



BlueCross BlueShield
of Texas



Your Health Care Benefits Program

Managed Health Care

Pharmacy Benefits

Dental Benefits

Texas & Southwestern Cattle Raisers Assn.

Group #025923 – Select Plan

0259230034.0619

CERTIFICATE OF COVERAGE

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

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



President of Blue Cross and Blue Shield of Texas

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

The Schedule(s) of Coverage specify benefits for:

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

Pharmacy Benefits

Dental Benefits

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

IMPORTANT NOTICE

To obtain information or make a complaint:

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

1-800-521-2227

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

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

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

1-800-252-3439

- You may write the Texas Department of Insurance at:

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

- **PREMIUM OR CLAIM DISPUTES:** Should you have a dispute concerning your premium or about a claim, you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.
- **ATTACH THIS NOTICE TO YOUR POLICY:** This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

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

1-800-521-2227

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

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

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

1-800-252-3439

- Puede escribir al Departamento de Seguros de Texas:

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

- **DISPUTAS SOBRE PRIMAS O RECLAMOS:** Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el la compania primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).
- **UNA ESTE AVISO A SU POLIZA:** Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

TABLE OF CONTENTS

Page No.

Certificate of Coverage Important Notice

Schedule(s) of Coverage(s) Enclosure

Introduction

Managed Health Care - In-Network Benefits	1
Managed Health Care - Out-of-Network Benefits	1
Pharmacy Benefits	2
Comprehensive Dental Benefits	2
Important Contact Information	2
Customer Service Helpline	2
BCBSTX Website	3
Mental Health/Chemical Dependency Preauthorization Helpline	3
Dental Customer Service Helpline	3
Medical Preauthorization Helpline	3

Who Gets Benefits

Eligibility Requirements for Coverage	4
Effective Dates of Coverage	4
Changes In Your Family	6

How the Plan Works

Allowable Amount	7
Case Management	7
Continuity of Care	7
Freedom of Choice	8
Identification Card	8
Medical Necessity	9
ParPlan	9
Specialty Care Providers	10
Use of Non-Contracting Providers	10

Preauthorization Requirements 11

Claim Filing and Appeals Procedures

Claim Filing Procedures	13
Review of Claim Determinations	15

Eligible Expenses, Payment Obligations, and Benefits

Eligible Expenses	18
Copayment Amounts	18
Deductibles	18
Coinsurance Stop-Loss Amount	19
Changes In Benefits	20

Covered Medical Services

Inpatient Hospital Expenses	21
Medical-Surgical Expenses	22
Extended Care Expenses	24
Special Provisions Expenses	26
Benefits for Treatment of Complications of Pregnancy	26
Benefits for Maternity	26
[Benefits for In Vitro Fertilization Services	26
Benefits for Treatment of Chemical Dependency	27
Benefits for Serious Mental Illness	27
[Benefits for Mental Health Care	27
Benefits for Emergency Care and Treatment of Accidental Injury	28
[Benefits for Urgent Care	29
Benefits for Routine Exams and Immunizations	29
Benefits for Mammography Screening	29
Benefits for Detection and Prevention of Osteoporosis	29

Benefits for Tests for Detection of Colorectal Cancer	29
Benefits for Certain Tests for Detection of Prostate Cancer	30
Benefits for Certain Tests for Detection of Human Papillomavirus and Cervical Cancer	30
Benefits for Early Detection Test for Ovarian Cancer	30
Required Benefits for Childhood Immunizations	31
Benefits for Certain Therapies for Children with Developmental Delays	31
Benefits for Screening Tests for Hearing Impairment	32
Benefits for Cosmetic, Reconstructive, or Plastic Surgery	33
Benefits for Dental Services	33
Benefits for Organ and Tissue Transplants	34
Benefits for Treatment of Acquired Brain Injury	36
Benefits for Autism Spectrum Disorder	36
Benefits for Treatment of Diabetes	38
Benefits for Physical Medicine Services	40
Benefits for Routine Patient Costs for Participants in Certain Clinical Trials	40
Benefits for Orally Administered Anticancer Medication	41
Benefits for Early Detection Tests for Cardiovascular Disease	40
Benefits for Foot Orthotics	41
Benefits for Speech and Hearing Services	41
Medical Limitations and Exclusions	42
Definitions	45
Pharmacy Benefits	
Covered Drugs	63
Selecting a Pharmacy	65
Your Costs	63
About Your Benefits	65
Limitations and Exclusions	63
Definitions	65
Comprehensive Dental Benefits	67
Benefits Provided	67
DentaBlue SM Dentists	67
How Benefits Are Calculated	67
Deductible	67
Allowable Amount Determination	68
Predetermination of Benefits	68
[Maximum Dental Benefits	69
Covered Dental Expenses	69
Dental Limitations and Exclusions	71
General Provisions	
Amendments	73
Assignment and Payment of Benefits	73
Conformity with State Statutes	73
Disclosure Authorization	73
Medicare	73
Participant/Provider Relationship	73
Refund Of Benefit Payments	74
State Government Programs	74
Subrogation	75
Coordination of Benefits	76
Termination of Coverage	80
Continuation Privilege	82
Amendments	
Notices	

SCHEDULE OF COVERAGE

Premium Plan

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Deductibles <ul style="list-style-type: none"> • Per-admission Deductible • Calendar Year Deductible 	\$250 per-admission Deductible \$1,500 – per individual \$4,500 – per family	\$500 per-admission Deductible \$3,000 – per individual \$9,000 – per family
Coinsurance Stop-Loss Amounts	\$4,000 – per individual \$8,000 – per family	\$6,000– per individual \$12,000 – per family
Copayment Amount Required <ul style="list-style-type: none"> • Physician office visit/consultation • Retail Health Clinic Copayment Amount • Virtual Visits Copayment Amount • Urgent Care center visit • Outpatient Hospital Emergency Room visit 	\$30 Copayment Amount \$30 Copayment Amount \$30 Copayment Amount \$45 Copayment Amount \$200 outpatient Hospital Emergency Room visit Copayment Amount	\$200 outpatient Hospital Emergency Room visit Copayment Amount
Inpatient Hospital Expenses All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	70% of Allowable Amount \$250 per-admission Deductible No penalty for failure to preauthorize services	50% of Allowable Amount \$500 per-admission Deductible \$250 penalty for failure to preauthorize services
Medical-Surgical Expenses <ul style="list-style-type: none"> • Office visit/consultation[, including lab and x-ray] • Lab & x-ray (including in other Outpatient facilities) • Inpatient visits and Certain Diagnostic Procedures • Home Infusion Therapy • Physician surgical services in any setting 	100% of Allowable Amount after \$30 Copayment Amount 100% of Allowable Amount 70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible 50% of Allowable Amount after Calendar Year Deductible 50% of Allowable Amount after Calendar Year Deductible

SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Extended Care Expenses Deductible applies as shown		
<ul style="list-style-type: none"> • Skilled Nursing Facility 	100% of Allowable Amount	50% of Allowable Amount after Calendar Year Deductible
	25 days per Calendar Year	
<ul style="list-style-type: none"> • Home Health Care 	100% of Allowable Amount	50% of Allowable Amount after Calendar Year Deductible
	60 visits per Calendar Year	
<ul style="list-style-type: none"> • Hospice Care <p>Hospice Care that is provided in a Hospital will include charges as described in Inpatient Hospital Expenses.</p>	100% of Allowable Amount	50% of Allowable Amount after Calendar Year Deductible
	Unlimited	
Treatment of Chemical Dependency	Covered same as any other sickness	Covered same as any other sickness
Serious Mental Illness		
Inpatient Services		
Hospital services (facility)	70% of Allowable Amount after per-admission Deductible	50% of Allowable Amount after per-admission Deductible
Physician services	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Outpatient Services		
Physician Expenses (office setting)	100% of Allowable Amount after \$30 Copayment Amount	50% of Allowable Amount after Calendar Year Deductible
Other Outpatient Services	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Mental Health Care		
Inpatient Services		
Hospital services (facility)	70% of Allowable Amount after per-admission Deductible	50% of Allowable Amount after per-admission Deductible
Physician services	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Outpatient Services		
Physician Expenses (office setting)	100% of Allowable Amount after \$30 Copayment Amount	50% of Allowable Amount after Calendar Year Deductible
Other Outpatient Services	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible

SCHEDULE OF COVERAGE

Plan Provisions	In–Network Benefits	Out–of–Network Benefits
Emergency Room Treatment Accidental Injury & Emergency Care <ul style="list-style-type: none"> • Facility Charges • Physician Charges 	70% of Allowable Amount after \$200 outpatient Hospital emergency room Copayment Amount 70% of Allowable Amount after Calendar Year Deductible	
Emergency Room Treatment Non–Emergency Care <ul style="list-style-type: none"> • Facility Charges • Physician Charges 	70% of Allowable Amount after \$200 outpatient Hospital emergency room Copayment Amount 70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after \$200 outpatient Hospital emergency room Copayment Amount and after Calendar Year Deductible 50% of Allowable Amount after Calendar Year Deductible
Urgent Care Services <ul style="list-style-type: none"> • Urgent Care center visit, including lab & x–ray services(excluding Certain Diagnostic Procedures) • Services received during an Urgent Care visit – Certain Diagnostic Procedures 	100% of Allowable Amount after \$45 Copayment Amount 70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible 50% of Allowable Amount after Calendar Year Deductible
Ambulance Services	70% of Allowable Amount after Calendar Year Deductible	
Preventive Care Services Routine physical examinations, well baby care, immunizations 6 years & over, routine lab, x–ray, vision and hearing exams Immunizations for Dependent children through the date of the child’s 6 th birthday	100% of Allowable Amount after \$30 Copayment Amount – Deductible waived 100%	50% of Allowable Amount after Calendar Year Deductible 100%
Speech and Hearing Services, including hearing aids	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
	1 per ear per 36–month period for hearing aids	
Physical Medicine Services	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
	35 visits each Calendar Year	

SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
<p>Cardiovascular Tests</p> <p>One of the following early detection tests for cardiovascular disease will be covered for a Participant who meets the age requirements and is a diabetic or has been determined to have a risk of developing coronary heart disease:</p> <ul style="list-style-type: none"> • Computed tomography (CT) scanning measuring coronary artery calcification • Ultrasonography measuring carotoid intima-media thickness and plaque. 	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
	Maximum benefit of 1 test every 5 years	

SCHEDULE OF COVERAGE

PHARMACY BENEFITS

Plan Provisions	Participating Pharmacy	Non-Participating Pharmacy
Retail Pharmacy One Copayment Amount per 30-day supply, up to a 90-day supply only	\$10 Copayment Amount Generic Drug \$40 Copayment Amount* Preferred Brand Name Drug \$60 Copayment Amount* – Non-Preferred Brand Name Drug	70% of Allowable Amount minus Copayment Amount
Mail-Order Program One Copayment Amount per 30-day supply, up to a 90-day supply	\$10 Copayment Amount Generic Drug \$40 Copayment Amount* Preferred Brand Name Drug \$60 Copayment Amount* – Non-Preferred Brand Name Drug	
Specialty Drugs Available In-Network through Specialty Pharmacy Program One Copayment Amount per 30-day supply, up to a 90-day supply	\$10 Copayment Amount Generic Specialty Drug \$40 Copayment Amount Preferred Brand Name Specialty Drug \$60 Copayment Amount* Non-Preferred Brand Name Specialty Drug	70% of Allowable Amount minus Copayment Amount
Vaccinations obtained through Pharmacies**	Flu vaccine \$15 Copayment Amount	
Pharmacy Deductible	\$200 per Participant each Calendar Year	
Limitations on Quantities Dispensed – Day Supply	Applies	

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

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

Dependent Child Age Limit to 26

SCHEDULE OF COVERAGE

DENTAL BENEFITS

GROUP I - DIAGNOSTIC AND PREVENTIVE CARE - 80%

GROUP II - BASIC CARE - 80%

GROUP III - MAJOR CARE - 50%

PREDETERMINATION AMOUNT - \$300.00

DEDUCTIBLE EACH CALENDAR YEAR FOR EACH PARTICIPANT - \$ 50.00

FAMILY DEDUCTIBLE - PARTICIPANTS

DEDUCTIBLE WAIVED FOR GROUP I

THREE-MONTH DEDUCTIBLE CARRYOVER

MAXIMUM CALENDAR YEAR BENEFITS FOR GROUP I, II AND III - \$1500.00

DEPENDENT CHILD AGE LIMIT TO AGE 26

INTRODUCTION

This Plan is offered by the Contractholder as one of the benefits of your membership. 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. In the event of any conflict between any components of this Plan, the Schedule of Specifications provided to the Contractholder by BCBSTX prevails.

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

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

Managed Health Care – In–Network Benefits

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

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

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

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

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

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

Managed Health Care – Out–of–Network Benefits

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

INTRODUCTION

You will be responsible for...

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

Pharmacy Benefits

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

- the Prescription Order is filled at a Participating Pharmacy, or at a Non-Participating Pharmacy, or through the Mail Service Prescription Drug Program; or
- a Generic Drug is dispensed; or
- a Preferred or Non-Preferred Brand Name Drug is dispensed.

Comprehensive Dental Benefits

Your Comprehensive Dental Plan provides benefits for the Covered Dental Expenses described in the benefit categories listed below. The benefit percentage to be applied to each benefit category is shown on your Schedule of Coverage.

- Diagnostic and Preventive Care
- Basic Care
- Major Care

BCBSTX has written contracts with Dentists (herein called DentaBluesm Dentists) and you may limit your out-of-pocket expenses by choosing a Dentist from the DentaBlue Directory. You do, however, have the freedom to go to either a contracting or non-contracting Dentist.

Benefits for Comprehensive Dental Plan are described in greater detail as indicated later in this Benefit Booklet under the section, **Comprehensive Dental Plan**.

Important Contact Information

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

INTRODUCTION

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 Plans
- Record comments about Providers
- Assist you with questions regarding the **PHARMACY BENEFITS**

BCBSTX Website

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

Mental Health Helpline

To satisfy Preauthorization requirements for Participants seeking treatment for Serious Mental Illness or Chemical Dependency, you, your Physician, Provider of services, or a family member may call the Mental Health/Chemical Dependency Preauthorization Helpline at any time, day or night.

Dental Customer Service Helpline

If you have any questions regarding dental coverage, call the Dental Customer Service Helpline, Monday – Friday 8:00 am – 4:30 pm, Central Time.

Toll free: 1-800-647-0620 or 1-800-521-2227

Medical Preauthorization Helpline

To satisfy all medical Preauthorization requirements, call the Medical Preauthorization Helpline.

WHO GETS BENEFITS

Eligibility Requirements for Coverage

The Eligibility Date is the date a person becomes eligible to be covered under the Plan. A person becomes eligible to be covered when he becomes a Member or a Dependent and is eligible to be covered under the Plan. The Eligibility Date is the first of the month following underwriting approval.

No eligibility rules or variations in premium will be imposed based on your health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status related factor. Coverage under this 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.

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

Effective Dates of Coverage

In order for a Member's coverage to take effect, the Member 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 Contract is shown on your Identification Card. It may be different from the Eligibility Date.

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 Carrier within 31 days of birth and pay any required premium within that 31-day period or a period consistent with the next billing cycle. Coverage will become effective on the date of birth. If Texas and Southwestern Cattle Raisers Association is notified after that 31-day period, the newborn child's coverage will be dependent upon underwriting approval.

2. *Special Enrollment Period for Adopted Children or Children Involved in a Suit for Adoption*

Coverage of an adopted child or child involved in a suit for adoption will be automatic for the first 31 days following the adoption or date on which a suit for adoption is sought. For coverage to continue beyond this time, the Carrier must receive all necessary forms and the required premium within the 31-day period or a period consistent with the next billing cycle. Coverage will become effective on the date of adoption or date on which a suit for adoption is sought. If Texas and Southwestern Cattle Raisers

WHO GETS BENEFITS

Association is notified after that 31-day period, the child's coverage will be dependent upon underwriting approval.

3. ***Court Ordered Dependent Children***

If a court has ordered a Member to provide coverage for a child, coverage will be automatic for the first 31 days after the date your Contractholder receives notification of the court order. To continue coverage beyond the 31 days, the Carrier must receive all necessary forms and the required premium within the 31-day period. If Texas and Southwestern Cattle Raisers Association is notified after that 31-day period, the Dependent child's coverage will be dependent upon underwriting approval.

4. ***Court Ordered Coverage for a Spouse***

If a court has ordered you, the Member, to provide coverage for a spouse, written enrollment must be received within 31 days after issuance of the court order. Coverage will become effective on the first day of the month following the date the application for coverage is received and the required premium is paid within the 31-day period. If Texas and Southwestern Cattle Raisers Association is notified after that 31-day period, your spouse's coverage will be dependent upon underwriting approval.

5. ***Other Dependents***

Written application must be received within 31 days of the date that a spouse or child first qualifies as a Dependent if approved by underwriting. 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 Texas and Southwestern Cattle Raisers Association is notified after that 31-day period, then your Dependent's coverage will be dependent upon underwriting approval.

Changes In Your Family

You should promptly notify the Texas and Southwestern Cattle Raisers Association 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 Contractholder receives a court order to provide health coverage for a Participant's child or your spouse, you must notify the Texas and Southwestern Cattle Raisers Association and the coverage of the Dependent will become effective as described in ***Dependent Enrollment Period***.

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

HOW THE PLAN WORKS

Allowable Amount

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

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

Case Management

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

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

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

Continuity of Care

In the event a Participant is under the care of a Network Provider at the time such Provider stops participating in the Network and at the time of the Network Provider's termination, the Participant has *special circumstances* such as a (1) disability, (2) acute condition, (3) life-threatening illness, or (4) is past the 13th week of pregnancy and is receiving treatment in accordance with the dictates of medical prudence, BCBSTX will continue providing coverage for that Provider's services at the In-Network Benefit level.

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

The continuity of coverage under this subsection will not extend for more than ninety (90) days, or more than nine (9) months if the Participant has been diagnosed with a terminal illness, beyond the date the Provider's termination from the Network takes effect. However, for Participants past the 13th week of pregnancy at the time the Provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery.

HOW THE PLAN WORKS

Freedom of Choice

<i>Each time you need medical care, you can choose to:</i>		
See a Network Provider	See an Out-of-Network Provider	
	ParPlan Provider <i>(refer to ParPlan, below, for more information)</i>	Out-of-Network Provider that is not a contracting Provider
<ul style="list-style-type: none"> • 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 BCBSTX Allowable Amount for covered services • Your Provider will preauthorize necessary services 	<ul style="list-style-type: none"> • You receive the lower level of benefits (Out-of-Network Benefits) • You are not required to file claim forms in most cases; <i>ParPlan</i> Providers will usually file claims for you • You are not balance billed; <i>ParPlan</i> Providers will not bill for costs exceeding the BCBSTX Allowable Amount for covered services • In most cases, <i>ParPlan</i> Providers will preauthorize necessary services 	<ul style="list-style-type: none"> • You receive Out-of-Network Benefits (the lower level of benefits) • You are required to file your own claim forms • You may be billed for charges exceeding the BCBSTX Allowable Amount for covered services • You must preauthorize necessary services

Identification Card

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

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

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

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

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

1. The unauthorized, fraudulent, improper, or abusive use of Identification Cards issued to you and your covered Dependents will include, but not be limited to, the following actions, when intentional:
 - a. Use of the Identification Card prior to your Effective Date;
 - b. Use of the Identification Card after your date of termination of coverage under the Plan;

HOW THE PLAN WORKS

- c. Obtaining prescription drugs or other benefits for persons not covered under the Plan;
 - d. Obtaining prescription drugs or other benefits that are not covered under the Plan;
 - e. Obtaining Covered Drugs for resale or for use by any person other than the person for whom the Prescription Order is written, even though the person is otherwise covered under the Plan;
 - f. Obtaining Covered Drugs without a Prescription Order or through the use of a forged or altered Prescription Order;
 - g. Obtaining quantities of prescription drugs in excess of Medically Necessary or prudent standards of use or in circumvention of the quantity limitations of the Plan;
 - h. Obtaining prescription drugs using Prescription Orders for the same drugs from multiple Providers;
 - i. Obtaining prescription drugs from multiple Pharmacies through use of the same Prescription Order.
2. The fraudulent or intentionally unauthorized, abusive, or other improper use of Identification Cards by any Participant can result in, but is not limited to, the following sanctions being applied to all Participants covered under your coverage:
- a. Denial of benefits;
 - b. Cancellation of coverage under the Plan for **all** Participants under your coverage;
 - c. Recoupment from you or any of your covered Dependents of any benefit payments made;
 - d. Pre-approval of drug purchases and 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 BCBSTX. Charges for services and supplies which BCBSTX determines are not Medically Necessary will not be eligible for benefit consideration and may not be used to satisfy Deductibles or to apply to the Coinsurance Stop-Loss Amount.

ParPlan

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

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

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

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

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

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.

HOW THE PLAN WORKS

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

Use of Non-Contracting Providers

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

PREAUTHORIZATION REQUIREMENTS

Preauthorization Requirements

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

The following types of services require Preauthorization:

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

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

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

Preauthorization for Inpatient Hospital Admissions

In order to receive maximum benefits, inpatient admissions must be Preauthorized by the Plan. In the case of an elective inpatient Hospital Admission, it is recommended that the call for Preauthorization should be made at least two working days before you are admitted unless it would delay Emergency Care. In an emergency, it is recommended that Preauthorization should take place within two working days after admission, or as soon thereafter as reasonably possible.

To satisfy Preauthorization requirements, you, your Physician, Provider of services, or a family member should call 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

PREAUTHORIZATION REQUIREMENTS

Time on Saturdays, Sundays and legal holidays. Calls made after these hours will be recorded and returned not later than 24 hours after the call is received. We will follow up with your Providers's office. -After working hours or on weekends, please call the **Medical Preauthorization Helpline** toll-free number listed on the back of your Identification Card. Your call will be recorded and returned the next working day. A benefits management nurse will follow up with your Provider's office. All timelines for Preauthorization requirements are provided in keeping with applicable state and federal regulations.

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

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

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

Preauthorization not Required for Maternity Care and Treatment of Breast Cancer Unless Extension of Minimum Length of Stay Requested

Your Plan is required to provide a minimum length of stay in a Hospital facility for the following:

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

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

Preauthorization for Extended Care Expense and Home Infusion Therapy

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

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

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

PREAUTHORIZATION REQUIREMENTS

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

Preauthorization for Chemical Dependency, Serious Mental Illness and Mental Health Care

In order to receive maximum benefits, all inpatient treatment for Chemical Dependency, Serious Mental Illness, and Mental Health Care must be Preauthorized by the Plan. Preauthorization is also required for certain outpatient services. Outpatient services requiring Preauthorization include psychological testing, neuropsychological testing, Repetitive transcranial magnetic stimulation, Intensive Outpatient Programs, applied behavioral analysis and electroconvulsive therapy. Preauthorization is not required for therapy visits to a Physician, Behavioral Health Practitioner and/or Professional Other Provider.

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

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

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

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

Failure to Preauthorize

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

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

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

If an inpatient Hospital Admission, Extended Care Expense, Home Infusion Therapy, any treatment of Chemical Dependency, Serious Mental Illness, and Mental Health Care or extension for any treatment or

PREAUTHORIZATION REQUIREMENTS

service described above is not Preauthorized and it is determined that the treatment, service, or extension was not Medically Necessary or Experimental/Investigational, benefits will be reduced or denied.

CLAIM FILING AND APPEALS PROCEDURES

CLAIM FILING PROCEDURES

Filing of Claims Required

Notice of Claim

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

Claim Forms

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

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

Who Files Claims

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

Contracting Providers

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

Non-Contracting Providers

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

Mail-Order Program

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

Participant-filed claims

Medical Claims

If your Provider does not submit your claims, you will need to submit them to BCBSTX using a Subscriber- filed claim form provided by BCBSTX. Texas and Southwestern Cattle Raisers Association 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

CLAIM FILING AND APPEALS PROCEDURES

because any Deductibles, maximum benefits, and other provisions are applied to each Participant separately. Include itemized bills from the health care Providers, labs, etc., printed on their letterhead and showing the services performed, dates of service, charges, and name of the Participant involved.

Prescription Drug Claims

When you receive Covered Drugs dispensed from a non-Participating Pharmacy, a *Prescription Reimbursement Claim Form* must be submitted. This form can be obtained from the Carrier, at www.bcbstx.com, or by calling Customer Service at the toll-free number on your Identification Card, or Texas and Southwestern Cattle Raisers Association. This claim form, accompanied by an itemized bill obtained from the Pharmacy showing the prescription services you received, should be mailed to the address shown below or on the claim form.

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

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

VISIT THE BCBSTX WEBSITE FOR SUBSCRIBER CLAIM FORMS AND OTHER USEFUL INFORMATION

www.bcbstx.com

Where to Mail Completed Claim Forms

Medical Claims

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

Prescription Drug Claims

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

Mail Order Program

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

Who Receives Payment

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

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

Benefit Payments to a Managing Conservator

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

the third party is named in a court order as managing or possessory conservator of the child; and

CLAIM FILING AND APPEALS PROCEDURES

BCBSTX has not already paid any portion of the claim.

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

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

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

When to Submit Claims

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

Receipt of Claims by BCBSTX

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

REVIEW OF CLAIM DETERMINATIONS

Claim Determinations

When BCBSTX receives a properly submitted claim, it has authority and discretion under the Plan to interpret and determine benefits in accordance with the Plan provisions. You have the right to seek and obtain a full and fair review by BCBSTX of any determination of a claim, any determination of a request for Preauthorization, or any other determination made by BCBSTX of your benefits under the Plan.

Note: If BCBSTX is seeking to discontinue coverage of prescription drugs or intravenous infusions for which you are receiving health benefits under the Plan, you will be notified no later than the 30th day before the date on which coverage will be discontinued.

If a Claim Is Denied or Not Paid in Full

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

The reasons for the determination;

A reference to the benefit Plan provisions on which the determination is based, or the contractual, administrative or protocol basis for the determination;

A description of additional information which may be necessary to perfect the claim and an explanation of why such material is necessary;

Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;

An explanation of BCBSTX's internal review/appeals and external review processes (and how to initiate a review/appeal or external review)[and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal];

CLAIM FILING AND APPEALS PROCEDURES

In certain situations, a statement in non-English language(s) that written notice of claim denials and certain other benefit information may be available (upon request) in such non-English language(s);

In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by BCBSTX;

The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;

Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;

An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;

In the case of a denial of an Urgent Care Clinical Claim, a description of the expedited review procedure applicable to such claim. An Urgent Care Clinical Claim decision may be provided orally, so long as a written notice is furnished to the claimant within 3 days of oral notification; and

Contact information for applicable office of health insurance consumer assistance or ombudsman.

Timing of Required Notices and Extensions

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

Urgent Care Clinical Claim is any Pre-Service Claim that requires Preauthorization, as described in this Benefit Booklet, for benefits for medical care or treatment with respect to which the application of regular time periods for making health claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment.

Pre-Service Claim is any non-urgent request for benefits or a determination with respect to which the terms of the benefit Plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.

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

CLAIM FILING AND APPEALS PROCEDURES

Urgent Care Clinical Claims*

Type of Notice or Extension	Timing
If your claim is incomplete, BCBSTX must notify you within:	24 hours
If you are notified that your claim is incomplete, you must then provide completed claim information to BCBSTX within:	48 hours after receiving notice
<i>BCBSTX must notify you of the claim determination (whether adverse or not):</i>	
if the initial claim is complete as soon as possible (taking into account medical exigencies), but no later than:	72 hours
after receiving the completed claim (if the initial claim is incomplete), within:	48 hours
If you require post-stabilization care after an Emergency within:	the time appropriate to the circumstance not to exceed one hour after the time of request

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

Pre-Service Claims

Type of Notice or Extension	Timing
If BCBSTX has received all information necessary to complete the review, BCBSTX must notify you within:	2 working days of our receipt of the complete claim or 3 calendar days of the request, whichever is sooner, if the claim is approved; and 3 calendar days of the request, if the claim is denied.
If you require post-stabilization care after an Emergency within:	the time appropriate to the circumstance not to exceed one hour after the time of request

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

CLAIM FILING AND APPEALS PROCEDURES

Post-Service Claims

Type of Notice or Extension	Timing
If your claim is incomplete, BCBSTX must notify you within:	30 days
If you are notified that your claim is incomplete, you must then provide completed claim information to BCBSTX within:	45 days after receiving notice
<i>BCBSTX must notify you of any adverse claim determination:</i>	
if the initial claim is complete, within:	30 days

Concurrent Care

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

Note: If BCBSTX is seeking to discontinue coverage of prescription drugs or intravenous infusions for which you are receiving health benefits under the Plan, you will be notified no later than the 30th day before the date on which coverage will be discontinued

Claim Appeal Procedures

Claim Appeal Procedures - Definitions

An “Adverse Benefit Determination” means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide in response to a claim, Pre-Service Claim or Urgent Care Clinical Claims, or make payment for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental/Investigational or not Medically Necessary or appropriate. A Rescission of coverage is also an Adverse Benefit Determination.

Expedited Clinical Appeals

If your situation meets the definition of an expedited clinical appeal, you may be entitled to an appeal on an expedited basis. An “expedited clinical appeal” is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care provider, -the denial of emergency or continued hospitalization , the denial of a Step Therapy exception request, or the discontinuance by BCBSTX of prescription drugs or intravenous infusions for which you were receiving health benefits under the Plan. Before authorization of benefits for an ongoing course of treatment/continued hospitalization is terminated or reduced, BCBSTX will provide you with notice and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an expedited pre-service or concurrent clinical appeal, BCBSTX will notify the party filing the appeal, as soon as possible, but in no event later than 24 hours after submission of the appeal, of all the information needed to review the appeal. BCBSTX will render a decision on the appeal within 24 hours after it receives the requested information, but no later than 72 hours after the appeal has been received by BCBSTX.

CLAIM FILING AND APPEALS PROCEDURES

How to Appeal an Adverse Benefit Determination

You have the right to seek and obtain a full and fair review of any determination of a claim, any determination of a request for Preauthorization, or any other determination made by BCBSTX in accordance with the benefits and procedures detailed in your Plan. An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care provider may appeal on his/her own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call BCBSTX at the number on the back of your Identification Card. If you believe BCBSTX incorrectly denied all or part of your benefits, you may have your claim reviewed. BCBSTX will review its decision in accordance with the following procedure:

Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to BCBSTX to request a claim review. BCBSTX will need to know the reasons why you do not agree with the Adverse Benefit Determination. Send your request to:

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

BCBSTX will honor telephone requests for information; however, such inquiries will not constitute a request for review.

In support of your claim review, you have the option of presenting evidence and testimony to BCBSTX. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the claim review process.

BCBSTX will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the review of your claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give you a chance to respond. If the initial benefit determination regarding the claim is based in whole or in part on a medical judgment, the appeal determination will be made by a Physician associated or contracted with BCBSTX and/or by external advisors, but who were not involved in making the initial denial of your claim.

If you have any questions about the claims procedures or the review procedure, write to BCBSTX's Administrative Office or call the toll-free Customer Service Helpline number shown in this Benefit Booklet or on your Identification Card.

This appeal process does not prohibit you from pursuing civil action available under the law.

If you have a claim for benefits which is denied or ignored, in whole or in part, and your Plan is governed by the Employee Retirement Income Security Act (ERISA), you may file suit under 502 (a) of ERISA.

CLAIM FILING AND APPEALS PROCEDURES

Timing of Appeal Determinations

BCBSTX will render a determination of the non-urgent concurrent or pre-service appeal as soon as practical, but in no event more than 30 days after the appeal has been received by BCBSTX.

BCBSTX will render a determination of the post-service appeal as soon as practical, but in no event more than 60 days after the appeal has been received by BCBSTX.

If You Need Assistance

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

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

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

Notice of Appeal Determination

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

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

The reasons for the determination;

A reference to the benefit Plan provisions on which the determination is based, and the contractual, administrative or protocol basis for the determination;

Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;

An explanation of BCBSTX's external review processes (and how to initiate an external review)[and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on external appeal];

In certain situations, a statement in non-English language(s) that written notice of claim denials and certain other benefit information may be available (upon request) in such non-English language(s);

In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by BCBSTX;

The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;

Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;

An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;

A description of the standard that was used in denying the claim and a discussion of the decision; and
Contact information for applicable office of health insurance consumer assistance or ombudsman.

If BCBSTX denies your appeal, in whole or in part, or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial

CLAIM FILING AND APPEALS PROCEDURES

and issue a final decision. Your external review rights are described in the *How to Appeal a Final Internal Adverse Determination to an Independent Review Organization (IRO)* section below.

How to Appeal a Final Internal Adverse Determination to an Independent Review Organization (IRO)

An “**Adverse Determination**” means a determination by BCBSTX or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service that is a covered service has been reviewed and, based upon the information provided, is determined to be Experimental/Investigational, or does not meet BCBSTX’s requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated.

A “**Final Internal Adverse Benefit Determination**” means an Adverse Benefit Determination that has been upheld by BCBSTX at the completion of BCBSTX’s internal review/appeal process.

This procedure (not part of the complaint process) pertains only to appeals of Adverse Determinations. In addition, in life-threatening urgent care circumstances, or if BCBSTX has discontinued coverage of prescription drugs or intravenous infusions for which you were receiving health benefits under the Plan, you are entitled to an immediate appeal to an IRO and are not required to comply with BCBSTX’s appeal of an Adverse Determination process.

Any party whose appeal of an Adverse Determination is denied by BCBSTX may seek review of the decision by an IRO. At the time the appeal is denied, BCBSTX will provide you, your designated representative or Provider of record must complete. In life-threatening urgent care situations, the denial of a Step Therapy exception request, or if BCBSTX has discontinued coverage of prescription drugs or intravenous infusions for which you were receiving health benefits under the Plan, you, your designated representative, or your Provider of record may contact BCBSTX by telephone to request the review and provide the required information.

BCBSTX will submit medical records, names of Providers and any documentation pertinent to the decision of the IRO.

BCBSTX will comply with the decision by the IRO.

BCBSTX will pay for the independent review.

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

- information relied upon to make the decision;
- information submitted, considered or generated in the course of making the decision, whether or not it was relied upon to make the decision;
- descriptions of the administrative process and safeguards used to make the decision;
- records of any independent reviews conducted by BCBSTX;
- medical judgments, including whether a particular service is Experimental/Investigational or not Medically Necessary or appropriate; and
- expert advice and consultation obtained by BCBSTX in connection with the denied claim, whether or not the advice was relied upon to make the decision.

The appeal process does not prohibit you from pursuing other appropriate remedies, including: injunctive relief; a declaratory judgment or other relief available under law, if the requirement to exhaust the process for appeal and review places your health in serious jeopardy. If your Plan is governed by the Employee Retirement Income Security Act (ERISA), you have the right to bring civil action under 502(a) of ERISA.

CLAIM FILING AND APPEALS PROCEDURES

Interpretation of Texas and Southwestern Cattle Raisers Association's Plan Provisions

The operation and administration of the Plan require uniformity regarding the intent of the Plan and the interpretation of the Plan provisions. The Texas and Southwestern Cattle Raisers Association has given BCBSTX full and complete authority to make decisions regarding the Plan provisions and determining questions of eligibility and benefits.

Actions Against BCBSTX

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

ELIGIBLE EXPENSES, PAYMENT OBLIGATIONS, AND BENEFITS

Eligible Expenses

The Plan provides coverage for four categories of Eligible Expenses:

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

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

Copayment Amounts

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

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

A Primary Care Copayment Amount as indicated on your Schedule of Coverage will be required for each Physician office visit charge you incur when services are received by a family practitioner, an obstetrician/gynecologist, a pediatrician, an internist, and a Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these listed Physicians, or a Professional Other Provider as described in the *Texas Insurance Code* and defined in the **DEFINITIONS** section of this Benefit Booklet.

A Specialty Copayment Amount, as indicated on your Schedule of Coverage, will be required for each office visit charge you incur:

- when services are rendered by a Specialty Care Provider (as classified by the American Board of Medical Specialist as a Specialty Care Provider), or
- when services are rendered by any other Professional Other Provider as defined in the **DEFINITIONS** section of this Benefit Booklet; with the exception of services provided by a Physician Assistant or Advanced Practice Nurse as described in the preceding paragraph.

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

- surgery performed in the Physician’s office;
- physical therapy billed separately from an office visit;
- occupational modalities in conjunction with physical therapy;
- allergy injections billed separately from an office visit;
- therapeutic injections;
- any services requiring Preauthorization;
- Certain Diagnostic Procedures;
- services provided by an Independent Lab, Imaging Center, radiologist, pathologist, and anesthesiologist;
- outpatient treatment therapies or services such as radiation therapy, chemotherapy, and renal dialysis.

ELIGIBLE EXPENSES, PAYMENT OBLIGATIONS, AND BENEFITS

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

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

- any services provided during the visit (i.e., lab and x-ray services);
- surgery performed in the Urgent Care center;
- physical therapy billed separately from an Urgent Care visit;
- occupational modalities in conjunction with physical therapy;
- allergy injections billed separately from an Urgent Care visit;
- therapeutic injections;
- any services requiring Preauthorization;
- Certain Diagnostic Procedures;
- services provided by an Independent Lab, Imaging Center, radiologist, pathologist, and anesthesiologist;
- outpatient treatment therapies or services such as radiation therapy, chemotherapy, and renal dialysis.

The Copayment Amounts indicated for Physician office visits Primary Care, Specialty and Urgent Care center visits will apply only to the first five (5) visits (combined) each Calendar Year. After five office and/or Urgent Care center visits each Calendar Year, benefits will be available as shown under the Medical/Surgical Expenses on your Schedule of Coverage.

Deductibles

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

Per-admission Deductible: The per-admission Deductible shown under “Deductibles” on your Schedule of Coverage will apply to **each** inpatient Hospital Admission of a Participant.

Calendar Year Deductible: The individual Deductible amount shown under “Deductibles” on your Schedule of Coverage must be satisfied by each Participant under your coverage each Calendar Year. This Deductible will be applied to all Medical-Surgical Expenses, Extended Care Expenses, and Special Provisions Expenses (unless otherwise indicated) before benefits are available under the Plan.

The following are exceptions to the Deductibles described above:

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

Eligible Expenses applied toward satisfying the “per individual” and “per family” Out-of-Network Deductible will apply toward both the Out-of-Network Deductible and the In-Network Deductible. *However*, Eligible Expenses applied toward satisfying the “per individual” and “per family” In-Network Deductible **will not** apply toward satisfying the Out-of-Network Deductible.

ELIGIBLE EXPENSES, PAYMENT OBLIGATIONS, AND BENEFITS

Coinsurance Stop-Loss Amount

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

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

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

Individual Coinsurance Stop-Loss Amount

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

Family Coinsurance Stop-Loss Amount

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

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

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

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

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

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 Expense for you and eligible Dependents. Each inpatient Hospital Admission requires Preauthorization. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for additional information.

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

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

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

COVERED MEDICAL SERVICES

Medical–Surgical Expenses

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

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

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

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

Medical–Surgical Expense shall include:

1. Services of Physicians and Professional Other Providers.
2. Consultation services of a Physician and Professional Other Provider.
3. Services of a certified registered nurse–anesthetist (CRNA).
4. Diagnostic x–ray and laboratory procedures.
5. Radiation therapy.
6. Dietary formulas necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.
7. Rental of durable medical equipment required for therapeutic use unless purchase of such equipment is required by BCBSTX. The term “durable medical equipment (DME)” shall not include:
 - a. Equipment primarily designed for alleviation of pain or provision of patient comfort; or
 - b. Home air fluidized bed therapy.

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

8. For Emergency Care, professional local 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

COVERED MEDICAL SERVICES

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. 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.

9. Anesthetics and its administration, when performed by someone other than the operating Physician or Professional Other Provider.
10. Oxygen and its administration provided the oxygen is actually used.
11. Blood, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for the Participant.
12. Prosthetic Appliances, including replacements necessitated by growth to maturity of the Participant.
13. 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.
14. Home Infusion Therapy.
15. Services or supplies used by the Participant during an outpatient visit to a Hospital, a Therapeutic Center, or a Chemical Dependency Treatment Center, or scheduled services in the outpatient treatment room of a Hospital.
16. Certain Diagnostic Procedures.
17. Outpatient Contraceptive Services, prescription contraceptive devices, and prescription contraceptive medications. NOTE: Prescription contraceptive medications are covered under the **PHARMACY BENEFITS** portion of your Plan.
18. Telehealth Services and Telemedicine Medical Services.
19. Foot care in connection with diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency.
20. Drugs that have not been approved by the FDA for self-administration when injected, ingested, or applied in a Physician's or Professional Other Provider's office.
21. Amino-acid based elemental formulas, regardless of the formula delivery method, used for the diagnosis and treatment of:

COVERED MEDICAL SERVICES

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

A Prescription Order from your Health Care Practitioner is required.

- 22. Covered Drugs purchased for use outside of a Hospital. Refer to the **PHARMACY BENEFITS** portion of this booklet for further information.

COVERED MEDICAL SERVICES

Extended Care Expenses

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

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

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

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

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

Services and supplies for Extended Care Expense:

1. For Skilled Nursing Facility:
 - a. All usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
 - b. Room and board and all routine services, supplies, and equipment provided by the Skilled Nursing Facility;
 - c. Physical, occupational, speech, and respiratory therapy services by licensed therapists.
2. For Home Health Care:
 - a. Part-time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
 - b. Part-time or intermittent home health aide services which consist primarily of caring for the patient;
 - c. Physical, occupational, speech, and respiratory therapy services by licensed therapists;
 - d. Supplies and equipment routinely provided by the Home Health Agency.

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

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

COVERED MEDICAL SERVICES

3. For Hospice Care:

For Home Hospice Care:

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

For Facility Hospice Care:

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

COVERED MEDICAL SERVICES

Special Provisions Expenses

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

Benefits for Treatment of Complications of Pregnancy

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

Benefits for Maternity Care

Benefits for Eligible Expenses incurred for Maternity Care will be determined on the same basis as for any other treatment of sickness. Dependent children will [not] be eligible for Maternity Care benefits.

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

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

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

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

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

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

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

COVERED MEDICAL SERVICES

Behavioral Health Services

Benefits for Treatment of Chemical Dependency

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

The Plan may use state guidelines to administer benefits for treatment of Chemical Dependency. Inpatient treatment of Chemical Dependency must be provided in a Chemical Dependency Treatment Center, Residential 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 **Benefits for Inpatient Hospital Expenses**.

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

Benefits for Serious Mental Illness

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

Medically Necessary services for Serious Mental Illness in a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, a Residential Treatment Center for Children and Adolescents, or a Residential Treatment Center in lieu of hospitalization will be considered Inpatient Hospital Expense. The Inpatient Hospital Expense benefit percentages for this Plan[, and any Deductible, as shown on your Schedule of Coverage will apply. Each full day of treatment in such facility will be considered equal to one-half of one day of a regular Hospital Admission for Serious Mental Illness.

Inpatient Hospital Expense for Serious Mental Illness will be limited to the number of inpatient days per Calendar Year shown on your Schedule of Coverage.

The Medical-Surgical Expense benefit percentages for this Plan[, and any Deductible] as shown on your Schedule of Coverage, will apply.

Medical-Surgical Expense incurred for Serious Mental Illness will be limited to the number of inpatient Physician, Behavioral Health Practitioner and/or Professional Other Provider visits per Calendar Year shown on your Schedule of Coverage.

All inpatient benefits used, including Hospital days and Physician/Behavioral Health Practitioner/Professional Other Provider visits, whether In-Network or Out-of-Network, apply to inpatient days or visits shown on the Schedule of Coverage under each level of benefits.

Benefits for Mental Health Care

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

COVERED MEDICAL SERVICES

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

The Medical-Surgical Expense benefit percentages for this Plan, and any Deductible as shown on your Schedule of Coverage, will apply.

COVERED MEDICAL SERVICES

Benefits for Emergency Care and Treatment of Accidental Injury

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

Benefits for Eligible Expenses for Accidental Injury or Emergency Care, including Accidental Injury or Emergency Care for Behavioral Health Services, will be determined on the same basis as for treatment of any other sickness. If admitted for the emergency condition as a direct result of the outpatient Hospital emergency room/treatment room visit. Preauthorization of the inpatient Hospital admission will be required.

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

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

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

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

Notwithstanding anything in this certificate to the contrary, for Out-of-Network Emergency Care services rendered by non-contracting Providers, the Allowable Amount shall be equal to the greatest of the following - not to exceed billed charges.

1. the Allowable Amount;
2. the median amount negotiated with In-Network Providers for Emergency Care services furnished;
3. the amount for the Emergency Care service calculated using the same method the Plan generally uses to determine payments for Out-of-Network services by substituting the In-Network cost-sharing provisions for the Out-of-Network cost sharing provisions; or
4. the amount that would be paid under Medicare for the Emergency Care service.

Each of these four amounts is calculated excluding any In-Network contracting Provider Copayment or Coinsurance imposed with respect to the Participant.

COVERED MEDICAL SERVICES

Benefits for Urgent Care

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

Benefits for Retail Health Clinics

Benefits for Eligible Expenses for Retail Health Clinics will be determined as shown on your Schedule of Coverage. Retail Health 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.

COVERED MEDICAL SERVICES

Preventive Care Services

Benefits for Routine Exams and Immunizations

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

- well–baby care (after newborn’s initial examination and discharge from the Hospital);
- routine annual physical examination;
- annual vision examination;
- annual hearing examinations, except for benefits as provided under ***Required Benefits for Screening Tests for Hearing Impairment***;
- immunizations for Participants age six and over.

Benefits for childhood immunizations will be provided as described in ***Required Benefits for Childhood Immunizations*** for children under the age of six. Benefits are not available for Inpatient Hospital Expense or Medical–Surgical Expense for routine physical examinations performed on an inpatient basis, except for the initial examination of a newborn child.

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

Benefits for Mammography Screening

If a Participant 35 years of age and older incurs Medical–Surgical Expense for a screening by low–dose mammography for the presence of occult breast cancer, benefits will be determined on the same basis as for other Medical–Surgical Expense as shown on your Schedule of Coverage, except that benefits will not be available for more than one routine mammography screening each Calendar Year. Low–dose mammography includes digital mammography or breast tomosynthesis.

Benefits for Detection and Prevention of Osteoporosis

If a Participant is a *Qualified Individual*, Medical–Surgical Expense benefits will be determined on the same basis as any other sickness 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.

Qualified Individual means:

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

Benefits for Tests for Detection of Colorectal Cancer

Benefits for Medical–Surgical Expense incurred for a diagnostic, medically recognized screening examination for the detection of colorectal cancer, for Participants [who are 50 years of age or older and who are at normal risk for developing colon cancer, will be determined on the same basis as any other sickness for;

COVERED MEDICAL SERVICES

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

Benefits for Certain Tests for Detection of Prostate Cancer

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

- (1) 50 years of age and asymptomatic; or
- (2) 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

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

Benefits will be determined on the same basis as for other Medical-Surgical Expenses as shown on your Schedule of Coverage, 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 Eligible Expenses incurred for an annual medically recognized diagnostic examination for the early detection of cervical cancer. 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 Early Detection Test for Ovarian Cancer

Benefits are available for a CA 125 blood test once every twelve months for female members age eighteen (18) and older.

COVERED MEDICAL SERVICES

Required Benefits for Childhood Immunizations

Benefits for Medical–Surgical Expense incurred by a Dependent child for childhood immunizations from birth through the date the child turns six years of age will be determined at 100% of the Allowable Amount. Deductibles, Copayment Amounts, and Coinsurance Amounts will not be applicable.

Benefits are available for:

- Diphtheria,
- Hemophilus influenza 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 Certain Therapies for Children with Developmental Delays

Medical–Surgical Expense benefits are available to a covered Dependent child for the necessary rehabilitative and habilitative therapies in accordance with an Individualized Family Service Plan issued by the Texas Interagency Council on Early Childhood Intervention under Chapter 73, *Texas Human Resources Code*.

Such therapies include:

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

The *Individualized Family Service Plan* must be submitted to BCBSTX prior to the commencement of services and when the Individualized Family Service Plan is altered.

After the age of 3, when services under the *Individualized Family Service Plan* are completed, Eligible Expenses, as otherwise covered under this Plan, will be available. All contractual provisions of this Plan will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximums.

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

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

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

COVERED MEDICAL SERVICES

Required 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.

COVERED MEDICAL SERVICES

Benefits for Cosmetic, Reconstructive, or Plastic Surgery

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

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

- Covered Oral Surgery;

Covered Oral Surgery means maxillofacial surgical procedures limited to:

1. Excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths;
 2. Incision and drainage of facial abscess;
 3. Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses;
 4. Surgical 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; and
 5. Removal of complete bony impacted teeth.
- 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 medical condition, to healthy, un-restored natural teeth and supporting tissues and limited to treatment provided within 24 months of the initial treatment. An injury sustained as a result of biting or chewing shall not be considered an Accidental Injury.

If a Participant is unable to undergo dental treatment in a dental office or under local anesthesia due to a document physical, mental or medical reason, as determined by the Participant's Physician or by the dentist providing the dental care, a Participant shall have coverage for Medically Necessary, non-dental services to the dental treatment.

Any other dental services, except as excluded in the **MEDICAL LIMITATIONS AND EXCLUSIONS** section of this Benefit Booklet, for which a Participant incurs Inpatient Hospital Expense for a Medically

COVERED MEDICAL SERVICES

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

COVERED MEDICAL SERVICES

Benefits for Organ and Tissue Transplants

- a. Subject to the conditions described below, benefits for covered services and supplies provided to a Participant by a Hospital, Physician, or Other Provider related to an organ or tissue transplant will be determined as follows, but only if all the following conditions are met:
- (1) The transplant procedure is not Experimental/Investigational in nature; and
 - (2) Donated human organs or tissue or an FDA-approved artificial device are used; and
 - (3) The recipient is a Participant under the Plan; and
 - (4) The transplant procedure is preauthorized as required under the Plan; and
 - (5) The Participant meets all of the criteria established by BCBSTX in pertinent written medical policies; and
 - (6) The Participant meets all of the protocols established by the Hospital in which the transplant is performed.

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

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

Benefits will be available for:

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

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

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

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

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

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

- (1) Such specific Preauthorization is required even if the patient is already a patient in a Hospital under another Preauthorization authorization.
- (2) At the time of Preauthorization, BCBSTX will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if BCBSTX determines that an extension is Medically Necessary.

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

COVERED MEDICAL SERVICES

Benefits for Treatment of Acquired Brain Injury

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

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

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

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

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

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

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

Benefits for Acquired Brain Injury will not be subject to any visit limit indicated on your Schedule of Coverage.

COVERED MEDICAL SERVICES

Benefits for Autism Spectrum Disorder

Generally recognized services prescribed in relation to Autism Spectrum Disorder by the Participant's Physician or Behavioral Health Practitioner in a treatment plan recommended by that Physician or Behavioral Health Practitioner are covered.

Individuals providing treatment prescribed under that plan must be:

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

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

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

Benefits for Autism Spectrum Disorder will not apply towards any maximum indicated on your Schedule of Coverage.

All contractual provisions of this Plan will apply, including but not limited to, defined terms, limitations and exclusions, Preauthorization and benefit maximums.

COVERED MEDICAL SERVICES

Benefits for Treatment of Diabetes

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

a. *Diabetes Equipment*

- (1) Blood glucose monitors (including noninvasive glucose monitors and monitors for the blind);
- (2) Insulin pumps (both external and implantable) and associated appurtenances, which include:
 - Insulin infusion devices,
 - Batteries,
 - Skin preparation items,
 - Adhesive supplies,
 - Infusion sets,
 - Insulin cartridges,
 - Durable and disposable devices to assist in the injection of insulin, and
 - Other required disposable supplies; and
- (3) Podiatric appliances, including up to two pairs of therapeutic footwear per Calendar Year, for the prevention of complications associated with diabetes.

b. *Diabetes Supplies*

- (1) Test strips specified for use with a corresponding blood glucose monitors,
- (2) Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein,
- (3) Lancets and lancet devices,
- (4) Insulin and insulin analog preparations,
- (5) Injection aids, including devices used to assist with insulin injection and needleless systems,
- (6) Biohazard disposable containers,
- (7) Insulin syringes,
- (8) Prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and
- (9) Glucagon emergency kits.

NOTE: *Insulin and insulin analog preparations, insulin syringes necessary for self-administration, prescriptive and non-prescriptive oral agents will be covered under the **PHARMACY BENEFITS**.*

COVERED MEDICAL SERVICES

- c. Repairs and necessary maintenance of insulin pumps not otherwise provided for under the manufacturer's warranty or purchase agreement, rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump.
- d. As new or improved treatment and monitoring equipment or supplies become available and are approved by the U. S. Food and Drug Administration (FDA), such equipment or supplies may be covered if determined to be Medically Necessary and appropriate by the treating Physician or Professional Other Provider who issues the written order for the supplies or equipment.
- e. Medical-Surgical Expense provided for the nutritional, educational, and psychosocial treatment of the *Qualified Participant*. Such *Diabetic Management Services/Diabetes Self-Management Training* for which a Physician or Professional Other Provider has written an order to the Participant or caretaker of the Participant is limited to the following when rendered by or under the direction of a Physician.

Initial and follow-up instruction concerning:

- (1) The physical cause and process of diabetes;
- (2) Nutrition, exercise, medications, monitoring of laboratory values and the interaction of these in the effective self-management of diabetes;
- (3) Prevention and treatment of special health problems for the diabetic patient;
- (4) Adjustment to lifestyle modifications; and
- (5) Family involvement in the care and treatment of the diabetic patient. The family will be included in certain sessions of instruction for the patient.

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

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

COVERED MEDICAL SERVICES

Benefits for Physical Medicine Services

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

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

COVERED MEDICAL SERVICES

Benefits for Routine Patient Costs for Participants in Approved Clinical Trials

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

[Benefits for Orally Administered Anticancer Medication

Benefits are available for Medically Necessary orally administered anticancer medication that is used to kill or slow the growth of cancerous cells. Coinsurance/Copayments and Deductible Amounts will not apply to certain orally administered anticancer medications. To determine if a specific drug is included in this benefit, contact Customer Service at the toll-free number on your Identification Card.]

Benefits for Early Detection Tests for Cardiovascular Disease

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

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

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

Benefits are limited as indicated on your Schedule of Coverage.

COVERED MEDICAL SERVICES

Benefits for Foot Orthotics

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

Benefits for Speech and Hearing Services

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

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

Coverage includes one cochlear implant, an external speech processor and controller, with necessary components replacement every thirty-six (36) months, per impaired ear. 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. Cochlear Implants may be replaced as Medically Necessary or audiological necessary.

MEDICAL LIMITATIONS AND EXCLUSIONS

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

1. Any services or supplies which are not Medically Necessary and essential to the diagnosis or direct care and treatment of a sickness, injury, condition, disease, or bodily malfunction.
2. Any Experimental/Investigational services and supplies.
3. Any portion of a charge for a service or supply that is in excess of the Allowable Amount as determined by BCBSTX.
4. Any services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
5. Any services or supplies for which benefits are, or could upon proper claim be, provided under any laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, except any program which is a state or federal plan for medical assistance (i.e., Medicaid or Medicare); 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 tax supported institution of the State of Texas.
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.

MEDICAL LIMITATIONS AND EXCLUSIONS

12. Any services or supplies provided for Dietary and Nutritional Services, except as may be provided under the Plan for:
 - an inpatient nutritional assessment program provided in and by a Hospital and approved by BCBSTX; or
 - *Benefits for Treatment of Diabetes* as described in **Special Provisions Expenses**; or
 - *Benefits for Certain Therapies for Children with Developmental Delays* as described in **Special Provisions Expenses**; or
 - *Benefits for Autism Spectrum Disorder* 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 or supplies (oral appliances, oral splints, oral orthotics, devices, or prosthetics) 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 Expense incurred for dental care and treatments, Covered Oral Surgery, or dental appliances, except as provided for in the *Benefits for Dental Services* provision in the **Special Provisions Expenses** portion of this Benefit Booklet.
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, except as may be provided under the *Benefits for Preventive Care* provision in the **Special Provisions Expenses** portion of this Benefit Booklet; or
 - Restoration of loss or correction to an impaired speech or hearing function, including hearing aids, except as may be provided under the *Benefits for Speech and Hearing Services* and *Benefits for Autism Spectrum Disorder* provision 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.

MEDICAL LIMITATIONS AND EXCLUSIONS

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);
 - Sexual dysfunctions; and
 - In vitro fertilization; and
 - Promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct intra-peritoneal insemination, trans-uterine tubal insemination, gamete intra-fallopian transfer, pronuclear oocyte stage transfer, zygote intra-fallopian transfer, and tubal embryo transfer.
23. Any procedures, equipment, services, supplies, or charges for abortions except for a pregnancy which, as certified by a Physician, places the woman in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed.
24. Any services or supplies in connection with routine foot care, including the removal of warts, corns, or calluses, the cutting and trimming of toenails in the absence of diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency.
25. Any services or supplies in connection with foot care for flat feet, fallen arches, or chronic foot strain.
26. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
27. Services or supplies for smoking cessation programs and the treatment of nicotine addiction.
28. 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.
29. Benefits for any covered services or supplies furnished by a Contracting Facility for which such facility has not been specifically approved to furnish under a written contract or agreement with BCBSTX will be paid at the Out-of-Network benefit level.
30. 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.
31. Any benefits in excess of any specified dollar, day/visit, or Calendar Year maximums.

MEDICAL LIMITATIONS AND EXCLUSIONS

32. 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.
33. Donor expenses for a Participant in connection with an organ and tissue transplant if the recipient is not covered under this Plan.
34. Replacement Prosthetic Appliances when necessitated by misuse or loss by the Participant.
35. Private duty nursing services
36. Any Covered Drugs for which benefits are available under the Pharmacy Benefits.
37. Any services or supplies for Mental Health Care.
38. Any services or supplies provided for reduction mammoplasty.
39. Any services or supplies provided for reduction of obesity or weight, including surgical procedures, even if the Participant has other health conditions which might be helped by a reduction of obesity or weight.
40. Any services or supplies not specifically defined as Eligible Expenses in this Plan.
41. Biofeedback except for an Acquired Brain Injury diagnosis or other behavior modification services.
42. Any related services to a non-covered service. Related services are:
 - a. services in preparation for the non-covered service;
 - b. services in connection with providing the non-covered service;
 - c. hospitalization required to perform the non-covered service; or
 - d. services that are usually provided following the non-covered service, such as follow-up care or therapy after surgery.

DEFINITIONS

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

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

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

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

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

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

When a Medicare reimbursement rate is not available or is unable to be determined based on the information submitted on the claim, the Allowable Amount for non-contracting Providers will represent an average contract rate in aggregate for Network Providers adjusted by a predetermined factor established by BCBSTX. Such factor shall be not less than 70% and shall be updated not less than every two years.

BCBSTX will utilize the same claim processing rules and/or edits that it utilizes in processing 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 BCBSTX does not have any claim edits or rules, BCBSTX may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The Allowable Amount will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including, but not limited to, disproportionate share and graduate medical education payments.

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

DEFINITIONS

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.

Notwithstanding the above, where applicable state or federal law requires another standard for a non-contracting claim, the Allowable Amount shall be the lessor of billed charge or the amount prescribed by law.

- **For multiple surgeries** – The Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount *plus* a determined percentage of the Allowable Amount *for each* of the other covered procedures performed.
- **For procedures, services, or supplies provided to Medicare recipients** – The Allowable Amount will not exceed Medicare's limiting charge.
- **For Covered Drugs as applied to Participating and Non-Participating Pharmacies** – The Allowable Amount for Participating Pharmacies and the Mail-Order Program will be based on the provisions of the contract between BCBSTX and the Participating Pharmacy or Pharmacy for the Mail-Order Program in effect on the date of service. The Allowable Amount for Non-Participating Pharmacies will be based on the Average Wholesale Price.
- **For Out-of-Network Emergency Care and care provided by an Out-of-Network Provider when a contracting provider is not reasonably available as defined by applicable law** – The Allowable Amount will be the usual or customary amount as defined by Texas law or as prescribed under applicable law or regulations.

Association means the Contractholder named on the front cover of the Benefit Booklet.

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

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

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

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

Certain Diagnostic Procedures means:

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

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

Complications of Pregnancy means:

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

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

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

DEFINITIONS

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

Contractholder means the Association named on the front cover of the Benefit Booklet.

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

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

Cosmetic, Reconstructive, or Plastic Surgery means surgery that:

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

Course of Treatment means any number of dental procedures or treatments performed by a Dentist in a planned series resulting from a dental examination concurrently revealing the need for such procedures or treatments.

Covered Dental Expenses means the professionally recognized dental services, supplies, or appliances for which a benefit is available to a Participant under the Plan which are provided to a Participant by a Dentist on or after the Effective Date of coverage and for which the Participant acquires an obligation for payment.

Covered Oral Surgery means maxillofacial surgical procedures limited to:

1. Excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths;
2. Incision and drainage of facial abscess;
3. Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses; and
4. Surgical 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; and
5. Removal of complete bony impacted teeth.

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

DEFINITIONS

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 before benefits under the Plan will be available.

Dentally Necessary or Dental Necessity means those services, supplies, or appliances covered under the Plan which are:

1. Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the dental condition or injury; and
2. Provided in accordance with and are consistent with generally accepted standards of dental practice in the United States; and
3. Not primarily for the convenience of the Participant or his Dentist; and
4. The most economical supplies, appliances, or levels of dental service that are appropriate for the safe and effective treatment of the Participant.

The dental staff of the Carrier shall determine whether a service, supply, or appliance is Dentally Necessary 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 Dentist may have prescribed treatment, such treatment may not be Dentally Necessary within this definition.

Dentist means a person, when acting within the scope of his license, who is a Doctor of Dentistry (D.D.S. or D.M.D. degree) and shall also include a person who is a Doctor of Medicine or a Doctor of Osteopathy. The terms Doctor of Dentistry, Doctor of Medicine, or Doctor of Osteopathy shall have the meaning assigned to them by the *Texas Insurance Code*.

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

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

For purposes of this Plan, the term *Dependent* will also include those individuals who no longer meet the definition of a Dependent, but are beneficiaries under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or under the appropriate provisions of the *Texas Insurance Code*.

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.

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

DEFINITIONS

Gold means alloys containing at least 70% gold metal by weight.

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

1. Accident only or disability income insurance, or a combination of accident-only and disability income insurance;
2. Credit-only insurance;
3. Disability insurance coverage;
4. Coverage for a specified disease or illness;
5. Medicare services under a federal contract;
6. Medicare supplement and Medicare Select policies regulated in accordance with federal law;
7. Long-term care coverage or benefits, home health care coverage or benefits, nursing home care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits;
8. Coverage that provides limited-scope dental or vision benefits;
9. Coverage provided by a single service health maintenance organization;
10. Coverage issued as a supplement to liability insurance;
11. Workers' compensation or similar insurance;
12. Automobile medical payment insurance coverage;
13. Jointly managed trusts authorized under 29 U.S.C. Section 141, et seq., that;
 - contain a plan of benefits for employees
 - is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees, and
 - is authorized under 29 U.S.C. Section 157;
14. Hospital indemnity or other fixed indemnity insurance;
15. Reinsurance contracts issued on a stop-loss, quota-share, or similar basis;
16. Short-term major medical contracts;
17. Liability insurance, including general liability insurance and automobile liability insurance;
18. Other coverage that is:
 - similar to the coverage described by this subdivision under which benefits for medical care are secondary or incidental to other insurance benefits; and
 - specified in federal regulations;
19. Coverage for onsite medical clinics; or
20. Coverage that provides other limited benefits specified by federal regulations.

Health Care Practitioner means an Advanced Practice Nurse, Doctor of Medicine, Doctor of Dentistry, Physician Assistant, Doctor of Osteopathy, Doctor of Podiatry, or other licensed person with prescription authority.

Health Status Related Factor means:

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

DEFINITIONS

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 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;

DEFINITIONS

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

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

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

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

Imaging Center means a Provider that can furnish technical or total services with respect to diagnostic imaging services and is licensed through the Texas State Radiation Control Agency.

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

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

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

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

1. Furnished at the direction or prescription of a Physician or Professional Other Provider; and
2. Provided by a Hospital or a Chemical Dependency Treatment Center; and
3. Furnished to and used by the Participant during an inpatient Hospital Admission.

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

Inpatient Hospital Expense shall include:

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

DEFINITIONS

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

Medically Necessary Mental Health Care or treatment of Serious Mental Illness or treatment of Serious Mental Illness in a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, a 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. These programs offer integrated and aligned assessment, treatment and discharge planning services for treatment of severe or complex co-occurring which make it unlikely that the Participants will benefit from programs that focus solely on mental illness conditions.

Life Threatening Disease or Condition means, for the purpose 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.

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 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 or Professional Other Provider if the listed service or supply is:

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

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

DEFINITIONS

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

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

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

Member means

- A person eligible to participate in the activities of the Contractholder.
- A person who meets the Contractholder's eligibility requirements.
- A person who is not an employee of the Contractholder.

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

1. The diagnosis or treatment of a mental disease, disorder, or condition listed in the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association*, as revised, or any other diagnostic coding system as used by the Carrier, whether or not the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin;
2. The diagnosis or treatment of any symptom, condition, disease, or disorder by a Physician or Professional Other Provider (or by any person working under the direction or supervision of a Physician or Professional Other Provider) when the Eligible Expense is:
 - a. Individual, group, family, or conjoint psychotherapy,
 - b. Counseling,
 - c. Psychoanalysis,
 - d. Psychological testing and assessment,
 - e. The administration or monitoring of psychotropic drugs, or
 - f. Hospital visits or consultations in a facility listed in subsection 5, below;
3. Electroconvulsive treatment;
4. Psychotropic drugs;
5. Any of the services listed in subsections 1 through 4, above, performed in or by a Hospital, Facility Other Provider, or other licensed facility or unit providing such care.

Network means identified Physicians, 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.

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

Nonprecious Metals means alloys of base metals of no special intrinsic value containing no Gold or platinum, such as stainless steel, chrome, copper, cobalt, or nickel.

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

1. **Facility Other Provider** – an institution or entity, only as listed:
 - a. Chemical Dependency Treatment Center
 - b. Crisis Stabilization Unit or Facility
 - c. Durable Medical Equipment Provider
 - d. Home Health Agency
 - e. Home Infusion Therapy Provider
 - f. Hospice

DEFINITIONS

- g. Imaging Center
 - h. Independent Laboratory
 - i. Prosthetics/Orthotics Provider
 - j. Psychiatric Day Treatment Facility
 - k. Renal Dialysis Center
 - l. Residential Treatment Center for Children and Adolescents
 - m. Skilled Nursing Facility
 - n. Therapeutic Center
2. **Professional Other Provider** – a person or practitioner, when acting within the scope of his license and who is appropriately certified, only as listed:
- a. Advanced Practice Nurse
 - b. Doctor of Chiropractic
 - c. Doctor of Dentistry
 - d. Doctor of Optometry
 - e. Doctor of Podiatry
 - f. Doctor in Psychology
 - g. Licensed Acupuncturist
 - h. Licensed Audiologist
 - i. Licensed Chemical Dependency Counselor
 - j. Licensed Dietitian
 - k. Licensed Hearing Instrument Fitter and Dispenser
 - l. Licensed Marriage and Family Therapist
 - m. Licensed Clinical Social Worker
 - n. Licensed Occupational Therapist
 - o. Licensed Physical Therapist
 - p. Licensed Professional Counselor
 - q. Licensed Speech–Language Pathologist
 - r. Licensed Surgical Assistant
 - s. Nurse First Assistant
 - t. Physician Assistant
 - u. Psychological Associates who work under the supervision of a Doctor in Psychology

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

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

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

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

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

Participant means a Member or Dependent whose coverage has become effective under this Contract.

DEFINITIONS

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

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

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

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

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

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

Primary Care Copayment Amount means the payment, as expressed in dollars, that must be made by or on behalf of a Participant for each office visit charge you incur when services are rendered by a family practitioner, an obstetrician/gynecologist, a pediatrician, Behavioral Health Practitioner, an internist, and a Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these listed Physicians.

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, Other Provider, or any other person, company, or institution furnishing to a Participant an item of service or supply listed as Eligible Expenses.

Psychiatric Day Treatment Facility means an institution which is appropriately licensed and is accredited by the Joint Commission on Accreditation of Healthcare Organizations as a Psychiatric Day Treatment

DEFINITIONS

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 to be in lieu of hospitalization.

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

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

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

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

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

Residential Treatment Center means a facility setting (including a Residential Treatment Center for Children and Adolescents) offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, wilderness programs, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities. Patients are medically monitored with 24 hour medical availability and 24 hour onsite nursing service for Mental Health Care and/or for treatment of Chemical Dependency. BCBSTX requires that any facility providing Mental Health Care and/or a Chemical Dependency Treatment Center must be licensed in the state where it is located, or accredited by a national organization that is recognized by BCBSTX as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

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

DEFINITIONS

5. The cost of a health care service that is specifically excluded from coverage under the Plan.

Semiprecious Metals means alloy noble metals or those metals of special intrinsic value, such as platinum.

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 BCBSTX (and in some instances with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care Provider of specialty services[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].

Specialty Copayment Amount means the payment, as expressed in dollars, that must be made by or on behalf of a Participant for each office visit charge you incur when services are rendered by a Specialty Care Provider.

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 professional's license, certification, or entitlement to a patient at different physical location than the health professional using telecommunications or information technology.

Telemedicine Medical Service means a health care service delivered by a Physician or a health professional Provider acting under the Physician delegation and supervision of a patient assessment by a health professional, diagnosis, or consultation by Physician's treatment or the transfer of medical data that requires the use of advanced telecommunications 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.

PHARMACY BENEFITS

Covered Drugs

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

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

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

Injectable Drugs

Injectable drugs approved by the FDA for self-administration are covered under the Plan. You are responsible for any [Deductibles,] [Copayment Amounts][,] [Coinsurance Amounts,] and pricing differences that may apply to the Covered Drug dispensed.

Diabetes Supplies for Treatment of Diabetes

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

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

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

All supplies, including medications and equipment for the control of diabetes will be dispensed as written, unless substitution is approved by your prescribing Physician or other Health Care practitioner who issues the written order for supplies or equipment.

Vaccinations obtained through select Participating Pharmacies

Benefits for vaccinations, as shown on your Schedule of Coverage, are available through certain Participating Pharmacies that have contracted with BCBSTX to provide this service. To locate one of these contracting

PHARMACY BENEFITS

Participating Pharmacies in the Pharmacy Vaccine Network in your area, and to determine which vaccinations are covered under this benefit, you may access our website www.bcbstx.com or call our Customer Service Helpline number shown in this booklet or on your Identification Card. At the time you receive services, present your BCBSTX Identification Card to the pharmacist. This will identify you as a Participant in the BCBSTX health care plan provided by the Association. The pharmacist will inform you of the appropriate Copayment Amount, if any. You are responsible for paying any Deductibles, Copayment Amounts, Coinsurance Amounts and any pricing differences, when applicable.

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

Formulas for the Treatment of Phenylketonuria or Other Heritable Diseases

Benefits are available for dietary formulas necessary for the treatment of phenylketonuria or other heritable diseases to the same extent as any other Covered Drug available only on the orders of a Health Care Practitioner.

Amino Acid-Based Elemental Formulas

Benefits are available for formulas, regardless of the formula delivery method, used for the diagnosis and treatment of:

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

A Prescription Order from your Health Care Practitioner is required.

Benefits for Orally Administered Anticancer Medication

Benefits are available for Medically Necessary orally administered anticancer medication that is used to kill or slow the growth of cancerous cells. Coinsurance or a Copayment Amount will not apply to orally administered anticancer medication. To determine if a specific drug is included in this benefit contact Customer Service at the toll-free number on your Identification Card.

Specialty Drugs

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

Smoking cessation

Prescription Drugs for smoking cessation and the treatment of nicotine addiction are covered.

Selecting a Pharmacy

Participating Pharmacy

When you go to a Participating Pharmacy:

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

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

PHARMACY BENEFITS

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

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

Although you can go to the Pharmacy of your choice, your benefits for drugs and other items covered under this provision will be greater when you obtain them from a Preferred Participating Pharmacy. Preferred Participating Pharmacies will charge less than Participating Pharmacies. Refer to your Schedule of Coverage for applicable payment levels.

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

Non-Participating Pharmacy

If you have a Prescription Order filled or obtain a covered vaccination at a non-Participating Pharmacy, you must pay the Pharmacy the full amount of its bill and submit a claim form to the Carrier with itemized receipts verifying that the Prescription Order was filled or a covered vaccination was provided. The Plan will reimburse you for Covered Drugs and covered vaccinations equal to:

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

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

Day Supply

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

Benefits will be provided for prescription drugs dispensed in the following quantities:

- Retail pharmacies and specialty pharmacy - during each one month period, up to a 30-day supply or 120 units (e.g. pills), whichever is less. If more than 120 units are needed to reach a 30 day supply, another copayment will apply to each additional 120 units (or portion thereof) purchased. Your retail Pharmacy and specialty pharmacy Copayments are shown on your Schedule of Coverage.
- Mail-order program - during each three month period, up to a 90-day supply or 360 units (e.g. pills), whichever is less. If less than a 90-day supply is ordered, the mail-order copay will still apply. If more than 360 units are needed to reach a 90-day supply, an additional mail-order Copayment will apply to each additional 360 units (or portion thereof) purchased. Your mail-order Copayment is shown on your Schedule of Coverage.

Benefits are not provided under this Plan for charges for prescription drugs dispensed in excess of the above stated amounts.

Mail-Order Program

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

PHARMACY BENEFITS

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

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

Specialty Pharmacy Program

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

The specialty pharmacy program delivery service offers:

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

A list identifying these Specialty Drugs is available by accessing the website at www.bcbstx.com or by contacting Customer Service at the toll-free number on your Identification Card. Your cost will be the appropriate Drug Copayment indicated on the Schedule of Coverage and any applicable pricing differences. You will also be responsible for any Deductible amounts that may apply to your coverage.

Your Cost

Pharmacy Deductible

The Pharmacy Deductible shown on your Schedule of Coverage is the dollar amount of Covered Drug expenses that each Participant must pay during each Calendar Year before benefits will be available. The Pharmacy Deductible will apply to Covered Drugs obtained through Participating and non-Participating Pharmacies. The Pharmacy Deductible will apply to Generic Drugs. After each Participant has satisfied his Pharmacy Deductible, that Participant will pay the appropriate Copayment Amount (and any pricing difference) for each Prescription Order filled or refilled or each covered vaccination provided for the remainder of the Calendar Year. After the Pharmacy Deductible is met, benefits as shown on your Schedule of Coverage will be available.

Whether you use a Participating Pharmacy or a non-Participating Pharmacy the Allowable Amount of your Covered Drug expenses will be applied toward satisfaction of your Pharmacy Deductible.

Copayment Amounts

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

If the Allowable Amount of the Covered Drug is less than the Copayment Amount, the Participant will pay the lower cost. When that lower cost is more than the amount you would pay if you purchased the drug without

PHARMACY BENEFITS

using your BCBSTX pharmacy benefits or any other source of drug benefits or discounts, you pay such purchase price.

How Preferred Brand Name Drug Pricing Difference Applies

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

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

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

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

Exceptions to this provision may be allowed for certain preventive medications (including prescription contraceptive medications) if your Health Care Practitioner submits a request to BCBSTX indicating that the Generic Drug would be medically inappropriate, along with supporting documentation. If BCBSTX grants the exception request, any difference between the Allowable Amount for the Brand Name Drug and the Generic Drug will be waived.

Drug Coupons, Rebates or Other Drug Discounts

Drug manufacturers may offer coupons, rebates or other drug discounts to Participants, which may impact the benefits provided under this Plan. The total benefits payable will not exceed the balance of the Allowable Amount remaining after all drug coupons, rebates or other drug discounts have been applied. BCBSTX does not accept cost-sharing payments from any third parties. These drug coupons, rebates and other discounts may not be applied towards your Deductible or your Out-of-Pocket Maximum.

About Your Benefits

Preferred Drug List

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

BCBSTX will routinely review the *Preferred Drug List* and periodically adjust it to modify the Preferred or Non-Preferred Brand Name Drug status of existing or new drugs. Changes to this list will be implemented on the Association's Contract Anniversary Date. The *Preferred Drug List* and any modifications will be made available to Participants. Participants may access our website at www.bcbstx.com or call the Customer Service Helpline at the telephone number shown in this Benefit Booklet or on your Identification Card to determine if a particular drug is on the *Preferred Drug List*. Drugs that do not appear on the *Preferred Drug*

PHARMACY BENEFITS

List are subject to the Non-Preferred Brand Name Drug Copayment Amount plus any pricing differences that may apply to the Covered Drug you receive.

Exception Requests

You, or your Health Care Practitioner, can ask for a Drug List exception if your drug is not on the Drug List. To request this exemption, your Health Care Practitioner can call the number on the back of your ID card to ask for a review. BCBSTX will conduct a review and notify you and your prescribing Health Care Practitioner of the coverage decision within 3 business days after they receive your request for standard review.

If the coverage request is denied, BCBSTX will let you and your Health Care Practitioner know why it was denied and offer you a covered alternative drug (if applicable). If your exception is denied, you may appeal the decision according to the appeals process you will receive with the denial determination. Call the number on the back of your ID card if you have any questions.

Prescription Refills

Once every 12 months, you will be able to synchronize the start time of certain Covered Drugs used for treatment and management of a chronic illness so they are refilled on the same schedule for a given time period. When necessary to fill a partial Prescription Order to permit synchronization, BCBSTX will prorate the Copayment Amount or Coinsurance Amount due for Covered Drugs based on the proportion of days the reduced Prescription Order covers to the regular day supply outlined in your Schedule of Coverage.

Dispensing Limits

Dispensing limits are based upon FDA dosing recommendations and nationally recognized guidelines. Coverage limits are based upon FDA dosing recommendations and nationally recognized guidelines. Coverage limits are placed on medications in certain drug categories. Limits may include: quantity of covered medication per prescription, quantity of covered medication in a given time period, coverage only for Participants within a certain age range, or coverage only for Participants of a specific gender. Quantities of some drugs are restricted regardless of the quantity ordered by the Health Care Practitioner. To determine if a specific drug is subject to this limitation, you may access the website at www.bcbstx.com or contact Customer Service at the toll-free number on your Identification Card.

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

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

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

PHARMACY BENEFITS

Step Therapy

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

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

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

Step Therapy Exception Requests: Your prescribing Physician or other Health Care Practitioner may submit a written request for an exception to the Step Therapy requirements. The Step Therapy Exception Request will be considered approved if We do not deny within 72 hours after receipt of the request. If your prescribing Physician or other Health Care Practitioner reasonably believes that denial of the Step therapy Exception Request could cause you serious harm or death, the request is considered approved if We do not deny 24 hours after receipt of the request. If your Step Therapy Exception Request is denied, you have the right to request an expedited internal appeal and also have the right to request review by an Independent Review Organization as explained in the Review of Claim Determinations section of this Benefit Booklet.

Prior Authorizations

Coverage for certain designated prescription drugs is subject to prior authorization criteria. This means that in order to ensure that a drug is safe, effective, and part of a specific treatment plan, certain medications may require prior authorization and the evaluation of additional clinical information before dispensing. A list of the medications which require prior authorization is available to you and your Health Care Practitioner by accessing the website at www.bcbstx.com or contact customer service at the toll-free number on your Identification Card.

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

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

Right of Appeal

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

PHARMACY BENEFITS

Limitations and Exclusions

Pharmacy benefits are not available for:

1. Drugs which do not by law require a Prescription Order from a Provider or authorized Health Care Practitioner (**except** insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and vaccinations administered through certain Participating Pharmacies as shown on your Schedule of Coverage); and Legend Drugs or covered devices for which no valid Prescription Order is obtained.
2. Non-FDA approved drugs.
3. Devices or durable medical equipment of any type (even though such devices may require a Prescription Order,) such as, but not limited to, contraceptive devices, therapeutic devices, including support garments and other non-medicinal substances, artificial appliances, or similar devices (except disposable hypodermic needles and syringes for self-administered injections and those devices listed as Diabetes Supplies).
4. Pharmaceutical aids such as excipients found in the USP-NF (United States Pharmacopeia- National Formulary), including but not limited to preservatives, solvents, ointment bases, and flavoring, coloring, diluting, emulsifying, and suspending agents.
5. Administration or injection of any drugs.
6. Vitamins (**except** those vitamins which by law require a Prescription Order and for which there is **no** non-prescription alternative).
7. Drugs dispensed in a Physician's or authorized Health Care Practitioner's office or during confinement while a patient is in a Hospital, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.
8. Covered Drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
9. Covered Drugs, devices, or other Pharmacy services or supplies for which benefits are, or could upon proper claim be, provided under any laws enacted by the Legislature of any state, or by the Congress of the United States, or the laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical assistance (Medicaid), or any prescription drug which may be properly obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law; provided, however, that the exclusions of this section shall not be applicable to any coverage held by the Participant for prescription drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
10. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery. Vaccinations shown on your Schedule of Coverage, administered through certain Participating Pharmacies are an exception to this exclusion.
11. Covered Drugs for which the Pharmacy's usual retail price to the general public is less than or equal to the Participant's cost share determined under this Plan.

PHARMACY BENEFITS

12. Oral and injectable infertility and fertility medications.
13. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
14. Drugs required by law to be labeled: “Caution – Limited by Federal Law to Investigational Use,” or experimental drugs, even though a charge is made for the drugs.
15. Drugs dispensed in quantities in excess of the day supply amounts stipulated in your Schedule of Coverage or as shown under the **Day Supply** section of this Benefit Booklet, [certain Covered Drugs exceeding the clinically appropriate predetermined quantity] [or dispensing limit], or refills of any prescriptions in excess of the number of refills specified by the Physician or authorized Health Care Practitioner or by law, or any drugs or medicines dispensed more than one year following the Prescription Order date.
16. Legend Drugs which are not approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation.
17. Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), unless approved by the FDA for self-administration, intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting. NOTE: This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases. This exception also does not apply to amino-acid based elemental formulas, regardless of the formula delivery method, used for the diagnosis and treatment of immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins, severe food protein-induced enterocolitis syndromes, eosinophilic disorders, as evidenced by the results of biopsy and disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract. A Prescription Order from your Health Care Practitioner is required.
18. Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control.
19. Drugs, that the use or intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.
20. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Identification Card.
21. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under the Association’s group health care plan or for which benefits have been exhausted.
22. Rogaine, minoxidil, or any other drugs, medications, solutions, or preparations used or intended for use in the treatment of hair loss, hair thinning, or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.
23. Services and supplies for smoking cessation programs and the treatment of nicotine addiction.
24. Compounded drugs that do not meet the definition of Compound Medications.
25. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.

PHARMACY BENEFITS

26. Prescription Orders for which there is an over-the-counter product available with the same active ingredient(s) in the same strength, unless otherwise determined by the Plan.
27. Retin A or pharmacologically similar topical drugs.
28. Athletic performance enhancement drugs.
29. Drugs to treat sexual dysfunction, including, but not limited to, sildenafil citrate (Viagra), phentolamine (Regitine), alprostadil (Prostin, Edex, Caverject), and apomorphine in oral and topical form.
30. Allergy serum and allergy testing materials.
31. Injectable drugs, except [Specialty Drugs or] those approved by the FDA for self-administration.
32. Prescription Orders which do not meet the required step therapy criteria.
33. Prescription Orders which do not meet the required prior authorization criteria.
34. Some equivalent drugs manufactured under multiple brand names. BCBSTX may limit benefits to only one of the brand equivalents available. If you do not accept the brand that is covered under this Plan, the Brand Name Drug purchased will not be covered under any benefit level. A list of brand or generic medications with lower cost therapeutic alternatives may exist. [Some drugs are manufactured under multiple brand names and have many therapeutic equivalents. Generic medications may also have several therapeutic equivalents. In such cases, BCBSTX may limit benefits to specific therapeutic equivalents. If you do not accept the therapeutic equivalents that are covered under your Plan, the drug purchased will not be covered under any benefit level.
35. Replacement of drugs or other items that have been lost, stolen, destroyed or misplaced.
36. Shipping, handling or delivery charges.
37. Nonsedating antihistamine drugs and combination medications containing a nonsedating antihistamine and decongestant
38. Drugs that are repackaged by anyone other than the original manufacturer.
39. Prescription Orders written by a member of your immediate family, or a self-prescribed Prescription Order.
40. Drugs determined by the Plan to have inferior efficacy or significant safety issues.

PHARMACY BENEFITS

Definitions

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

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

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

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

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

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

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

Covered Drugs means any Legend Drug:

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

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

Generic Drug means a drug that has the same active ingredient as a Brand Name Drug and is allowed to be produced after the Brand Name Drug's patent has expired. In determining the brand or generic classification

PHARMACY BENEFITS

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

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

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

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

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

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

Pharmacy means a state and federally licensed establishment where the practice of pharmacy occurs, that is physically separate and apart from any Provider’s office, and where Legend Drugs and devices are dispensed under Prescription Orders to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he practices.

Preferred Brand Name Drug means a Brand Name Drug which does not appear on the preferred Drug List as a Preferred Brand Name Drug and is subject to the Preferred Brand Name Drug Copayment. This preferred Drug List is available by accessing the website at www.bcbstx.com.

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

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

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

To determine which drugs are Specialty Drugs, refer to the Drug List which is available by accessing the website at www.bcbstx.com.

Specialty Pharmacy Provider means a Participating Pharmacy from which Specialty Drugs can be obtained.

COMPREHENSIVE DENTAL BENEFITS

BENEFITS PROVIDED

Benefits for the Covered Dental Expenses described in this Benefit Booklet are determined by the benefit categories listed below. The benefit percentage to be applied to each benefit category is shown on your Schedule of Coverage.

- Group I - Diagnostic and Preventive Care
- Group II - Basic Care
- Group III - Major Care

Your benefits are calculated on a Calendar Year benefit period basis unless otherwise stated. At the end of a Calendar Year, a new benefit period starts for each Participant.

DENTABLUESM DENTISTS

You have the freedom to go to either a contracting or non-contracting Dentist. You may limit your out-of-pocket expenses by choosing a contracting Dentist from the DentaBlue Directory.

When you receive care from a DentaBlue Dentist:

- Confirm the Dentist's continued DentaBlue participation at each visit.
- Ask about procedures for claim filing/payment policy.
- You are not responsible for charges that exceed the Allowable Amount.

You are responsible for:

- Deductible
- Coinsurance
- Services that are limited or not covered by the Plan.

HOW BENEFITS ARE CALCULATED

Your benefits are based on a percentage of the Dentist's Allowable Amount. To determine your benefits, subtract the Deductible (if not previously satisfied) from your Covered Dental Expenses, then, multiply the difference by the benefit percentage applicable to the benefit category. The resulting total is the amount of benefits available. The remaining unpaid expenses, including any excess portion above the Allowable Amount, will be your responsibility to pay to your Dentist.

DEDUCTIBLE

The Deductible shown on your Schedule of Coverage will be subtracted once during each Calendar Year from the total eligible Covered Dental Expenses incurred for that Calendar Year. It will apply to each benefit category, unless your Schedule of Coverage indicates it is waived for a particular benefit category. It will apply to each Participant. The following exceptions will apply:

1. If "Three-month Deductible Carryover" is shown on your Schedule of Coverage, any Covered Dental Expenses incurred during the last three months of a Calendar Year and applied toward satisfaction of the Deductible for that Calendar Year, may be applied toward satisfaction of that Deductible for the following Calendar Year.

COMPREHENSIVE DENTAL BENEFITS

2. When the total number of family Participants shown under “Family Deductible” on your Schedule of Coverage have each, individually, satisfied the Deductible for a Calendar Year, any other Participants under your coverage will not have to satisfy a Deductible for that Calendar Year.

ALLOWABLE AMOUNT DETERMINATION

In determining the Allowable Amount, the Carrier will consider such factors as your Dentist’s usual fee and fees charged by other Dentists in the area with similar training and experience and any special circumstances. The portion of the charges by your Dentist that exceeds the Allowable Amount of the Carrier will be your responsibility to pay to your Dentist. In other words, a certain amount of the Dentist’s charge may not be considered for benefits.

For purposes of this portion of the Plan, **Allowable Amount** means the maximum amount determined by BCBSTX to be eligible for consideration of payment for a particular service, supply or procedure. To calculate the Allowable Amount, the Carrier uses the most appropriate method in consideration of the Dentist and/or type of service.

In the instance or absence of a contract between the Dentist and the Carrier:

1. For certain Dentists contracting with the Carrier, Allowable Amount is based on the terms of the Dentist’s contract and the Carrier’s methodology in effect on the date of service. The methodology used may include relative value, resource-based relative value scales (RBRVS), global pricing, or a combination of methodologies.
2. For Dentists not contracting with the Carrier, Allowable Amount is based on the amount the Carrier would have paid for the same covered service, supply or procedure if performed or provided by a contracting Dentist.

Unless otherwise stipulated by a contract between the Dentist and Carrier:

1. For services performed in Texas, Allowable Amount is based upon the applicable methodology for Dentists in the same locale as described by the Carrier.
2. For services performed outside of Texas, Allowable Amount is based upon the applicable methodology for Dentists in the Dallas locale, or higher, if deemed appropriate by the Carrier.
3. For multiple surgical procedures performed in the same operative area, the Allowable Amount for all procedures combined will be the amount for the single procedure with the highest Allowable Amount plus an additional Allowable Amount for covered supplies or services.
4. When a less expensive professionally acceptable service, supply or procedure is available, the Allowable Amount will be based upon the least expensive service. This is not a determination of Dental Necessity, but merely a contractual benefit allowance.

PREDETERMINATION OF BENEFITS

Your Schedule of Coverage indicates a “Predetermination Amount.” If a Course of Treatment for non-emergency services can reasonably be expected to involve Covered Dental Expenses in excess of this amount, a description of the procedures to be performed and an estimate of the Dentist’s charge must be filed with and predetermined by BCBSTX prior to the commencement of treatment.

COMPREHENSIVE DENTAL BENEFITS

BCBSTX may request copies of existing x-rays, photographs, models, and any other records used by the Dentist in developing the Course of Treatment. BCBSTX will review the reports and materials, taking into consideration alternative Courses of Treatment. BCBSTX will notify you or the Dentist of the benefits to be provided under the Plan. Predetermination gives you and your Dentist the opportunity to know the extent of the benefits available and any cutbacks made in his charges before any dental procedures are done.

MAXIMUM DENTAL BENEFITS

Maximum Calendar Year Benefits

The maximum amount of benefits available for all combined Groups I, II, and III Covered Dental Expenses for a Calendar Year for any one Participant is the amount shown in your Schedule of Coverage. This Calendar Year maximum benefit does not include Group IV Covered Dental Expenses.

Maximum Lifetime Benefits

The maximum lifetime benefit available for any one Participant for Group IV Covered Dental Expenses is the amount shown in your Schedule of Coverage. This maximum lifetime benefit amount does not apply to Groups I, II, and III Covered Dental Expenses.

COVERED DENTAL EXPENSES

The Plan will provide benefits for the following Covered Dental Expenses, subject to the limitations and exclusions described in this Benefit Booklet. The benefit percentage applicable to each benefit category is shown on your Schedule of Coverage. If You are unable to undergo dental treatment in a dental office or under local anesthesia due to a documented physical, mental or medical reason, You shall have coverage for Medically Necessary, non-dental related services to the dental treatment.

Group I - Diagnostic and Preventive Care

- Routine oral examinations (limited to two in any 12-month period)
- X-rays - full mouth (limited to one in any 36-month period); bitewing (limited to four in any six-month period); other x-rays as necessary for diagnosis (except in connection with a program of orthodontics)
- Professional cleaning (limited to two in any 12-month period)
- Topical application of fluoride/sealants C fluoride application limited to two in any 12-month period and to Participants under 19 years of age; sealants limited to one lifetime sealant per tooth, permanent molars only, for Participants under 14 years of age.

Group II - Basic Care

- Emergency pain relief (limited to emergency treatment of an abscess or infection of the tooth or supporting structures)
- Extractions
- Fillings - amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations. Gold and baked porcelain fillings are not covered
- Space maintainers for Participants under 19 years of age
- Injection of antibiotic drugs
- Repair or recementation of crowns, inlays, onlays, bridgework, or dentures. Relining or rebasing of dentures more than six months after the denture was installed (limited to one service within any 36-month period).

COMPREHENSIVE DENTAL BENEFITS

Group III - Major Care

- Inlays, onlays, crowns and other Gold and baked porcelain restorations (but only when the tooth is damaged beyond restoration by a routine filling)
- Initial installation of bridgework (including inlays and crowns as abutments)
- Initial installation of partial or full removable dentures (including any adjustments during the six-month period following installation)
- Replacement of an:
 1. existing partial; or
 2. full removable denture; or
 3. fixed bridgework by a new denture or new bridgework; or
 4. the addition of teeth to an existing partial removable denture or bridgework.

Satisfactory evidence must be presented that:

1. Added teeth are required by the extraction of teeth after the denture or bridgework was installed; or
2. The existing denture or bridgework cannot be made serviceable and if it was installed under this Plan, at least five years have elapsed after its installation, or
3. The immediate existing temporary denture cannot be made permanent and its replacement occurs within 12 months of its installation.

Normally, dentures will be replaced by dentures, but if achieving a professionally acceptable Course of Treatment requires bridgework, such bridgework may be covered.

- Oral surgery, including biopsies of oral tissues
- General anesthesia, including I.V. sedation, when administered in connection with oral or maxillofacial surgery (excluding analgesia gases)
- Treatment of disease of the gums and related tissue
- Treatment of the tooth pulp, including root canal therapy and pulp vitality tests

DENTAL LIMITATIONS AND EXCLUSIONS

In addition to those benefit maximums and limitations described in the **Covered Dental Expenses** section, the benefits of the Plan are not available for any Covered Dental Expenses incurred:

1. In connection with an occupational illness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
2. For which benefits are, or could upon proper claim be, provided under any laws enacted by the Legislature of any state, or by the Congress of the United States, or the laws, regulations or established procedures of any county or municipality, except any program which is a state plan for dental assistance (Medicaid); provided, however, this exclusion shall not be applicable to any coverage held by the Participant for dental expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
3. As a result of disease contracted or injuries sustained as a result of war, declared or undeclared, or any act of war.
4. Primarily for cosmetic purposes, except for:
 - (a) Services provided for correction of defects incurred through traumatic injuries sustained by the Participant while covered under the Plan; or
 - (b) Covered orthodontic diagnostic procedures and treatment; or
 - (c) Services provided to a newborn child which are necessary for treatment or correction of congenital defects.
5. For which a benefit is not specifically listed on the Schedule of Coverage, or for procedures which the American Dental Association has not approved a specific procedure code.
6. For services provided or received for consultation purposes.
7. For replacement of dentures, removable or fixed prostheses, and dental restorations due to theft, misplacement or loss; or for replacement of dentures, removable or fixed prostheses, and dental restorations for any other reason within five years after receiving such dentures, prostheses or restorations.
8. For any full-mouth x-ray provided within three years from the date of the Participant's last full-mouth x-ray. Any bitewing x-ray or prophylaxis provided within six months of the previous bitewing x-ray or prophylaxis.
9. For which a professionally acceptable alternative Course of Treatment is more economical.
10. For personalized complete or partial dentures, overdentures and their related procedures, or other specialized techniques not normally taught in regular dental school classes.
11. For treatment provided before the Effective Date of a Participant's coverage or after termination of coverage under the Plan.
12. For appliances, restorations, or special equipment used to increase vertical dimension, correct or determine proper occlusion except as provided for under Comprehensive Dental Benefits; or to correct temporomandibular joint (TMJ) dysfunction or pain syndromes.
13. For the administration or cost of drugs and/or gases used for sedation or as an analgesia.
14. For which benefits are otherwise provided under *Inpatient Hospital Expense* or *Medical-Surgical Expense* coverages.
15. For treatment by other than a Dentist, except that x-rays, scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is provided under the supervision and guidance of the Dentist.
16. For prosthetic devices (including bridges), crowns, inlays, onlays, and the fitting thereof, or duplication of such devices, which began before the Effective Date of the Participant's coverage under the Plan.

DENTAL LIMITATIONS AND EXCLUSIONS

17. For replacement or repair of an orthodontic appliance.
18. For treatment provided through a medical department, clinic, or similar facility furnished or maintained by the Participant's Contractholder.
19. For which no charge is made; for which the Participant is not legally obligated to pay; for which no charge would be made in the absence of this or similar dental coverage; or "discounts" or waiver of a Deductible or Copayment.
20. For services or supplies which do not meet accepted standards of dental practice, including charges for services or supplies which are Experimental/ Investigational in nature or not fully approved by a Council of the American Dental Association.
21. For a duplicate prosthetic device, other duplicate appliances or duplicate dental restoration.
22. For dietary instructions or a plaque control program.
23. For services or supplies not Dentally Necessary.
24. For any charge:
 - (a) Resulting from the failure of a Participant to keep a scheduled visit with a Dentist;
 - (b) For completion of any insurance forms;
 - (c) For telephone consultations; or
 - (d) For records or x-rays necessary for the Carrier to make a benefit determination.
25. For a partial or full denture or fixed bridge which includes replacement of a tooth which was missing before the Participant was covered under the Plan, except replacement of a missing tooth extracted while covered under the Plan, which is not an abutment for a denture or fixed bridge installed during the preceding five years; provided, however, this exclusion shall not apply:
 - (a) If such partial or full denture or fixed bridge also includes replacement of a missing tooth which was extracted after coverage becomes effective under the Plan for such Participant;
 - (b) If the Participant has been continuously covered under a group dental care contract, which includes prosthetic benefits, held by the Contractholder with this Carrier for a period of 24 consecutive months following the Participant's Effective Date; or
 - (c) To Participants effective on the Effective Date of this Plan who were covered under a previous group dental care contract held by the Contractholder with another carrier immediately prior to the Effective Date of the Plan.
26. For implants.
27. For splinting of teeth, including double abutments for prosthetic abutments.
28. For prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
29. For any services or supplies not specifically listed as Covered Dental Expenses under this Contract.

GENERAL PROVISIONS

Amendments

The Plan may be amended or changed at any time by agreement between the Contractholder and BCBSTX.

Assignment and Payment of Benefits

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

Conformity with State Statutes

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

Disclosure Authorization

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

Incontestability

Except as to issues concerning nonpayment of Premiums due:

- The validity of the Plan may not be contested after the Plan has been in force for two years after its date of issue.
- In the absence of fraud, no statement made by any individual covered under the Plan relating to the individual's insurability may be used in contesting the validity of the coverage with respect to which the statement was made:
 - After the coverage has been in force before the contest for two years; and
 - Unless the statement is contained in written instrument signed by the individual making the statement.

GENERAL PROVISIONS

Rescission of Coverage

Rescission is the retroactive cancellation or discontinuance of coverage due to an act, practice, or omission that constitutes fraud or an intentional misrepresentation of a material fact by you or by a person seeking coverage on your behalf. Rescission is subject to 30 days' prior notification and is retroactive to the Effective Date. Please call BCBSTX at the toll-free number listed on the back of your Identification Card for additional information regarding your appeal rights concerning Rescission. If the decision to rescind coverage is upheld at the completion of the internal appeal process, external review by an Independent review organization may be requested. Rescission is subject to the Incontestability provision above.

Medicare

Special rules apply when you are covered by this Plan and by Medicare. Generally, the Plan is a Primary Plan until you have enrolled in Medicare due to attaining age 65 or for reason other than age. Upon enrollment to Medicare, Medicare is a primary plan and this Plan becomes a secondary plan.

Participant/Provider Relationship

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

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

Refund of Benefit Payments

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

If your group's benefit plan or BCBSTX pays benefits for Eligible Expenses incurred by you or your Dependents and it is found that the payment was more than it should have been, or was made in error ("Overpayment"), your group's Plan and BCBSTX have the right to obtain a refund of the Overpayment 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's benefit Plan and/or BCBSTX (in its capacity as insurer or administrator) have the right to deduct any refund for any Overpayment due, up to an amount equal to the Overpayment, from:

- (a) any future benefit payment made to any person or entity under this Benefit Booklet, whether for the same or a different Participant; or,
- (b) any future benefit payment made to any person or entity under another BCBSTX-administered ASO

GENERAL PROVISIONS

benefit program and/or BCBSTX-administered insured benefit program or policy; or,

(c) any future benefit payment made to any person or entity under another BCBSTX-insured group benefit plan or individual policy; or,

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

(e) any future payment owed to one or more Participating Providers or Out-of-Network Providers.

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

State Government Programs

1. If a Participant under the Plan is also a Medicaid recipient, any benefits for services or supplies under the Plan will not be excluded solely because benefits are paid or payable for such services or supplies under Medicaid. Any benefits available under the Plan will be payable to the Texas Department of Human Services to the extent required by the *Texas Insurance Code*; and
2. All benefits paid on behalf of a child or children under the Plan must be paid to the Texas Department of Human Services where;
 - a. The Texas Department of Human Services is paying benefits pursuant to provisions in the *Human Resources Code*; and
 - b. The parent who is covered under the Plan has possession or access to the child pursuant to a court order, or is not entitled to access or possession of the child and is required by the court to pay child support; and
 - c. The Carrier receives written notice at its Administrative Office affixed to the benefit claim when the claim is first submitted, that the benefits claimed must be paid directly to the Texas Department of Human Services.

GENERAL PROVISIONS

Subrogation

If the Carrier pays or provides benefits for you or your Dependents under this Plan, the Carrier 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 Carrier has paid or provided. That means the Carrier 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 Carrier) in the place of another (you or your Dependent) with reference to a lawful claim, demand or right, so that he or she who is substituted succeeds to the rights of the other in relation to the debt or claim, and its rights or remedies.

Right of Reimbursement

In jurisdictions where subrogation rights are not recognized, or where subrogation rights are precluded by factual circumstances, the Carrier 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 Carrier paid benefits under this Plan, you or your Dependent agree to reimburse the Carrier from the recovered money for the amount of benefits paid or provided by the Carrier. That means you or your Dependent will pay to the Carrier 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 Carrier.

Right to Recovery by Subrogation or Reimbursement

You or your Dependent agree to promptly furnish to the Carrier all information which you have concerning your rights of recovery from any person, organization, or insurer and to fully assist and cooperate with the Carrier in protecting and obtaining its reimbursement and subrogation rights. You, your Dependent or your attorney will notify the Carrier 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 Carrier to be limited or harmed by any acts or failure to act on your part.

GENERAL PROVISIONS

Coordination of Benefits

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

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

Coordination of Benefits – Definitions

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

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

Plan does not include:

- a. any coverage held by the Participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy;
- b. a policy of health insurance that is individually underwritten and individually issued;
- c. school accident type coverage; or
- d. a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

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

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

3. **Primary Plan/Secondary Plan**

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

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

4. **Allowable Expense** means a necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part by one or more Plans covering the Participant for whom claim is made.
5. **Claim Determination Period** means a Calendar Year. However, it does not include any part of a year during which a Participant has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.
6. **We or Us** means Blue Cross and Blue Shield of Texas.

GENERAL PROVISIONS

Order of Benefit Determination Rules

1. General Information

- a. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless (a) the other Plan has rules coordinating its benefits with those of This Plan, and (b) both those rules and This Plan's rules require that This Plan's benefits be determined before those of the other Plan.
- b. If this Contract contains any dental or vision benefits, the benefits provided by the health portion of this contract will be the Secondary Plan.

2. Rules

This Plan determines its order of benefits using the first of the following rules which applies:

- a. ***Non-Dependent/Dependent.*** The benefits of the Plan which covers the Participant as a Member 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 Member), then the benefits of the Plan covering the Participant as a Dependent are determined before those of the Plan covering that Participant other than a Dependent.
- b. ***Dependent Child/Parents Not Separated or Divorced.*** Except as stated in Paragraph c below, when This Plan and another Plan cover the same child as a Dependent of different parents:
 - (1) The benefits of the Plan of the parent whose birthday falls earlier in a Calendar Year are determined before those of the Plan of the parent whose birthday falls later in that Calendar Year; but
 - (2) If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

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

- c. ***Dependent Child/Parents Separated or Divorced.*** If two or more Plans cover a Participant as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - (1) First, the Plan of the parent with custody of the child;
 - (2) Then, the Plan of the spouse of the parent with custody, if applicable;
 - (3) Finally, the Plan of the parent not having custody of the child.

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

GENERAL PROVISIONS

- 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 Member.** The benefits of a Plan which covers a Participant as a Member or subscriber who is neither laid off nor retired are determined before those of a Plan which covers that Participant as a laid off or retired Member. The same would hold true if a Participant is a Dependent of a person covered as a retired Member and a Member. 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 a 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 a 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.

GENERAL PROVISIONS

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right to Recovery

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

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

GENERAL PROVISIONS

Coordination of Benefits

Coordination of Benefits (“COB”) applies when you have health care coverage through more than one Health Care Plan. The order of benefit determination rules govern the order in which each Health Care Plan will pay a claim for benefits. The Health Care Plan that pays first is called the primary plan. The primary plan must pay benefits in accord with its policy terms without regard to the possibility that another plan may cover some expenses. The Health care Plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans equal 100 percent of the total Allowable Expense.

For purposes of this section only, the following words and phrases have the following meanings:

Allowable Expense means a health care expense, including deductibles, coinsurance, and copayments, that is covered at least in part by any Health Care Plan covering the person for whom is made. When a Health Care Plan (including this Health Care Plan) provides benefits in the form of services, the reasonable cash value of each service rendered is considered to be both an Allowable Expense and a benefit paid. In addition, any expense that a health care provider or Physician by law or in accord with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

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

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

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

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

BCBSTX has the right to coordinate benefits between this Health Care Plan and any other Health Care Plan covering you.

GENERAL PROVISIONS

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

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

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

1. **Nondependent or Dependent.** The Health Care Plan that covers the person other than as a Dependent, for example as a member, policyholder, subscriber, or retiree, is the primary plan, and the Health Care Plan that covers the person as a Dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Health Care Plan covering the person as a dependent and primary to the Health Care Plan covering the person as other than a dependent, then the order of benefits between the two plans is reversed so that the Health Care Plan covering the person as a member, policyholder, subscriber, or retiree is the secondary plan and the other Health Care Plan is the primary plan. An example includes a retired member.
2. **Dependent Child Covered Under More Than One Health Care Plan.** Unless there is a court order stating otherwise, Health Care Plans covering a Dependent child must determine the order of benefits using the following rules that apply.
 - a. For a Dependent child whose parents are married or are living together, whether or not they have ever been married.
 - (i) The Health Care Plan of the parent whose birthday falls earlier in the Calendar Year is the primary plan; or
 - (ii) If both parents have the same birthday, the Health Care Plan that has covered the parent the longest is the primary plan
 - b. For a Dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:
 - (i) if a court order states that one of the parents is responsible for the Dependents child's health care expenses or health care coverage and the Health Care Plan of that parent has actual knowledge of those terms, that Health Care Plan is primary. This rule applies to plan years commencing after the Health Care Plan is given notice of the court decree.
 - (ii) if a court order states that one of the parents is responsible for the Dependents child's health care expenses or health care coverage, the provisions of 2.a. must determine the order of benefits.
 - (iii) if a court order states parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 2.a. must determine the order of benefits.

GENERAL PROVISIONS

- (iv) if there is no court order allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
- (I) the Health Care Plan covering the custodial parent;
 - (II) the Health Care Plan covering the spouse of the custodial parent;
 - (III) the Health Care Plan covering the noncustodial parent; then
 - (IV) the Health care Plan covering the spouse of the noncustodial parent.
- c. For a Dependent child covered under more than one Health Care Plan of individuals who are not the parents of the child, the provisions of 2.a or 2.b must determine the order of benefits as if those individuals were the parents of the child
- d. For a Dependent child who has coverage under either or both parents' Health Care Plans and has his or her own coverage as a Dependent under a spouse's Health Care Plan, paragraph 5. below applies.
- e. In the event the dependent child's coverage under the spouse's Health Care Plan began on the same date as the Dependent child's coverage under either or both parents' Health Care Plans, the order of benefits must be determined by applying the birthday rule in 2.a. to the dependent child's parent(s) and the Dependent's spouse.
3. **Active, Retired, or Laid-off Member.** The Health Care Plan that covers a person as an active member, that is, a member who is neither laid off nor retired, is the primary plan. The Health Care Plan that covers that same person as a retired or laid-off member is the secondary plan. The same would hold true if a person is a Dependent of an active member and that same person is a Dependent of a retired or laid-off member. If the Health Care Plan that covers the same person as a retired or laid-off member or as a Dependent of a retired or laid-off member does not have this rule, and as a result, the Health Care Plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if paragraph 1. above can determine the order of benefits.
4. **COBRA or State continuation Coverage.** If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another Health Care Plan, the Health Care Plan covering the person as a member, subscriber, or retiree or covering the person as a dependent of a member, subscriber, or retiree is the primary plan, and the COBRA, state, or other federal continuation coverage is the secondary plan. If the other Health Care Plan does not have this rule, and as a result, the Health Care Plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if paragraph 1. above can determine the order of benefits.
5. **Longer or Shorter Length of Coverage.** The Health Care Plan that has covered the person as a member, policyholder, subscriber, or retiree longer is the primary plan, and the Health Care Plan that has covered the person the shorter period is the secondary plan.
6. If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the Health Care Plans meeting the definition of Health Care Plan. In addition, this Health Care Plan will not pay more than it would have paid had it been the primary plan.

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

GENERAL PROVISIONS

secondary plan must credit to its plan deductible (if applicable) any amounts it would have credited to its deductible in absence of other health care coverage.

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

For purposes of this provision, BCBSTX may, subject to applicable confidentiality requirements set forth in this Plan, release to or obtain from any insurance company or other organization necessary information under this provision. If you claim benefits under this Plan, you must furnish all information deemed necessary by Us to implement this provision.

None of the above rules as to coordination of benefits shall delay your health services covered under this Plan.

Whenever payments have been made by BCBSTX with respect to Allowable Expenses in a total amount, at any time, in excess of 100% of the amount of payment necessary at that time to satisfy the intent of this Part, We shall have the right to recover such payment, to the extent of such excess, from among one or more of the following as We shall determine: any person or persons to, or for, or with respect to whom, such payments were made; any insurance company or companies; or any other organization or organizations to which such payments were made.

GENERAL PROVISIONS

Termination of Coverage

BCBSTX may discontinue offering Traditional Medical Benefit contracts to associations if, at least ninety (90) days before the date coverage will be discontinued, BCBSTX (1) provides written notice to each association and each Member covered under the contract being discontinued, (2) offers to the association the option to purchase any other health benefit plan currently being offered by the Carrier to associations; and (3) acts uniformly without regard to any health status-related factor of covered Members or Dependents or new members or dependents who may become eligible for the coverage.

BCBSTX may discontinue offering all health benefit plans offered to associations only, if at least 180 days before the date coverage will expire, BCBSTX (1) provides a written notice to the Commissioner of the Texas Department of Insurance, each association, and each covered Member (2) discontinues and does not renew all health benefit plans issued in this state to associations, and (3) acts uniformly without regard to any health status-related factor of covered Members or Dependents of covered Members, if Dependent coverage is offered, or new members or dependents who may become eligible for coverage.

Termination of Individual Coverage

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

1. Your premium is not received timely by Texas and Southwestern Cattle Raisers Association; or
2. You no longer satisfy the definition of a Member as defined in this Benefit Booklet; or
3. The Plan is terminated or the Plan is amended, at the direction of the Contractholder, to terminate the coverage of the class of Members to which you belong; or
4. A Dependent ceases to be a Dependent as defined in the Plan.

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

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

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

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

Termination of the Group

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

Extension of Benefits

If this Contract terminates (as described in the Contractholder's Contract), any Participant who is *Totally Disabled* on the effective date of the termination of the Contract shall be entitled to receive benefits as

GENERAL PROVISIONS

described in this Benefit Booklet, subject to the benefit limitations and maximums, for the continued treatment of the condition causing the *Total Disability*. Benefits will be available for the period of the *Total Disability* or for 90 days following the termination date of the Contract, whichever is less.

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

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

Total Disability or *Totally Disabled* means as applied to:

1. A Member, the complete inability of the Member to perform all of the substantial and material duties and functions of his occupation and any other gainful occupation in which the Member earns substantially the same compensation earned prior to disability; and
2. A Dependent, confinement as a bed patient in a Hospital.

GENERAL PROVISIONS

Continuation Privilege

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

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

1. The date the group coverage would otherwise terminate; or
2. The date the Participant is given notice of the right of continuation by the group Contractholder.

A Participant electing continuation must pay the amount of contribution required to the Contractholder, plus two percent of the group rate for the insurance being continued under the contract. The first payment must be made within 45 days after the initial election of coverage. All subsequent payments must be made no later than 30 days after the payment due date.

Continuation may not terminate until the earliest of:

1. The date on which the maximum continuation period is exhausted, which is:
 - a. For covered persons not eligible for COBRA continuation coverage, nine months after the date of state continuation coverage; or
 - b. For covered persons covered under COBRA continuation coverage, six additional months following any period of COBRA continuation coverage;
2. The date on which failure to make timely payments would terminate coverage;
3. The date on which the group coverage terminates in its entirety;
4. The date on which the covered person is or could be covered under Medicare;
5. The date on which the covered person is covered for similar benefits by another hospital, surgical, medical, or major medical expense insurance policy or hospital or medical subscriber contract or medical practice or other prepayment plan or any other plan or program;
6. The date the covered person is eligible for similar benefits whether or not covered therefor under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or
7. Similar benefits are provided or available to such person, pursuant to or in accordance with the requirements of any state or federal law.

Additional Continuation for Certain Dependents - State

If coverage terminates as the result of a Member's death, retirement, or divorce, a Dependent's coverage can continue. The Dependent must have been covered under the Contract for at least one year, except in the case of a Dependent who is an infant under one year of age. Continuation does not require evidence of insurability.

In addition, continuation is not available when coverage terminates due to any of these circumstances:

GENERAL PROVISIONS

1. The Contract is canceled; or
2. The Dependent fails to make any timely premium payments.

Continuation ends after the earliest of the following:

1. The third anniversary of the severance of the family relationship or the retirement or death of the Subscriber;
2. The insured fails to make premium payments within the time required to make the payments;
3. The insured becomes eligible for substantially similar coverage under another plan or program, including a group health insurance policy or contract, hospital, or medical service subscriber contract, or medical practice or other prepayment plan; or
4. The Contract is canceled.

Notification Requirements

The Dependent must notify the Carrier within 15 days of the Member's death, retirement, or divorce. The Carrier will immediately provide written notice to the Dependent of the right to continue coverage and will send the election form and instructions for premium payment.

Within 60 days of the Member's death, retirement, or divorce, the Dependent must give written notice to the Carrier of the desire to exercise the right of continuation or the option expires. Coverage remains in effect during the 60-day period provided premium is paid.

AMENDMENTS

NOTICES



**BlueCross BlueShield
of Texas**



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