and to remit the recovered amount to the other Blue Cross and Blue Shield plan or policy.

Rescission

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

Subrogation

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

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

Right of Reimbursement

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

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

Right to Recovery by Subrogation or Reimbursement

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

Coordination of Benefits

The availability of benefits specified in This Plan 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; or
   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 Benefit Booklet 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 Plan 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 Benefit Booklet contains any dental or vision benefits, the benefits provided by the health portion of This Plan 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 Plan 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; or
2. insurance companies; or
3. Hospitals, Physicians, or Other Providers; or
4. any other person or organization.

Termination of Coverage

Termination of Individual Coverage

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

1. Your contribution for coverage under the Plan is not received timely by the Plan Administrator; 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 the Plan is amended, at the direction of the Plan Administrator, to terminate the coverage of the class of Employees to which you belong; 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 of Group Coverage - Federal** in the **GENERAL PROVISIONS** section of this Benefit Booklet.

The Claim Administrator 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 your Schedule of Coverage if the child continues to be both:

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

Disabled means any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. The child must be covered under the Plan and the disability must begin before the child attains the limiting age. You must submit satisfactory proof of the disability and dependency through your Plan Administrator to the Claim Administrator prior to 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 Claim Administrator 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.

Continuation of Group Coverage - Federal

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 Employer is exempt from the provisions of COBRA.

Minimum Size of Group

The Group must have normally employed more than twenty (20) employees on a typical business day during the preceding Plan Year. This refers to the number of 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 Plan 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 contribution is not made to the Plan with respect to the qualified beneficiary.
4. The Group Health Plan is canceled.
5. The date, after the date of the election, upon which the qualified beneficiary first becomes covered under any other group health 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.

Value Based Design Programs

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

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

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

AMENDMENTS

BENEFIT BOOKLET
NO SURPRISES ACT AMENDMENT

Amendment Effective Date: This Amendment is effective on the Employer's Contract Anniversary Date or for the Plan Year of Your Employer's Group Health Plan occurring on or after January 1, 2022.

The terms of this Amendment supersede the terms of the Benefit Booklet to which this Amendment is attached and becomes a part of the Benefit Booklet. Unless otherwise required by Federal or Texas law, in the event of a conflict between the terms on this Amendment and the terms of the Benefit Booklet, the terms on this Amendment apply. However, definitions set forth in this Amendment are for purposes of this Amendment only. Additionally, for purposes of this Amendment, references to You and Your mean any member, including Participant and Dependents.

The Benefit Booklet is hereby amended as indicated below:

I. Continuity of Care

If You are under the care of a Participating Provider as defined in the Benefit Booklet who stops participating in the Plan's network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), You may be able to continue coverage for that Provider's covered services at the in-network benefit level if one of the following conditions is met:

1. You are undergoing a course of treatment for a serious and complex condition,
2. You are undergoing institutional or inpatient care,
3. You are scheduled to undergo nonelective surgery from the Provider (including receipt of postoperative care from such Provider with respect to such surgery),
4. You are pregnant or undergoing a course of treatment for Your pregnancy, or
5. You are determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if You are currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), and (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date the Plan notifies You of the Provider's termination, or any longer period provided by state law. If You are in the second or third trimester of pregnancy when the Provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery. You have the right to appeal any decision made for a request for benefits under this provision, as explained in the Benefit Booklet.

II. Federal No Surprises Act

1. Definitions

The definitions below apply only to this No Surprises Act Amendment. To the extent the same terms are defined in both the Benefit Booklet and this Amendment, those terms will apply only to their use in the Benefit Booklet or this Amendment, respectively.

"Air Ambulance Services" means, for purposes of this Amendment only, medical transport by helicopter or airplane for patients.

"Emergency Medical Condition" means, for purposes of this Amendment only, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition: (i) placing the health of the individual, or with respect to a pregnant woman her unborn child in serious jeopardy; (ii) constituting a serious impairment to bodily functions; or (iii) constituting a serious dysfunction of any bodily organ or part.

"Emergency Services" means, for purposes of this Amendment only,

- a medical screening examination performed in the emergency department of a hospital or an Independent Freestanding Emergency Department;
- further medical examination or treatment You receive at a Hospital, regardless of the department of the Hospital, or an Independent Freestanding Emergency Department to evaluate and treat an Emergency Medical Condition until Your condition is stabilized; and
- covered services You receive from a Non-Participating Provider during the same visit after Your Emergency Medical Condition has stabilized unless:
    1. Your Non-Participating Provider determines You can travel by non-medical or non-emergency transport;
    2. Your Non-Participating Provider has provided You with a notice to consent form for balance billing of services; and
    3. You have provided informed consent.

"Non-Participating Provider" means, for purposes of this Amendment only, with respect to a covered item or service, a physician or other health care provider who does not have a contractual relationship with BCBSTX for furnishing such item or service under the Plan to which this Amendment is attached.

"Non-Participating Emergency Facility" means, for purposes of this Amendment only, with respect to a covered item or service, an emergency department of a hospital or an Independent Freestanding Emergency Department that does not have a contractual relationship with BCBSTX for furnishing such item or service under the Plan to which this Amendment is attached.

"Participating Provider" means, for purposes of this Amendment only, with respect to a covered service, a physician or other health care provider who has a contractual relationship with BCBSTX

setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to which this Amendment is attached regardless whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

"Participating Facility" means, for purposes of this Amendment only, with respect to covered service, a hospital or ambulatory surgical center that has a contractual relationship with BCBSTX setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to which this Amendment is attached. Whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

"Qualifying Payment Amount" means, for purposes of this Amendment only, a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

"Recognized Amount" means, for purposes of this Amendment only, an amount determined pursuant a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no state law that provides a method for determining the total amount payable for the item or service, the lesser of the Qualifying Payment Amount or billed charges.

2. <u>Federal No Surprises Act Surprise Billing Protections</u>

a. The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by Non-Participating Providers and Non-Participating Emergency Facilities. The items and services included in these protections ("Included Services") are listed below.

- Emergency Services obtained from a Non-Participating Provider or Non-Participating Emergency Facility.
- Covered non-Emergency Services performed by a Non-Participating Provider at a Participating Facility (unless You give written consent and give up balance billing protections).
- Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider.

b. <u>Claim Payments</u>

For Included Services, the Plan will send an initial payment or notice of denial of payment directly to the Provider.

c. <u>Cost-Sharing</u>

For non-Emergency Services performed by Non-Participating Providers at a Participating Facility, and for Emergency Services provided by a Non-Participating Provider or Non-Participating Emergency Facility, the Recognized Amount is used to calculate Your cost-share requirements, including Deductibles, Copayment Amounts, and Co-Share Amount.

For Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider, the amount used to calculate Your cost-share requirements, including Deductibles, Copayment Amounts, and Co-Share Amount, will be the lesser of the Qualifying Payment Amount or billed charges.

For Included Services, these cost-share requirements will be counted toward Your in-network Deductible and/or Out-of-Pocket Maximum, if any.

3. Prohibition of Balance Billing

You are protected from balance billing on Included Services as set forth below.

If You receive Emergency Services from a Non-Participating Provider or non-Participating Emergency Facility, the most the Non-Participating Provider or non-Participating Emergency Facility may bill You is Your in-network cost-share. You cannot be balance billed for these Emergency Services unless You give written consent and give up Your protections not to be balanced billed for services You receive after You are in a stable condition.

When You receive Covered Non-Emergency Services from a Non-Participating Provider at a Participating Facility, the most those Non-Participating Providers may bill You is Your Plan's in-network cost-share requirements. When You receive emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services at a Participating Facility, Non-Participating Providers can't balance bill You and may not ask You to give up Your protections not to be balance billed. If You get other services at Participating Facilities, Non-Participating Providers can't balance bill You unless You give written consent and give up Your protections.

If Your Plan includes Air Ambulance Services as a covered service, and such services are provided by a Non-Participating Provider, the most the Non-Participating Provider may bill You is Your in-network cost-share. You cannot be balance billed for these Air Ambulance Services.

NOTE: The revisions to Your Plan made by this Amendment are based upon the No Surprises Act, a federal law enacted in 2020 and effective for plan years beginning on or after January 1, 2022. To the extent federal regulations are adopted or additional guidance is issued by federal regulatory agencies that alter the terms of this Amendment, the regulations and any additional guidance will control over conflicting language in this Amendment.

NOTICES

NOTICE

Other Blue Cross and Blue Shield Plans Separate Financial Arrangements with Providers

Out-of-Area Services

Blue Cross and Blue Shield of Texas (BCBSTX) has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of BCBSTX service area, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard Program, and may include negotiated National Account arrangements available between BCBSTX and other Blue Cross and Blue Shield Licensees.

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

A. BlueCard® Program

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

For inpatient facility services received in a Hospital, the Host Blue's participating Provider is required to obtain Prior Authorization. If Prior Authorization is not obtained, the participating Provider will be sanctioned based on the Host Blue's contractual agreement with the Provider, and the Participant will be held harmless for the Provider sanction.

Whenever you access covered healthcare services outside BCBSTX's service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to us.

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

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

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

B. Negotiated (non-BlueCard Program) National Account Arrangements

As an alternative to the BlueCard Program, your claims for covered healthcare services may be processed through a negotiated National Account arrangement with a Host Blue.

The amount you pay for covered healthcare services under this arrangement will be calculated based on the lower of either billed covered charges or negotiated price (Refer to the description of negotiated price under Section A., BlueCard Program) made available to us by the Host Blue.

C. Non-Participating Healthcare Providers Outside BCBSTX Service Area

1. In General

   When Covered Services are provided outside of the Plan's service area by non-participating healthcare Providers, the amount(s) you pay for such services will be calculated using the methodology described in the Benefit Booklet for non-participating healthcare Providers located inside our service area. You may be responsible for the difference between the amount that the non-participating healthcare Provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

2. Exceptions

   In some exception cases, the Plan may, but is not required to, in its sole and absolute discretion negotiate a payment with such non-participating healthcare Provider on an exception basis. If a negotiated payment is not available, then the Plan may make a payment based on the lesser of:

   a. the amount calculated using the methodology described in the Benefit Booklet for non-participating healthcare Providers located inside your service area (and described in Section C(a)(1) above); or
   b. The following:

      1. for professional Providers, an amount equal to the greater of the minimum amount required in the methodology described in the Benefit Booklet for non-participating healthcare Providers located inside your service area; or an amount based on publicly available Provider reimbursement data for the same or similar professional services, adjusted for geographical differences where applicable, or

      2. for Hospital or facility Providers, an amount equal to the greater of the minimum amount required in the methodology described in the Benefit Booklet for non-participating healthcare Providers located inside your service area; or an amount based on publicly available data reflecting the approximate costs that Hospitals or facilities have incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the Hospital or facility.

In these situations, you may be liable for the difference between the amount that the non-participating healthcare Provider bills and the payment Blue Cross and Blue Shield of Texas will make for the Covered Services as set forth in this paragraph.

D. Value-Based Programs BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not bear any portion of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees of such arrangement, except when a Host Blue passes these fees to Blue Cross and Blue Shield of Texas through average pricing or fee schedule incentive adjustments.

Under the Agreement, Employer has with Blue Cross and Blue Shield of Texas, Blue Cross and Blue Shield of Texas and Employer will not impose cost sharing for Care Coordinator Fees.

E. Blue Cross Blue Shield Global Core Program

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

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

NOTICE

- **Inpatient Services**

In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts/Deductibles, Co-Share Amounts, etc. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. **You must contact the Plan to obtain Prior Authorization for non-emergency inpatient services.**

- **Outpatient Services**

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

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

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

NOTICE

The Women's Health and Cancer Rights Act of 1998 requires this notice. This Act is effective for plan year anniversaries on or after October 21, 1998. This benefit may already be included as part of your coverage.

In the case of a covered person receiving benefits under their plan in connection with a mastectomy and who elects breast reconstruction, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

1. Reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Deductibles, Co-Share and copayment amounts will be the same as those applied to other similarly covered medical services, such as surgery and prostheses.

NOTICE

ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER HEALTH CARE PRACTITIONERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR HEALTH BENEFIT PLAN.

NOTICE

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.

Information Provided by your Employer

This includes travel and lodging for Congenital Heart Disease (CHD), Obesity surgery services,
Transplantation services, and Cancer-related treatments. A combined overall maximum Benefit
of $10,000 per Covered Person applies

Travel and Lodging

The Claims Administrator will assist the patient and family with travel and lodging arrangements related to:

- *Congenital Heart Disease (CHD).*
- *Obesity surgery services.*
- *Transplantation services.*
- *Cancer-related treatments.*

For travel and lodging services to be covered, the patient must be receiving services at a
Designated Facility.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the patient, provided he or she is not
covered by Medicare, and a companion as follows:
Transportation of the patient and one companion who is traveling on the same day(s) to
and/or from the site of the cancer-related treatment, the obesity surgery service, the CHD service, or the transplant for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.

- Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one
companion. Benefits are paid at a per diem (per day) rate of up to $50 per day for the
patient or up to $100 per day for the patient plus one companion.
- If the patient is an enrolled Dependent minor child, the transportation expenses of two
companions will be covered, and lodging expenses will be reimbursed at a per diem rate
up to $100 per day.

Travel and lodging expenses are only available if the recipient lives more than 50 miles from
the Designated Facility for BRS, CRS, transplantation or CHD. BCBSTX must receive valid receipts for such charges before you will be reimbursed. Examples of travel
expenses may include:

- Airfare at coach rate.

■ Taxi or ground transportation.
■ Mileage reimbursement at the IRS rate for the most direct route between the patient's home
and the Designated Facility.

A combined overall maximum Benefit of $10,000 per Covered Person applies for all travel
and lodging expenses reimbursed under this Plan in connection with all cancer treatments,
transplant procedures, CHD treatments and obesity surgery services during the entire period
that person is covered under this Plan.

Pharmacy Benefits Plan at a Glance

<table>
<tr><td rowspan="8">What you pay for prescription drugs
Retail: 30-day supply
Mail order: 90-day supply

Network and out-of-network cost sharing amounts are combined for the deductible and annual out-of-pocket maximum.

Cost sharing amounts are combined with the medical benefit out of pocket maximum.</td><td></td><td>Retail Network Pharmacy
(30-day)</td><td>CVS/Caremark Mail Order Service
(90-day)</td><td>Retail Out-of-Network Pharmacy
(30-day)</td></tr>
<tr><td>Deductible</td><td>$3,300 Single
$6,000 Family</td><td>$3,300 Single
$6,000 Family</td><td>$5,000 Single
$10,000 Family</td></tr>
<tr><td>Generic formulary</td><td>$0 after Deductible

Drugs on Preventive Drug List: $0 Copay</td><td>$0 after Deductible

Drugs on Preventive Drug List: $0 Copay</td><td>Deductible and coinsurance</td></tr>
<tr><td>Formulary brand</td><td>$0 after Deductible

Drugs on Preventive Drug List: $20 Copay</td><td>$0 after Deductible

Drugs on Preventive Drug List: $20 Copay</td><td>Deductible and coinsurance</td></tr>
<tr><td>Non-formulary brand</td><td>$0 after Deductible

Drugs on Preventive Drug List: $40 Copay</td><td>$0 after Deductible

Drugs on Preventive Drug List: $40 Copay</td><td>Deductible and coinsurance</td></tr>
<tr><td>Specialty</td><td>$0 after deductible</td><td>N/A</td><td>No Coverage</td></tr>
<tr><td>Annual out-of-pocket maximum</td><td>$3,300 Single
$6,000 Family</td><td>$3,300 Single
$6,000 Family</td><td>$7,000 Single
$14,000 Family</td></tr>
<tr><td>Your Benefit Year</td><td colspan="3">October 1 – September 30</td></tr>
<tr><td>Filing claims</td><td colspan="4">When you use a network pharmacy, the pharmacy will file the claim for you.

If you use an out-of-network pharmacy, you must file the claim within the plan guidelines to receive benefits.</td></tr>
<tr><td>When coverage ends</td><td colspan="4">Pharmacy benefit coverage ends at the end of the month in which your eligibility ends.</td></tr>
</table>

How Prescription Drug Benefits Work

Your Prescription Drug Benefit has three parts. These parts may be subject to Plan exclusions, conditions, limitations and cost sharing requirements.

1. Retail pharmacy prescription drug program. This is for short-term prescriptions. You can conveniently pick up these prescriptions at your local pharmacy that is in the network.

2. Mail order prescription program for maintenance or long term prescriptions. These will be mailed to your home and you have the option to conveniently pick them up at your local retail CVS Pharmacy.

3. Specialty prescription program for specialty medications that require extra care, handling and/or service. You will use the CVS / Specialty Pharmacy for all your Specialty medication needs. You have the option to conveniently pick them up at your local CVS Pharmacy.

Need Help?

Questions about your prescription coverage, locating a network pharmacy; or want to know more about the Formulary (see the definition of Formulary).

- Download and register on the CVS/caremark App on your mobile device.
- Register on the CVS/caremark website at www.caremark.com,
- Call CVS/caremark at 800-776-1355.

Understanding Your Prescription Drug Benefits

Here are some terms to help you better understand how Prescription drug benefits work and to get the most from your Plan.

Annual Out-of-Pocket Maximum

This is the most you will pay under the Plan during the plan year. It combines both Medical and Prescription Drug expenses. Prescription Copayments count toward the out-of-pocket maximum.

Brand Name Drug

This is a drug that has is protected by one or more patents.

Copay Cards

Dollars offered by pharmaceutical manufacturers to reduce the cost of prescription drugs. Any dollars used on a copay card for any prescription drug do not count toward your Annual out-of-Pocket Maximum (deductible or out-of-pocket). This applies to all drugs that offer non-financial-needs-based copay cards.

Copayment

The amount you will pay for each Prescription Drug when you use Network pharmacies.

Dispenses As Written (DAW)

DAW1 is when the medical provider who wrote the prescription indicates only to dispense the Brand Drug.

DAW2 is when the medical provider who wrote the prescription indicates Brand or Generic prescriptions are acceptable to dispense and you request a Brand Drug.

If your medical provider indicates DAW1 or if you request the Brand Drug you will pay the Brand cost sharing.

Exclusive Specialty

CVS / Specialty is the only specialty pharmacy and they use Prudent Rx to simplify your specialty drug care needs with a consistent member experience. They offer you the convenience to pick up your specialty medication at your CVS Retail Pharmacy.

Formulary or Preferred Drug List

This is the list of preferred drugs evaluated by CVS/caremark and found to be clinically effective for use. CVS/caremark has a Pharmacy and Therapeutics (P&T) Committee that reviews and approves Food and Drug Administration (FDA) approved drugs based on their safety and efficacy.

The name of your formulary is Advanced Control Formulary. The preferred drugs on this list changes periodically. When a change is made, and you are impacted, both you and your prescribing doctor will receive a notice about the change and the preferred alternative medications.

To learn more about the Advanced Control Formulary

- Download and register on the CVS/caremark App on your mobile device.
- Register on the CVS/caremark website at www.caremark.com,
- Call CVS/caremark at 800-776-1355.

Generic Drug

This is a drug that has the same active ingredient and is chemically equivalent to the Brand Name drug and, by law, must meet the same standards for safety, purity, strength and quality as a Brand Name Drug.

Maintenance (long-term) or Mail Order Prescriptions

You take Maintenance drugs on a regular basis to treat chronic conditions (for example: high blood pressure, heart conditions and diabetes).

When you get any prescription, please ask your medical provider if it is a maintenance medication. If it is a maintenance medication, then you should ask your medical provider to write two prescriptions:

1. For a 30-day supply to be filled immediately with one or two refills at the local Retail Network Pharmacy, and
2. For up to a 90-day supply to be filled by CVS/caremark through the mail order program.

They must be filled through the CVS/caremark mail order service or you can pick it up a CVS Retail Pharmacy. Reminder, you may fill or refill a maintenance prescription by

- Downloading and registering on the CVS/caremark App on your mobile device.
- Register on the CVS/caremark website at www.caremark.com,
- Call CVS/caremark at 800-776-1355.

Retail (Short Term or Acute) Prescriptions

These are prescription drugs prescribed for 30 days or less. Simply give your prescription to the Retail Network Pharmacy and pay your cost sharing. The Retail Network pharmacy will bill the Plan for the remainder. If you use an Out of Network Retail Pharmacy you will need to file a claim on your own.

Retail Network Pharmacy

A Retail Network Pharmacy has agreed with CVS/caremark to accept your cost sharing amount and electronically bill the Plan for the Plan's portion of the cost. You do not need to file a claim when you use a Retail Network Pharmacy.

Out-of-Network Retail Pharmacy

These Pharmacies are NOT part of your Retail Pharmacy Network. Short-term prescriptions filled at an Out-of-Network retail pharmacy are covered by the Plan. However, you will need to submit a paper claim form to CVS/caremark for coverage consideration under the Plan.

Over the Counter Drug

An over the counter drug is a one you can buy without a prescription. Some over the counter drugs are equivalent to a prescription drug. Your plan does NOT cover a prescription drug that has an over the counter equivalent.

Specialty Drug

A specialty drug is a prescription drug that can be a traditional drug, a biotech or a biological drug used to manage specific chronic or genetic disease or requires special handling, distribution, administration, monitoring or patient education and counseling. These must be filled by CVS Specialty.

Vaccines

Seasonal and nonseasonal vaccines are covered. Your Plan does not cover travel vaccines.

Utilization Management Programs

Programs, guidelines, requirements designed to improve the quality of care you receive and control overall Plan costs.

Advanced Control Formulary / Advanced Control Specialty Formulary

A formulary that provides access to quality medications and drives savings for you and the Plan.

Compound Strategy

Applies a clinically based prior authorization (PA) criteria for compounds that are more than $300. The review has timely initial coverage determinations by a pharmacist. If an appeal is necessary, it will be managed by a physician.

Drug Savings Review

Uses evidence-based clinical standards to identify opportunities to change medications that lead to improved drug therapy and cost savings. CVS uses timely, actionable, clinically supported, interventions when working with prescribers.

Generic Step Therapy

Generic Drugs will always be the first step before a brand name drug is considered when they are available.

Opioid Utilization Management

Designed to positively influence the prescribing and use of opioids to treat pain, while helping provide appropriate access to these medications. It aligns with the Guideline for Prescribing Opioids for Chronic Pain from the Centers for Disease Control and Prevention (CDC)

Prior Authorization (PA)

Some medications require additional information from your prescribing doctor before being dispensed. Your doctor can either access it electronically or they will be contacted by the pharmacist when a prior authorization is necessary.

Quantity Limits (QL)

Medications with the potential for over or misuse have a limitation on the maximum quantities which may be dispensed.

Specialty Guideline Management

Evidence based guidelines from the CVS/caremark Pharmacy and Therapeutics Committee are applied to a specialty drug before it is dispensed. Any changes to your medication will be approved by your physician prior it being changed.

Specialty Preferred Drug Step Therapy

The lowest net-cost specialty drugs in select therapeutic categories must be used before other higher-cost drugs are approved.

Utilization Review (UR) Pharmacy

A CVS/caremark pharmacist will evaluate patient drug utilization to identify prescription use that may lead to a severe medical condition and/or unnecessary medical costs. CVS/caremark contacts your physician if a potential drug-induced disease or interaction is identified.

Drugs and Services Not Covered and Limitations

Just because a licensed medical provider prescribes a medicine does not make it medically necessary or covered by the Plan. The Plan does NOT cover everything. We are providing more common items here; you should always contact CVS caremark with any questions about whether your drug or service is covered.

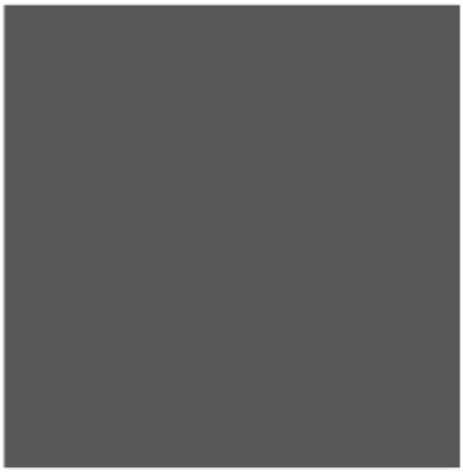
- Dispensed before the effective date of you or your dependent's participation in the Plan or after you or your dependent's participation in the Plan ends.
- That are refilled later than one year after the date of the original prescription date.
- For which Federal Law does not require a prescription (although one may be required under State Law) from an authorized provider (except insulin, insulin analogs, insulin pens and prescriptive and nonprescriptive oral agents for controlling blood sugar level); and drugs, insulin or covered devices for which no valid Prescription is obtained.
- Cosmetic drugs used primarily to enhance appearance, including, but not limited to correction of skin wrinkles and skin aging.
- Athletic performance enhancing drugs.
- That are entirely consumed or administered at the time and place the prescription order is issued (e.g. at a hospital or nursing home). See your medical plan SPD to see whether such drugs are covered by that plan (often being considered part of the medical services).
- Associated with the administration of any drug.
- Received from a source other than a retail or mail-order pharmacy.
- For which you (or the pharmacy) do not file a claim within 365 days after the prescription or service is provided.
- That exceed the supply limitations.
- That exceed the prescribed quantity.

- That are blood derivatives that are not officially classified as drugs except blood derivative products used as an ingredient in a biotech drug.
- That are used for off-label use, except as otherwise approved by the Claims Administrator.
- Shipping, handling or delivery charges.
- Traditional insulin pumps
- Allergy– injectable and non-injectable
- Nutritional supplements
- Arestin
- IV injectables
- Nebulizers
- Syringes other than insulin
- Cosmetic drugs
- Over the Counter Medications
- Travel Vaccines

Other Drug Limits

The plan places limits on the benefits it provides for the following types of drugs:

- Opioids Initial fill Immediate Release (IR) products 7 day limit with Morphine Milligram Equivalence (MME) limit.
- Opioids moving from IR to Extended Release (ER) go through step therapy and have MME limit.
- Topical lidocaine quantities are limited and a Prior Authorization is required for additional quantities.
- Anabolic steroids – a Prior Authorization is required.
- Antidiabetic GLP-1 agents may require a Prior Authorization.
- Disposable Insulin Pumps – a Prior Authorization is required.
- Fertility drugs – a Prior Authorization is required and a lifetime benefit of $15,000 applies.
- Growth hormones – a Prior Authorization is required.
- Certain medications for the prevention of Migraines may require Prior Authorization.
- Opzelura – a Prior Authorization is required.
- Oral and Intranasal Fentanyl Products – a Prior Authorization is required.
- Specialty Medications – a Prior Authorization is required
- Testosterone Products – a Prior Authorization is required.
- Weight Loss Medications – a Prior Authorization is required.









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